PNHP-CT, PNHP @ YALE, AND H-PAT PRESENT:

STICKER SHOCK:

BRADY AUDITORIUM
310 CEDAR ST, NEW HAVEN, CT
MONDAY NOV 1, 6.00 PM

ON THE ILLUSIONS OF HOSPITAL COSTS AND ACCOUNTING FROM A CPA

LYNN PETROVICH, CPA MBA

Lynn, aka "The Green CPA," runs a year-round tax clinic in a low-income community at the Jersey Shore where she meets "the most wonderfully diverse and engaging citizens of this nation." Recently, she authored a widely-acclaimed op-ed titled featuring her personal experience and befuddlement with hospital accounting practices. Catch the op-ed at http://commonsense2.com/2010/09/health-care/hospital-accounting-its-complicated/

Sticker Shock: Nonprofit Hospital Accounting Practices – A Rip-off Report
Why we desperately need Universal Single-Payer Health Care

Introduction

Inevitably someone you know will be hospitalized at some time in their life; and the days, weeks, or even months that follow can be a stressful, worrisome time for family and friends. Once the patient is discharged, there's usually an overall sigh of relief as they attempt to return to daily activities which often include rehabilitation. What patients don't realize is that while they're seeking normalcy, a series of events are unfolding in the hospital's accounting department that are aggressively dysfunctional. I call this process "The Preparation of The Ever-Lovin' Hospital Bill by Systematically Categorizing Patients into (1) Those Who Have Some Ilk of Health Insurance and (2) Everyone Else".

Ask any American to explain how their hospital invoice was calculated and you'd probably see scratching of the head, confusion, and silence - because they have absolutely no idea. No one outside the hospital's accounting department, executive council, and board of directors has the "insight" into how the bills are determined.

That is on purpose.

Most nonprofit hospitals pride themselves on presenting invoices to patients containing numbers which are not only ridiculous (does the hospital room *really* cost $8,600 per night?) but something seen in Marx Brothers' films:

> "Why, a four-year-old child could understand this report.
> Run out and find me a four-year-old child. I can't make heads or tails out of it."
>
> Groucho Marx
> *Duck Soup*

This practice, referred to by those who represent patients' rights, as "wallet-ectomies", is not only prevalent, premeditated, and perverse but is purposely purported to confuse patients – as they're recovering *from illnesses or injuries so severe they required hospitalization!* Why? So patients will pull out their checkbooks, credit cards, or dip into pension funds and pay the damn bill…get rid of it…and move on.

If patients, however, can *not* afford the sticker price, well, watch out. They are in for the most repulsive financial ride of their lives despite the fact that (1) nonprofit hospitals' mission statements are to serve the poor and indigent *regardless of ability to pay,* and (2) *these nonprofit hospitals receive very special tax considerations for this privilege.*

If you are poor, uninsured, or under-insured, nonprofit hospitals will try every trick in the book to take you to the cleaners. The purpose is twofold: As a warning to stay away from the hospital and to extract as much money *as possible* to pay for the extravagant compensation packages of those at the top. This financial ransom, *a practice among almost every nonprofit hospital in America*, will make you sick and disgusted. I suggest you have a ready supply of non prescription antacid available before continuing with this report, Sticker Shock.

Lynn M. Petrovich, CPA, MBA

Sticker Shock: Nonprofit Hospital Accounting Practices – A Rip-off Report
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Executive Summary

- Nonprofit hospital billing practices are designed to confuse and confound patients, obscure the true costs of services rendered, while enhancing the outrageous compensation, severance, bonus, and perks of executives at the top of the organizations.

- Nonprofit hospitals aggressively pursue the poor, uninsured or under-insured patients for puffed up hospital invoices - which are often 10 or *twenty* times the cost of services rendered. Hospitals spend millions on advertisements, media events, so-called "charity" balls, photo ops, payments to already wealthy athletes for their endorsements, private country club memberships, low-interest personal home mortgage loans and other financial rewards to a select few – economic incentives directly tied to maximizing the bottom line.

- Nonprofit hospitals have hundreds of millions or *billions* in surplus fund balances – money which is legally required to be used for their mission statements – but which instead sits as cash in the bank as they pursue the poor for unpaid bills.

- Charity Care, a state-run bureaucracy, forces patients to jump through numerous, time-consuming, ineffective, and costly hoops in order to prove they are too poor to pay for the medical care they desperately needed. After the dust settles, many who "qualify" for this program end up paying outrageous "co-payments" anyway in the thousands of dollars.

- The Patient Protection and Affordable Care Act (PPACA), signed into law in March 2010 by President Obama is a bloated, cumbersome, bureaucratic nightmare, a gift (on a silver platter) to the for-profit health insurance industry and does nothing to address, curb, curtail, or halt the abusive practices at nonprofit hospitals. In fact this legislation makes things worse by exposing more patients to nonprofit hospital practices.

- Universal Single Payer Health Care – also known as improved and expanded Medicare for all – is an affordable, common-sense solution to America's health care crisis and specifically addresses the abuses at nonprofit hospitals, curtailing or stopping them. It is a sane, effective plan – already in place in over 30 countries – equitably distributed, and offering billions of dollars in health care savings annually. It is womb to tomb coverage.

