

VALUE IN NORTHEAST OHIO

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Jackknife Ahead

The Teamsters Central States Pension Fund is on the critical list. As of December 31, 2007 it reported an Unfunded Vested Benefit liability of \$13.7 billion. Given last year's investment performance, -29.81% it will grow significantly.

The fund already is in "critical status" based upon their actuary's report dated 3/24/2008 and the succeeding report dated 3/31/09.

Multi-Employer pension funds have a structural problem that needs to be addressed. One an employer fails, the remaining employers in the fund pick up the cost of the failed company's employees. There is no Pension Benefit Guaranty Corporation (PBGC) contributions made by the companies, no benefits paid by PBGC, and no adjustment of benefits to the retirees in the wake of the failure.

The deregulation of the trucking industry created new non-union companies that have lower cost structures. Companies in the Central States Fund have failed leaving the burden on the remaining participants.

United Parcel Service saw the direction this was heading and bought their freedom for \$6.1 billion in 2007. Their employees are

no longer part of the Central States Fund.

YRC (the combination of Yellow Freight and Roadway) was kicked out of the fund on July 16 because of their inability to meet their contribution obligations. YRC was the largest employer in the fund at the start of this year. In an interesting twist, because of YRC's intention to return to the fund in 18 months the trustees of the Central States Fund voted not to treat this as "complete and permanent." The ramifications is that doing so would trigger a withdrawal liability. It is also not treating it as a "Rehabilitation Withdrawal" which would reduce benefits to YRC beneficiaries.

YRC was scheduled to resume payments to the fund as of January 15, 2010, but because of concessions by other creditors this will not occur. As I am writing, YRC is trading at \$1.02 giving it a market capitalization of \$60 million. The book value at 9/30 was -\$225 million and their most recent quarter's net income was -\$159 million and operations used up \$72 million. The chances of a YRC liquidation are rising which will force recognition of YRC's unfunded liabilities.

The fund is trying to get back within IRS funding guidelines by imposing 8% annual



Jackknife Ahead, Continued

increases on contributions for the next five years. This will not help YRC or the other Central States members and will likely help cause additional failures. The current economic environment will cause some failures as well. The result will be fewer companies bearing a greater unfunded burden.

Will the Central States Pension Fund fail? I think without governmental intervention the answer increasingly appears to be yes. The increasing contribution requirements fueling more failures which will require still higher contributions is a readily foreseeable scenario. The timing of the failure is beyond me to predict.

So who should pay the freight (I couldn't resist)? Clearly having the surviving companies bearing the entire liability burden won't work. The remaining companies are incurring excessive costs that are only their fault insofar as their successful operations help drive under their competition.

The retirees could pick up some of the costs. This happens now when compa-

nies go bankrupt. The PBGC does not pay 100% of the promised benefits. If it is shared across all retirees in a bargaining unit it has some of the insuring characteristics that the employers have.

This leaves retirees at risk of having diminishing incomes as they get older which may put them in a difficult financial position or needing varying degrees of public assistance.

Should the government get involved? I think that it wouldn't be unreasonable that when companies fail the PBGC would contribute what they would have paid had the companies had stand-alone pensions. That would also require the multi-employer plans to make PBGC contributions.

Investors should be aware of the exposure a company has to multi-employer pension plans. These are disclosed in the notes to financial statements. Also remember that, as we have seen with the Central State Fund, these amounts may not fully reflect the true exposure these companies have.



Healthcare Reform Myth #1

Open up competition by allowing people to buy insurance from companies in other states will drive down premiums.

This sounds reasonable enough. Increased competition restrains profit margins. There would be greater choice in coverage. People may be able to

choose levels of coverage that may better suit their needs and economic circumstances.

Yet it ignores a couple factors that make this undesirable. First, insurance is regulated at the state level. Because of this, the various state governments



Myth #1, Continued

pass rules and regulations that prescribe policy features and underwriting rules that apply to policies sold in their state. Allowing people to buy policies based on rules in place in another state would strip state government of this authority.

Secondly, while there are costs to insurance companies getting licensed and their policy forms approved in other states, these costs are small, particularly in a line of business as large as health insurance. I worked at PIE Mutual which was licensed in a dozen states and wrote \$190 million in premium. To put this into some perspective, Medical Mutual wrote almost \$2 billion in Ohio alone in 2008. It makes little sense to presume that regulatory barriers are what prevents larger number of insurance companies from competing in a given market.



