The HMOs in Philadelphia

The major HMOs in the Philadelphia metropolitan region (including Bucks, Chester, Delaware, Montgomery and other continguous counties), as of the third quarter 1995, ranked by percentage of market share (of HMO enrollees), are:

1. U.S. Healthcare (HMO of Pennsylvania), 43%; Aetna, 8% (as of 1996, Aetna owns U.S. Healthcare)
2. Keystone East (Independence Blue Cross), 33%
3. Health Partners, 5%
4. Greater Atlantic, 5%
5. Oaktree, 3%
6. CIGNA, 2%
7. PruCare Philadelphia, 2%

U.S. Healthcare, Inc., based near Philadelphia, in the town of Blue Bell, merged earlier this year with Aetna Life & Casualty Co., in an $8.9 billion deal, to form one of the nation's largest HMOs. The new firm now accounts for well over 50% of all HMO enrollees in the greater Philadelphia region. HMO strategists now project that Philadelphia would "need" only 1.91 beds per 1,000 if 100% HMO "managed care" took over the "market." (Estimate from *Hospitals and Health Networks,* Oct. 5, 1994.)

U.S. Healthcare, Inc. makes big bucks

U.S. Healthcare, Inc. had an average return-on-equity rate of 37.4% over a five-year period, ending 1993, the highest for all HMOs in the nation. This reflects the aggressive HMO enrollment, severe cost-cutting, and limiting of care. The founder and chief executive of U.S. Healthcare, Inc., Leonard Abramson, is now one of *Forbes* magazine's 400 richest men in America. Abramson's total compensation from U.S. Healthcare, Inc. in 1994, for example, was $3.87 million. According to *Washington Post* coverage of the merger, the filing with the Securities and Exchange Commission shows that Abramson "will gain a $1 billion bonus as a result. In addition, Abramson has a $10 million, five-year consultant contract that does not call for him to work full-time." In describing the Aetna-U.S. Healthcare, Inc. merger, the *Philadelphia Inquirer* on April 2, 1996 noted, "The end result will be fewer players—hospitals, doctors and insurers."

TABLE 1
The top managed-care firms
(ranked by enrollment, as of Jan. 1, 1995)

	No. of plans	Enrollment (millions)
1. Blue Cross and Blue Shield Association	80	8.118
2. Kaiser Foundation Health Plans Inc.	12	6.666
3. United Healthcare Corp.	20	2.548
4. Prudential Health Care Plans Inc.	32	1.810
5. U.S. Healthcare	9	1.793
6. Humana, Inc.	16	1.754
7. FHP Inc.	11	1.753
8. Health Systems International Inc.	7	1.544
9. PacifiCare Health Systems Inc.	6	1.496
10. Cigna Healthcare Plans Inc.	37	1.282
11. Aetna Health Plans	24	1.230
12. Health Insurance Plan of Greater New York	3	1.131
13. Foundation Health Corp.	6	.942
14. Sanus Corp. Health Systems Inc.	5	.839
15. Group Health Cooperative of Puget Sound	2	.644
16. Metra Health	22	.640
17. Physician Corp. of America	5	.577
18. Harvard Community Health Plan	1	.570
19. Mid-Atlantic Medical Services Inc.	1	.543
20. Oxford Health Plans Inc.	3	.534
21. Healthsource Inc.	14	.510
22. Principal Health Care Inc.	16	.492
23. Coventry Corp.	4	.469
24. Henry Ford Health Care Corp.	1	.429
25. Heritage National Healthplan Inc.	2	.296

Source: The InterStudy Competitive Edge (Minneapolis, Minn.); cited in *Managed Healthcare,* December 1995.

'Managed care' boosts profits for insurers

by Anthony K. Wikrent

Among the top 25 "managed care" firms in the United States as of 1995 (**Table 1**), are some of the most prominent names in "Big Insurance"—Prudential, Aetna, Metropolitan Life, CIGNA—all part of the international financial aristocracy that has positioned itself to make huge profits by looting the economic base of the nation.

The system of health maintenance organizations (HMOs) evolved over the 1970s-90s, the 30-year "post-industrial" policy shift, as enabling legislation was rammed through favoring the financial interests behind HMOs. In 1988, private insurance companies were granted the right to directly own and operate "managed care" health services, instead of to run them through "fronts" and subdivisions. Then, in the 1990s, a wave of mergers and takeovers occurred among the giants in "managed care," creating even bigger, new companies, making profits off the managed care system of limiting medical treatment, bullying medics, hospitals, and nurses, and courting new enrollees.

Executives and stockholders of HMOs have been making a killing—literally. One of the most egregious examples of HMOs reaping riches while the Grim Reaper grins, is Leonard Abramson, who calls himself just a "former Philadelphia pharmacist." Abramson is the head of US Healthcare, Inc., which merged earlier this year with Aetna, to create the third largest HMO in the nation.