Lynn M. Petrovich, CPA, MBA

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Author's Note

Sticker Shock is intended to be a wake up call to Americans about the grossly abusive practices of nonprofit hospitals – organizations which are given special tax exemptions by the Internal Revenue Service – and as a result are subsidized by taxpayer dollars. It is not intended to malign any employee of nonprofit hospitals. To the contrary, its intention is to magnify the premeditated inequalities, the self-serving policies and procedures, and the priorities which protect (and continually enhance) the outrageous compensation packages and perks of those at the very top - at the expense of patients, employees, communities, and the taxpayers.

For the past decade as a CPA, each tax season I've dedicated at least half my time preparing personal income tax returns pro bono at clinics in low-income communities at the Jersey Shore. I've seen countless W-2 statements and prepared hundreds of returns for hospital orderlies, nurses, custodians, administrative and billing clerks, those working in the morgue, the laundry, and maintaining the OR. Their wages are almost always a pittance of what those at the top pull in year after year.

These abusive practices at nonprofit hospitals grossly contribute to America's health care disaster, a crisis which is costly, redundant, dysfunctional, inequitable and fractured beyond any help. The only solution is the implementation of a sane, simple, savings-oriented, unbiased system known as Universal Single-Payer Health Care.

It is my hope that Sticker Shock will help guide Americans on how they can stop the madness occurring at nonprofit hospitals, empowering them to take control of the reins, not only of their own health care costs, but passing along this information to other citizens for their consideration as well.

Lynn M. Petrovich, CPA, MBA

Disclaimer

Significant efforts have been made to insure accuracy. The author of this report has relied upon publicly available information filed by hospitals to the Internal Revenue Service as required by tax code. Those submitted forms were then compiled by **GuideStar USA, Inc**., an entity which makes available to the public, information on more than 1.7 million IRS-recognized nonprofit organizations. **GuideStar** is a neutral source of nonprofit information and does not rate or rank the organizations in its database.

Additional publicly-obtained information contained in this Report is listed in the References.

The author disclaims any liability arising from inaccurate information, or information which has been revised, or rescinded by individual hospitals.

Interpretative opinions are those of the author.

To report an error, please contact Lynn Petrovich, MBA, CPA at TheGreenCPA@aol.com.

TABLE OF CONTENTS

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Almost anyone who has ever received an invoice for services from a hospital can attest to surprise, confusion, and then after reviewing the bill – **shock** - at what they are being asked to pay. Within the past year, a family member had to go into the hospital and was discharged after a total of 37 hours. The bill presented to us by Monmouth Medical Center, a nonprofit hospital located at the Jersey Shore, totaled $16,808 including such brazenly billed items as $8,786 for the hospital room (one night), $2,609 for the emergency room (2 hours) and $368 for *one* X-ray. After paying the deductible, our insurance company remitted - and the hospital accepted as full payment - $2,739. That's it.

Which begs the question: Which was the cost of services rendered, $16,808 or $2,739?

As a CPA, concerned community citizen/activist, and a passionate advocate for Universal Single-Payer Health Care, I spent the last year trying to get an answer to this question from the hospital: *What was the cost of services rendered $16,808 or $2,739?*

I contacted the hospital's executive director, accounting department, collection agency, the City's mayor and council, local State representatives, professional peers and colleagues, all to no avail. I can attest firsthand nonprofit hospitals are anything but transparent and are extremely reluctant to respond to *any* inquiry.

I. An American Challenge

So I was challenged to initiate my own investigation into nonprofit hospital accounting practices.

> What I found was not only shocking, but borders on illegal, grossly dishonest, and unethical behavior which leaves the most vulnerable – *that is, those they profess to be serving first and foremost* – beaten down, battered, intimidated, chronically sick, and **Bankrupt**.

II. Health Care in America Today

According to a report published in March 2010 by the Kaiser Health Institute www.kaiseredu.org (KHI), in 2008 health care expenditures in America surpassed $2.3 billion "more than three times the $714 billion spent in 1990 and over eight times the $253 billion spent in 1980".

KHI further stated

> "In 2008, US health care spending was about $7,681 per resident and accounted for 16.2% of the nation's Gross Domestic Product (GDP); this is among the highest of all industrialized countries. Total health care expenditures grew at an annual rate of 4.4 percent in 2008, a slower rate than recent years, yet still outpacing inflation and the

growth in national income. Absent reform, there is a general agreement that health costs are likely to continue to rise in the foreseeable future."

Additionally, as pointed out in KHI, Medicare and Medicaid account for a significant share of health care spending but "they have increased at a slower rate than private insurance" implying that p*remiums* and *pushing more of the cost to plan participants* remain the driving force behind increased health care costs.

According to the Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group which broke down how US health care dollars are consumed, by far the largest percentage of health care expenditures – at 31% - is to hospitals.

In the United States, hospitals have a mix of ownership types among nonprofit entities, for-profit corporations, and government run and operated (i.e. veteran's hospitals). In 2006, the variation of hospital control was as follows:

70% nonprofit
16% government
14% private

Given that thirty one percent of total health care expenditure is on hospital care, and seventy percent of all hospitals are nonprofit entities, an investigation into the accounting practices and procedures of nonprofit hospitals became the foundation for this report, *Sticker Shock - Nonprofit Hospital Accounting Practices – A Rip-off Report…Why we desperately need Universal Single-Payer Health Care.*

My question to the hospital was: Which was the cost of services rendered $16,808 or $2,739?