So why are there so few choices? I believe the answer is that a significant source of competitive differentiation is the ability to negotiate favorable rates with healthcare providers. The insurers leverage in these negotiations in part is the size of their base of insureds. A company with 25% of the market has considerable leverage or else the provider risks losing a substantial source of business. A small company lacks that kind of clout.

And who has the best negotiated rates? Medicare and Medicaid do. They control an enormous portion of the healthcare purchases so even though their reimbursement rates are frequently viewed as inadequate most providers continue to accept those patients because the alternative is disastrous. It's tough to walk away from half your business.

Those of us with insurance benefit as much from the negotiated rates as the actual indemnity payments. Frequently my bills are cut in half because I am insured. Those without insurance face scary prices, although in many instances those can be negotiated down with the provider.

The structure of the healthcare marketplace makes having large numbers of insurance companies a near impossibility. Company may have some good rates with doctors in Pittsburgh, but who is going to drive their to take advantage? People predominantly buy healthcare where they live. The small carriers on average will have higher prices due to their lack of negotiating clout and that ultimately will render them uncompetitive.

Aside from infringing upon the states' ability to regulate the insurance industry the competitive impact of allowing interstate competition will be short-lived at best.

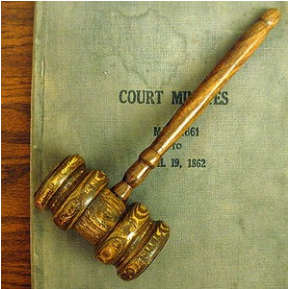
Healthcare Reform Myth #2

I sent the following as a letter to the editor of the Ohio Society of CPA's Voice publication:

I used to be in charge of accounting for the

largest medical malpractice insurer in Ohio. During my tenure I heard arguments about how tort reform would lower health care costs. I was always doubtful of that position because the national market

Myth #2, Continued



for medical malpractice insurance at that time amounted to about \$5 billion, far less than 1% of aggregate health care spending at that time. Today the cost of tort liability is significantly higher as premiums have almost doubled, large institutions that self-insured are not included in the \$5 billion figure, and there is the nebulous issue of “defensive medicine.”

In Ohio we have had significant tort reform starting in 2003. Over the past four years malpractice premiums charged by the largest carriers in the state have eased each year with an aggregate reduction of about 15% since 2005. While there are some competitive market conditions that have contributed to the decline, there is little doubt that tort reform has played a part.

Yet in spite of the reductions to malpractice costs, health insurance costs continue to grow far faster than inflation. My personal health insurance has gone up by about 60% since 2007, without my costing my carrier virtually any indemnity payments, and with neither my wife nor I crossing any major age category threshold or having changes in our medical conditions. Unless we are unique in our health insurance purchasing experience, the quantitative evidence strongly indicates that tort reform as a method to slow the increasing cost of healthcare is a failure.

A simple analysis of the economics would explain why tort reform doesn't affect the cost of healthcare. On the demand side, when people buy healthcare they are usually completely unaware of the cost of the

services they are purchasing, except for maybe the most routine office visit. This fundamentally rules out any arguments about efficient markets. In addition, most purchasers of healthcare do not directly pay for what they purchase beyond the co-payments and deductibles in their policies. Except for those people with high deductibles, there is little relationship to what they pay out of pocket and the cost of what they are buying if they have any hospitalization or significant drug or other therapy regimen. The consumer is largely insulated from the cost of their healthcare purchasing decisions.

The supply side view has hospital systems continuing to build, expand and consolidate, and most doctors that I know are not short of patients. The healthcare providers are getting squeezed by Medicaid and Medicare on their reimbursement rates. They are raising their rates for private insurance and everyone else to compensate for this. Healthcare is not like most other industries that have to absorb some of the costs of government mandates or rising costs because healthcare supply currently cannot keep up with demand. If malpractice premiums go down, hospitals will be more profitable and doctors will make more, but the consumer will continue to bear the burden of rising unit consumption and the higher per unit costs that follows.

I have seen attempts at putting a figure on the cost of defensive medicine, but any specific figure is merely opinion masquerading as fact. As an example if a person comes into an emergency room and has a



Myth #2, Continued

\$150 test performed where it has a 1 in 1,000 chance of finding a serious problem is that good medicine or defensive. What if the odds are 1 in 10,000 or the test is \$25 or \$1,500? What is the cost of missing the diagnosis: surgery, pain, loss of work, death? Ultimately we are dealing with shades of gray, which is why precise figures should be viewed with suspicion.