In the early 1970s, Abramson became the vice president for corporate development at R. H. Medical, Inc., a small company that managed hospitals. Abramson devised practices

that were the forerunners of today's "managed care." Abramson left to start US Healthcare, Inc., with $3 million in start-up money in the form of loans from the federal government. In 1981, Abramson discarded the non-profit status of US Healthcare, and in 1983, transformed it into a publicly traded company.

The results have been extremely lucrative for Abramson. US Healthcare became the fifth largest HMO, with nearly 1.8 million enrollees by January 1995; in 1995, it had $380.6 million in profits on $3.6 billion in revenue. The Sept. 22, 1995 *New York Post* reported that Abramson, founder and chairman of US Healthcare, was paid $3.85 million in salary and bonuses in 1994, and by September 1995, held company stock options worth $1.8 million and 1.88 million shares worth $63.2 million. In addition, US Healthcare paid $800,000 in salaries and bonuses to his two daughters and a son-in-law. One of Abramson's benefits was that the company paid the $405,177 premium for his life insurance.

The same year, the U.S. government paid $178.4 million to US Healthcare for its Medicare enrollees, and another $62 million for Medicaid enrollees.

'US Healthcare is a bank'

One Wall Street analyst, who reviewed the financial position of the company, noted holdings of $1.13 billion in liquid cash and short-term securities, and exclaimed, "US Healthcare is essentially a bank. They are a bank!" The analyst said that the company's 13.15% profit rate on $2.876 billion in premium revenues was "three times the average for computers and peripherals, three times apparel, more than two times chemicals and mining and food."

According to the *Post,* Abramson was the sixth best paid HMO executive that year. The average cash and stock awards to top executives of the seven biggest for-profit HMOs, the *Post* calculated, was $7 million in 1994. The eighth best paid HMO executive in 1994 was Steven Wiggins, founder and CEO of Oxford Health Plans, who was paid $857,000 in salary and bonuses, and had $35.5 million worth of stock options. He also held 1.372 million shares of Oxford, worth $97.2 million.

In April 1996, it was announced that US Healthcare would merge with Aetna Health Plans, the 11th largest HMO, to become the third largest HMO, after the Blue Cross and Blue Shield system, and Kaiser Permanente. The payoff for Abramson is staggering—almost $1 billion in cash and Aetna stock, one of the largest financial payoffs ever given an individual in a single transaction.

According to a July 19, 1996 filing with the Securities and Exchange Commission, Abramson holds 15.755 million shares of US Healthcare stock, each share of which Aetna will exchange for $34.20 in cash; 0.2246 shares of Aetna common stock; 0.2246 rights to Aetna common; and 0.0749 shares of Aetna preferred C stock. At a market price on Oct. 7 of $70 for Aetna common, and $73 for Aetna preferred, Abramson will receive: $247.66 million worth of Aetna common, $86.14 million worth of Aetna preferred, and $538.85 million in cash. Abramson will receive more, if Aetna's stock price goes up, and depending on what the value of the rights is.

Time magazine on April 15, 1996 reported that 14.5¢ of every dollar US Healthcare takes in goes to administration, and another 10.5¢ goes to profit, "an interesting contrast to the 2¢ of every Medicare dollar that goes to administrative costs." Thus, only 75¢ of every dollar paid to US Healthcare, actually goes for medical care.

But as HMOs reach the saturation point of signing up only healthy people, and more of their enrollees become elderly and require more costly care, profit margins are being squeezed. That makes Wall Street decidedly unhappy. In mid-September, Salomon Brothers advised clients: "We expect the HMO industry will undertake a number of steps to reduce the higher medical costs that have plagued the industry this year."

Expert Testimony

If nurses are fired, patients will die

The following testimony, by Laura Gasparis Vonfrolio, was delivered on Sept. 12, 1996 at a hearing of the Pennsylvania House of Representatives Committee on Health and Human Services. Vonfrolio has been a nurse for over 20 years, holding positions from staff nurse to tenured professor of nursing. She is currently editor of Revolution—The Journal of Nurse Empowerment, *a national nursing journal, and travels throughout the United States lecturing to over 40,000 nurses annually. Vonfrolio made the testimony available to* EIR, *which we have excerpted below.*

I am very concerned about the delivery of health care. It is said that when health care becomes a primary threat to quality patient care, advocacy by necessity must move from the bedside into the political arena. . . .

There is a redesigning in the delivery of health care in the name of profit. Hospitals are initiating a radical de-skilling of nursing, concealed under phrases such as "patient-driven health care," "patient-focussed care"—and giving unlicensed personnel titles such as "patient care assistants" and "patient care technicians." These are labels cleverly designed to give the appearance of improving care, when they in fact are about improving profitability.

Hospitals are restructuring, downsizing, rightsizing, in order to provide a cost-effective delivery of health care at the expense of patient safety. According to a June 1995 Hospital