III. What is a Non Profit?

In the US, in order to operate as a nonprofit, the organization must make application and be approved to operate as such by the Internal Revenue Service. This process involves an in-depth, articulated mission statement, dedicated corporate organizational structure, and specialized accounting policies and procedures. The entity's purpose, which cannot discriminate, must advance the welfare of the public.

Earnings (not referred to as profits, but as "surplus") shall not benefit any individual or stakeholder and must be retained by the organization and used to further their stated purpose.

When determination is approved by the IRS to operate as a nonprofit, these corporations are known as 501(c)(3) entities and are obligated to adhere to strict guidelines. This is because 501(c)(3)s pay no state or federal income, property, or sales taxes. Contributions are tax deductible to the extent the donation is in excess of the value of any benefit. For example, if a donation to a 501(c)(3) organization is $100 but the donor receives a coffee mug valued at $15, then the tax deductible portion to the donor is $85 ($100 less $15 value of mug). Additionally, if average annual gross income (revenue) over a three year period is in excess of $25,000, nonprofit organizations must file IRS Form 990 which reconciles the accounting activities for the year. Form 990 is not specifically a tax return, but more accurately an *informational* return showing statement of activity for nonprofit purpose.

Nonprofit entities pay NO
(1) Sales Taxes
(2) Property Taxes
(3) Federal Income Taxes
(4) State or Local income Taxes

These returns are public information which can be obtained at www.guidestar.org where, at no cost, the most recent three year's returns filed with the IRS can be viewed.

IV. What Does Non Profit Form 990 Reveal?

Form 990 discloses information including Board of Directors, Trustees, Officers, employees, volunteers, unrelated business income which may be subject to income taxes, basic (and invaluable) financial information such as two year look at revenue, expenses, balance and income statements, and fund balance. A critically important section of this form details information on highly compensated individuals, disqualified persons, as well as a listing of the highest paid independent contractors. Depending upon size of the organization and volume of activity, Form 990 can be anywhere from 30 to 180 pages.

Exhibit A Form 990, 2008, page 1, Meridian Health System, Inc., Neptune, New Jersey.

Line 3 - Number of Voting Members of the Entity	20
Line 4 - Number of Voting Members who are Independent	11
Line 5 - Number of Employees	9,660
Line 6 - Number of Volunteers	1,501
Line 12 - Total Revenue for 2008	$1,051,895,386
Line 18 - Total Expenses	$1,013,729,556
Line 19 - Revenue less expenses	$ 38,165,830
Line 22 – Net Assets or Fund Balance (money in the bank)	$ 360,419,000

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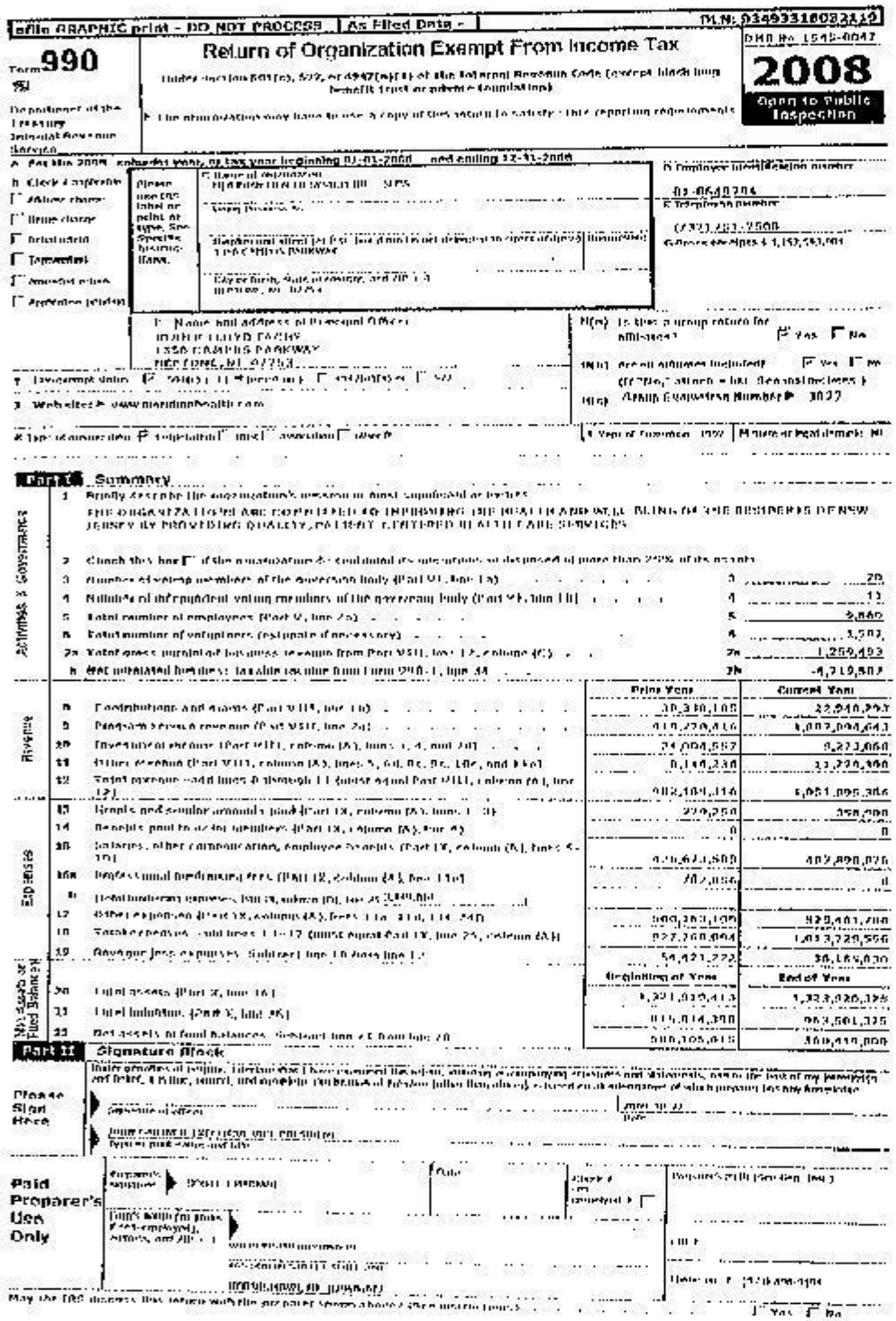