The need for tort reform in Ohio was because liability costs were rising at double digit rates for the prior decade or two. The cost of insurance was driving some physicians to retire or leave the state. National tort reform may address some of the retirements attributable to perceived rising liability costs, but would not make a difference as far as where doctors

would practice unless they plan to go to Mexico or Singapore. It is somewhat ironic that the same politicians that frequently grouse about eroding state rights versus expanding federal authority are advocating this expansion of federal authority.

Tort reform as a method to reduce health-care costs is as phony as a \$3 bill. The economic forces driving up the aggregate cost of healthcare costs are far too large relative to tort reform. Unless the supply/demand balance changes dramatically, any changes in the cost liability insurance or self insurance will be retained by the providers. I'm afraid that the advocates of national tort reform are more motivated by partisan politics than public policy.

Healthcare Reform Myth #3

An insurance company sponsored by the federal government is a good idea!!!? I suppose given the recent success of the Fannie Mae and Freddie Mac, not to mention the U.S. Postal Service and Medicare and state run institutions like the Ohio Bureau of Workers Compensation and Michigan Catastrophic Claims Association that people would conclude that government run businesses would be best (I probably should use a different font for sarcasm).

As I said in Myth #1, leverage is required to negotiate the best rates with healthcare providers. And we have already seen that the Federal government has the best leverage of all. Access to a large insured base, no profit or capital requirements, and unlimited borrowing capacity and you have an unbeatable monster. Private companies will lose leverage and pay higher prices to compensate for pro-

viders' loss of revenue from Public Option.

The fear of opponents of the Public Option is that it will ultimately destroy private insurance and become the Only Option. Any promises that it is not the intention of the Congress cannot be relied upon because 1) it probably is the intention and 2) future Congresses may not respect that commitment (remember the Gramm-Rudman-Hollings Balanced Budget Act?)

Insurance companies, like plaintiff attorneys, make easy punching bags for partisan politicians. For example, Wellpoint, one of the largest health insurers, had \$60 billion in revenue and made almost 4% as net profit. That level of margin cannot be the driving force behind rising health costs as much as some folks would like you to believe it is.



Healthcare Reform Partial Solutions

To truly reform the healthcare system will require making difficult choices, something people in Washington D.C. avoid like the plague. Currently the philosophy is that every person is entitled to the worlds greatest healthcare regardless of cost. That philosophy is why we see ever expanding costs.

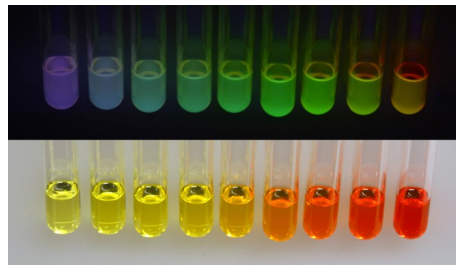
My experience is that if people are connected to the costs of their healthcare decisions they will generally make more cost effective ones. I have HSA coverage and use a pill splitter to cut 10 mg Singulair tablets into the 5mg doses prescribed and cutting my cost in half in the process. When I experience abdominal pain I went to the Urgent Care Center, not the Emergency Room.

While I am not looking to fault the Insurance Industry, I think there is an overdependence on insurance that insulates people from directly experiencing the cost of their decisions. Compare a person's behavior at a Chinese restaurant when they order each item individually as opposed to how they eat at the Chinese buffet. The food is probably better at the restaurant yet they eat more food at the buffet.

I would legislate that there should be copayments through a higher maximum. The copayment percentage does not need to be very high, maybe 20% up to \$5,000 and maybe 10% up to \$20,000. That should include prescriptions.

Obesity is considered a significant factor driving up healthcare utilization. I would add an additional copayment for obese people being treated for conditions correlated to obesity (which, at the moment, would include myself). This provides financial incentive to lose the weight and is better than taxing soda and snacks, products that have been around for over 100 years and penalizing non-obese and healthy users equally in the process.

The difficult part is dealing with people that can't afford to pay and the Medicaid system. I am afraid that we cannot park a Cadillac in everyone's garage anymore than we can pay for indigent care as we are. This a difficult area that requires vision and courage as well as sensitivity. The solution will need sacrifices both from the taxpayers and the beneficiaries.



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