Form 990 (2008)

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

2008

Open to Public Inspection

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
THE ORGANIZATION IS COMMITTED TO IMPROVING THE HEALTH AND WELL-BEING OF THE RESIDENTS OF NEW JERSEY BY PROVIDING QUALITY, PATIENT-CENTERED HEALTH CARE SERVICES

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	30,340,105	32,940,297
9	Program service revenue (Part VIII, line 2g)	919,220,816	1,007,004,643
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	24,004,587	9,273,060
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	8,144,330	33,720,356
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	982,101,114	1,081,096,356
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	229,250	358,000
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	470,671,800	482,898,026
16a	Professional fundraising fees (Part IX, column (A), line 11e)	782,856	0
b	Total fundraising expenses (Part IX, column (D), line 25) 3,840,000		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f)	399,383,108	929,481,288
18	Total expenses. Add lines 13–17 (must equal Part IX, line 25, column (A))	927,260,894	1,013,729,566
19	Revenue less expenses. Subtract line 18 from line 12	54,821,222	68,166,830

		Beginning of Year	End of Year
20	Total assets (Part X, line 16)	1,321,035,413	1,323,026,196
21	Total liabilities (Part X, line 26)	811,814,398	963,581,335
22	Net assets or fund balances. Subtract line 21 from line 20	509,105,015	359,444,861

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Please Sign Here

Signature of officer — Date

Type or print name and title

Paid Preparer's Use Only

Preparer's signature — Date — Check if self-employed — Preparer's PTIN (see instr.)

Firm's name (or yours if self-employed), address, and ZIP + 4

Phone no.

May the IRS discuss this return with the preparer shown above? (see instr.) Yes No

Exhibit B Form 990, 2008, page 2 – Statement of Program Service Accomplishments

This form is particularly important because it reconciles the income (revenue) and expenses of the entity for the year to report financial activity solely for the hospital's stated purpose, Part II, Line 1:

"Expenses incurred in providing medically necessary cardiac services to all individuals in a non-discriminatory manner regardless of race, color, national origin, religion or ability to pay. During 2008, the organization had 26,180 cardiac cases for a total of 51,126 patient days."

It is not always easy to determine hospital revenue and expenses for these services by looking at this form (many times lines 4a and 4b and 4c and 4d must be added):

Total Program Service Revenue (add lines 4a thru 4e)	$1,028,947,093
Total Program Service Expenses (line 4e)	$ 776,999,606
Net Program Service Revenue greater than Expenses	$ 251,947,487

Translation: For this hospital's stated purpose (i.e. medical care), income was greater than expenses by a quarter of a million dollars.

Program Service Revenue includes payments hospitals receive from (1) Medicaid, (2) Medicare, (3) For Profit Insurance Companies, and (4) Other income such as income paid from workman's compensation insurance, charity care, or payment of invoices directly from patients. This list can be found in Part VIII – Statement of Revenue.

Program Service Expenses are expenses directly related to the medical care of patients such as salaries including pension and payroll taxes, medical supplies, office, travel, depreciation, insurance, bad debt, purchased services. This list can be found in Part IX – Statement of Functional Expenses.

Program Service Revenue and Expenses are the most critical portion of Form 990 filed by nonprofit hospitals because those figures – reported to the IRS - specifically communicate the cost of medical care administered to patients for the entity's stated purpose

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Page 2 of Meridian Health System's Form 990 – Exhibit B

Form 990 (2008)

Part III Statement of Program Service Accomplishments (See the instructions.)

Page 2

1 Briefly describe the organization's mission:

EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY CARDIAC SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. DURING 2008 THE ORGANIZATION SERVICED 26,100 CARDIAC CASES FOR A TOTAL OF 51,126 PATIENT DAYS. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☑ No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting or make significant changes in how it conducts any program services? . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and (4) organizations and 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 343,260,000 including grants of $) (Revenue $ 162,353,000)

EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY CARDIAC SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. DURING 2008 THE ORGANIZATION SERVICED 26,100 CARDIAC CASES FOR A TOTAL OF 51,126 PATIENT DAYS. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT

4b (Code:) (Expenses $ 99,000,000 including grants of $) (Revenue $ 105,445,000)

EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY ORTHOPEDIC/NEUROSCIENCE/REHABILITATION SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. DURING 2008 THE ORGANIZATION SERVICED 17,185 ORTHOPEDIC/NEUROSCIENCE/REHABILITATION CASES FOR A TOTAL OF 81,325 PATIENT DAYS. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT

4c (Code:) (Expenses $ 84,870,000 including grants of $) (Revenue $ 85,059,000)

EXPENSES INCURRED IN PROVIDING MEDICALLY NECESSARY ONCOLOGY SERVICES TO ALL INDIVIDUALS IN A NON-DISCRIMINATORY MANNER REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, RELIGION OR ABILITY TO PAY. DURING 2008 THE ORGANIZATION SERVICED 11,321 ONCOLOGY CASES FOR A TOTAL OF 21,623 PATIENT DAYS. PLEASE REFER TO SCHEDULE O FOR THE ORGANIZATION'S COMMUNITY BENEFIT STATEMENT

4d Other program services (Describe in Schedule O.)
(Expenses $ 449,059,606 including grants of $) (Revenue $ 291,524) (Revenue $ 676,396,093)

4e Total program service expenses $ 776,999,606 *Must equal Part IX, Line 25, column (B).*

Form 990 provides a snapshot of activity of nonprofit hospitals and my review of hundreds of these forms for hospitals across America gives great insight into their accounting policies and procedures and more importantly, how these practices *directly affect the cost of health care especially to poor, uninsured, and under-insured patients.*

V. My Investigation into Non Profit Hospital Accounting Practices

I began my investigation by pulling the most recent three year's returns, Form 990, of Monmouth Medical Center, a nonprofit hospital located in Long Branch, New Jersey. The following mission statement is taken directly from their 2008 return:

Expenses incurred in providing various medically necessary health care services to all individuals regardless of race, color, national origin, religion, or ability to pay.

Revenue for 2008 (the most recent year available) was $266 million which would include amounts sent as invoices to patients like the one I received – and using my invoice as an example – a posting to income in the amount of $16,808 regardless of the fact the hospital would – in less than 2 week's time - accept an amount as payment in full from the insurance company which would be *83% less* than that entry.

VI. Hospital Accounting - Booking the Invoice to Patients

In order to avoid "off the books" accounting (also known as "under the table" strategies), under Generally Accepted Accounting Principals (GAAP) which is *the* gold standard of compliance for businesses, both profit and nonprofit, every invoice submitted to patients for services rendered must have a bookkeeping entry on the entity's accounting system to "book" (i.e. recognize) the receivable (asset) and revenue (income). Any invoice not accounted for on the entity's official books would be in violation of GAAP.

So to comply with GAAP, the hospital would have recorded:

Debit Accounts Receivable	$16,808	
Credit Revenue		$16,808

And then sent out the invoice to shock, confuse, and intimidate its patients who are still recovering from trauma requiring medical services.

When the hospital received payment of $2,739 from the insurance company, the entry to record the payment would be:

Debit Cash	$2,739	
Credit Accounts Receivable		$2,739

As a note, if this hospital actually received $8,786 for each night a patient was hospitalized, the total annual revenue *for that one room* would be $3 million. At an annual occupancy rate of just 56% (Monmouth Medical Center is a 527 bed hospital), the revenue alone for room usage *would be almost $1 billion,* demonstrating the absurdity of submitting an invoice for an $8,786 room charge and is an indication of how hospitals discriminate based on ability to pay.

OK, but since the $2,739 paid this account *in full*, there is still *a balance* in on the hospital's Accounts Receivable ledger in the amount of $14,069 ($16,808 less $2,739). For purposes of this transaction, since the account is settled, the hospital must reverse the entry to back out the (over stated) revenue by $14,069 and also reduce the receivable.

But what about billing accounts not settled so quickly? What do hospitals do with inflated amounts (perpetually) stuck in their accounts receivable?

An even more pressing question is: Can it be, at any point in time, hospital revenue and receivables are possibly overstated (inflated) *by somewhere around 83%*?

What's going on here?

Well, hospitals receive revenue from a variety of sources, including, but not limited to:

(01) Medicaid
(02) Medicare
(03) For-profit insurance companies (there are at least 1,300 across the nation each with their own set of policies, procedures and paperwork)
(04) TriCare (the civilian portion of veteran's benefits)
(05) Charity Care
(06) SCIP (State Children's Insurance Programs)
(07) Workman's Compensation Insurance
(08) Liability Insurance
(09) Homeowner's Insurance
(10) Auto Insurance
(11) Collection Agencies
(12) Attorneys
(13) And a host of other revenue streams

Under our current health care system, hospitals' medical staff must jump through many hoops, expending inefficient, redundant overhead in the (timely) claims filing process. It is a costly and burdensome administrative task for hospitals to secure revenue.

If you are fortunate enough to be able to both (1) afford for-profit health insurance and (2) have a somewhat 'adequate' policy, depending upon the type and scope of your agreement, the amount paid by insurance may or may not satisfy the entire hospital bill.

Factors which affect *for-profit insurance reimbursement* to hospitals are in the fine print of agreements with patients who never know what its worth until they need to use it. **Many policies leave patients grossly underinsured and personally responsible for**:

(01) High deductibles;
(02) High co-payments;
(03) High participating co-insurance clauses;
(04) Services performed in non participating hospitals or facilities (perhaps while visiting a relative in another state, on vacation, or business);
(05) Cap on benefits either per person or family;
(06) Benefits flatly denied;
(07) Benefits not covered;
(08) Benefits on appeal;
(09) Benefits "under consideration" that never seem to be resolved

Don't forget that any amount paid by patients for deductibles, co-pays and co-insurance are satisfying *an inflated* hospital invoice.

A person who can afford to pay for an adequate for-profit health insurance policy (family premiums can be anywhere from $14,000 to $22,000 per year) *might* be able to have a participating hospital (discussed later) accept $2,739 for services rendered.

Those are the lucky ones.

If you are in the large and ever growing percentage of patients who cannot afford "somewhat adequate" insurance, have only partial, or can't afford insurance at all, well, nonprofit hospitals, in direct conflict with their mission statement, will often take you to the cleaners.
It is a long and ugly ride.

VII. The Number Crunchers employed by For-Profit Insurance Companies

For-profit health insurance companies have a multitude of resources (paid for by plan participants in the form of premiums) and deploy cost accountants who work year round in hospitals aggressively scrutinizing and analyzing the previous year's hospital costs with their own generated list of average charges. The list includes every surgical procedure, medication, bandage, tissue, ointment, salve, stitch, magnetic imaging machines, lab work, physician "consult" (even if only to stick their head in the room or glance at a chart), nursing shift cost (including cost of taxes and benefits), cost of changing bed linens, custodial overtime, and overhead charges such as laundry, utilities,

insurance, maintenance, office expense, depreciation, amortization, interest expense, promotion – and yes administrative staff to secure payment for services.
These negotiations between hospitals and the mega for-profit corporations – among them Aetna, Blue Cross, Humana, and WellPoint - are ongoing.

For-profit insurance companies are well aware of the number of scans processed by MRIs and cumulative X-rays expended on X-ray machines. They have depreciation down to a science. They are mindful, for example, that a typical MRI machine will produce nothing but pure profit after a set number of images, say 2,000 to 3,000, which will have totally paid for the machine by year two (for example), and as a result do not reimburse hospitals for these machine "profit centers" after the year their cost has been totally recovered.

However, under or un-insured patients are not privy to this information.

For-profit health insurance companies have thoroughly calculated every penny they're willing to spend to satisfy your hospital bill and for that service, they charge enormous (and ever increasing) premiums. The hospital is also well aware of the cost which is why they accept payment at 17% from the insurance companies of what was billed to the patient. Hospitals can't pull out their bag of magic tricks and illusions as they juggle idiotic reasons why their exorbitant medical bills should be paid. The for-profit heath insurance industries have crunched the numbers, and they're not falling for that gobbledygook.

OK so why don't hospitals just charge the under- and uninsured the same rate as those who have insurance since they are fully aware of the costs?

The answer is two-fold:

(1) Because then hospital executives wouldn't be able to hide behind the American Hospital Association's assertion that Medicaid and Medicare reimbursements do not fully cover hospital costs, giving license for hospitals to make up the difference on the backs of other patients; and

(2) Because then hospitals wouldn't be able to play The Health Care War Economy shell game which allows them the freedom to spend health care dollars elsewhere.

VIII The American Hospital Association

Founded in 1898, the American Hospital Association (AHA) is a national nonprofit – 501(c)(6) organization which represents, services, and advocates for its member hospitals and health care networks which total about 5,000 hospitals (both profit and nonprofit) and another 37,000 individual members. The following is from AHA website:

"The AHA vision is of a society of health communities, where all individuals reach their highest potential for health."

According to the AHA's Form 990 (2008), they earned $22 million profit on revenues of $120 million (primarily from member dues). Fund balance was $100 million. (AHA president pulled in $2.1 million in compensation; in fact the top 18 officers made almost $11 million.)

The American Hospital Association's "Underpayment by Medicare and Medicaid Fact Sheet" (Nov 2009), sets the stage for hospitals to "gross up" charges:

"Payment rates for Medicare and Medicaid, with the exception of managed care plans, are set by law rather than through negotiation process as with private insurers. These payment rates are currently set below the costs of providing care resulting in underpayment [which] is the difference between the costs incurred and the reimbursement received for delivering care to patients. Underpayment occurs when the payment received is less than the costs of providing care, i.e., the amount *paid by* hospitals for the personnel, technology and other goods and services required to provide hospital care is less than the amount *paid to* them by Medicare or Medicaid for providing that care [emphasis not added]."

The foregoing explanation by the AHA, gives hospitals validation to increase – or "gross up" - their invoices for services rendered *to other than* Medicaid, Medicare, or for-profit insurance company patients. And who are they?

The underinsured
The uninsured
The poor

According to the online website plastics.com 2/20/10 article "***Hospitals Told To Stop Using Uncle Sam as An Excuse and give a Break to Uninsured Patients***: Despite the AHA's admission that pricing and billing schemes for hospital costs are a mess, the organization had gone on record as saying that is was necessary to charge uninsured patients the full retail rate for services rendered."

Further, the AHA November 2009 Report, found:

"For Medicare, hospitals received payment of *only 91 cents* for every dollar spent by hospitals caring for Medicare patients in 2008. For Medicaid, hospitals received payment of *only 89 cents* for every dollar spent by hospitals caring for Medicaid patients in 2008 [emphasis not added]."

Here's something interesting to note, the Report continues:

"In 2008, 53 percent of hospitals received Medicare payments less than cost, while 56 percent of hospitals received Medicaid payments less than cost."

Translation: Almost half the hospitals surveyed were made whole (that is, were *not* underpaid) when reimbursed for Medicaid and Medicare patients.

IX The IHSP Hospital Report

The Institute for Health and Socio-Economic Policy (IHSP) is a nonprofit policy and research organization who was commissioned by the California Nurses Association to prepare a report reviewing the billing practices of over 238 hospitals across America. Most of the contributor hospitals were nonprofit because for-profit hospitals "demonstrated a reluctance to participate".

According to The Report dated 12/13/2005 (www.calnurses.org), "The Third Annual IHSP Hospital 200: The Nation's Most – and Least – Expensive Hospitals Fiscal Year 2003/2004" ["The Report"]:

"When pressed, the hospital industry habitually states that gross hospital charges are irrelevant since actual payments from Medicare and other payers are reimbursed via fixed rates. The question left unasked and unanswered is, if reimbursement rates are **absolutely** fixed, then why are not hospital gross charges – the "list prices' – fixed and indexed to the same rate?"

The Report, p. 5

What this report found in its study was a shell game referred to as "The Health Care War Economy" (The Report, pages 14 – 15):

"High hospital charges have provided ideological cover for health plans to raise once again premium rates by double digits – and to dramatically increase their profits – thus increasing health care costs for large and small employers and federal, state and local government agencies. This has prompted a number of businesses to scale back on the quality of the plan available for their employees and has been a significant contributor to the growing ranks of the uninsured whose only recourse to care is the hospital emergency room – the most expensive form of care. Hospitals then cost shift that economic burden to other payers by raising charges in so far as possible, particularly drug, medical supply and operating room charges, contributing to a self-perpetuating and self-defeating Health Care War Economy of more expensive care, less care, higher premium rates, and more uninsured…

This brings us full circle and is exactly what one should expect as the necessary outcome of the ongoing but unwinnable battle within the Health Care War Economy struggles among pharmaceutical corporations, insurers, and hospitals **as they do their best to** exploit each other in a market care-blind to the nation's health needs."

"They [pharmaceutical corporations, insurers, and hospitals] do their best to exploit each other in a market care-blind to the nation's health needs."

The Report details in Table 9, pages 34 through 38, the average total billings-to-cost-ratio of the top 100 Hospitals by State. Some of the most egregious offenders, at *one thousand seventy five percent above cost*, are Tenet Healthcare (for-profit corporation that owns or leases at least 50 hospitals, $9 billion in 2009 sales) and Temple University in Pennsylvania - nonprofit 501(c)(3) - *at nine hundred ninety percent above cost*.

The Report found

"Maryland had the lowest charge-to-cost-ratio of any state, with a ratio of 123.24% [2004], up only a few points from last year's 120.24%. It is also the most highly regulated state in the nation. At the same time, 73.2% of its hospitals had a positive net income, or about the same percentage as the national average."

The Report, p.10

This, our standard industry-wide health "care" practice, indicates health care costs are not necessarily increasing, but instead *are artificially inflated* in an effort to maximize revenues from those least able to pay for it

X Lawsuits from Poor Patients who are Sick and Tired of Being Overcharged

The Report reviewed lawsuits filed on behalf of patients who claimed they were unfairly treated:

"Scott Ferguson, a retired artist without health insurance, was billed $66,500 for treatment of a heart condition at St. Anthony Central Hospital in Denver last December [2004]. If he had had insurance, his attorneys claim the tab would have been about $10,000."

The Report, p. 94

(Note: St. Anthony Central Hospital in Denver is privately owned by Centura Health whose mission statement is "We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities." Nevertheless, as of 3:00 pm on 12/20/2010, the Board of Directors at St. Anthony's Central Hospital voted to halt part of that nurturing process by discontinuing obstetrical and newborn services at the hospital. Centura's 2008 revenue exceeded $1.6 *billion*).

The aggressive pursuit of payment from the poorest of the poor and the uninsured by *nonprofit hospitals* has become such a chronic problem several lawsuits have been filed over the past decade.

In July of 2004, a class-action lawsuit was brought against seven hospitals and the American Hospital Association in Florida, Georgia, Michigan, New Mexico, New York, Ohio, and Pennsylvania alleging that American Hospital Association encouraged hospitals to perform "*wallet biopsies*" on uninsured patients by "gouging the uninsured with exorbitantly inflated prices."

The lawsuit also alleged if the uninsured patient can't pay, the defendant hospital systems intimidate and harass the patient through "goon-like" and predatory collection tactics including the trauma of personal bankruptcy. These "goon-like" tactics have the effect of discouraging the uninsured patient from ever again seeking healthcare at these hospitals, thus "enabling the hospitals to avoid its government obligation to provide charity healthcare".

The lawsuit alleged "goon-like" and predatory collection tactics, wallet biopsies, and manipulative accounting techniques that "siphon" money from communities and patients in the trillions of dollars.

Further, the lawsuit alleged the AHA teamed up with co-defendant hospitals

> "with respect to *manipulative accounting techniques* and 'spinning' the public and governmental authorities away from the wrongdoings being perpetrated."

The most egregious claim of this class-action lawsuit addressed the high cost of health care in America:

> [These] hospitals have for years siphoned from the country's financially hard-pressed health systems, local communities and states potentially *trillions* of dollars."

XI Charity Care – How Does it Work?

In NJ the number of lawsuits against hospitals for outrageous billing practices was so great that in July 2008, former governor, Jon Corzine, signed the Compassionate Care Billing Law which prohibits hospitals from charging patients whose income is below 500% of the federal poverty level (for a family of 4 must be less than $110,250) more than 115% of the Medicare rate for the same services (the law did not take effect until 2/4/2009).

Let's step back; what is Charity Care?

In NJ, for example, Charity Care is a program for patients who are low-income, have partial or no health insurance and are not eligible for Medicaid or SCHIP (State's health care for children). Charity Care may pay part or your entire hospital bill depending upon eligibility. Every hospital is required to inform patients about Charity Care and also assist in the application process.

According to the NJ Charity Care Guidelines:

"Hospital assistance and reduced charge care are available only for necessary hospital care. Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions, are separate from hospital charges and may not be eligible for reduction."

Even if a patient qualifies for 100% of Charity Care, they still may be liable for payment of "other" hospital services (billed at 'grossed up' rates) not considered hospital services even though they were performed in the hospital and as a result of a medical emergency.

.
There's more. Under the NJ Charity Care guidelines, individual assets cannot exceed $7,500 and family assets cannot exceed $15,000:

"Should an applicant's assets exceed these limits, he/she may 'spend down' the assets to the eligible limits through payment of the excess toward the hospital bill and other approved out-of-pocket medical expenses."

Qualification of charity care is based on US Poverty Rates and full eligibility would take effect for 2010 if annual gross income for the 12 months before hospital care was not more than $21,660 for a family of one, $29,140 (family of 2), $36,620 (family of 3), $44,100 (family of 4).

If income is greater than these amounts, the patient would be responsible for a portion of the hospital bill in what is called a sliding fee scale (Exhibit C – Legal Services of NJ).

Table II. Income Requirements for Reduced-Cost Care
(Patients pay between 20% and 80% of their bill if their income is between 200% and 300% of the federal poverty guidelines, using 2010 guidelines.)

	You Pay 20% of Your Bill	You Pay 40% of Your Bill	You Pay 60% of Your Bill	You Pay 80% of Your Bill
Family Size	>200% to 225%	>225% to 250%	>250% to 275%	>275% to 300%
1	$21,661 to $24,368	$24,369 to $27,075	$27,076 to $29,783	$29,784 to $32,490
2	$29,141 to $32,783	$32,784 to $36,425	$36,426 to $40,068	$40,069 to $43,710
3	$36,621 to $41,198	$41,199 to $45,775	$45,776 to $50,353	$50,354 to $54,930
4	$44,101 to $49,613	$49,614 to $55,125	$55,126 to $60,638	$60,639 to $66,150
5	$51,581 to $58,028	$58,029 to $64,475	$64,476 to $70,923	$70,924 to $77,370
6	$59,061 to $66,443	$66,444 to $73,825	$73,826 to $81,208	$81,209 to $88,590
7	$66,541 to $74,858	$74,859 to $83,175	$83,176 to $91,493	$91,494 to $99,810
8	$74,021 to $83,273	$83,274 to $92,525	$92,526 to $101,778	$101,779 to $111,030
For each additional person, add:	$6,160 for 200% limit $8,415 for 225% limit	$8,415 for 225% limit $9,350 for 250% limit	$9,350 for 250% limit $10,285 for 275% limit	$10,285 for 275% limit $11,220 for 300% limit

You may be eligible for extra help if you qualify for reduced-cost care as described in the income guidelines in Table II above. If your family's medical expenses within a 12-month

According to the New Jersey Hospital Care Payment Assistance Fact Sheet:

"If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% *is considered hospital care payment assistance."*

What does that mean?

Well, after maneuvering through the extensive Charity Care paperwork, income limitations, proof of assets, employer information and verification, identification, phone calls, and dealing with the repeated hospital invoices, appeals, in an effort to satisfy the cumbersome requirements, the good news is that if you've already paid over 30% of your income in medical expenses during the previous 12-month period, the hospital will reduce any amount over the 30% limit to zero and then count that (inflated) amount as charity care.

How would that work?

Assume a single employee of a big box store with no health insurance (can't afford the premiums) falls at home and fractures a leg bone. After going to the hospital emergency room, the patient is guided to the hospital's charity care services director for application into the Charity Care process. The patient's annual income for the 12 month period prior to the leg fracture was $25,000 and assuming all other tests are met (asset, identification, etc), the patient would be responsible *for 40% of the hospital bill and also payment of any services not deemed covered under Charity Care such as interpretation of lab results, doctor fees, prescriptions, etc.*

But the good news for that patient is if in the 12 month period prior to the fracture, the patient paid over $7,500 (30% of $25,000) for medical expenses (perhaps on a credit card or depleting savings), the hospital would discount the patient's 40% portion and be able to count that as charity care. The State of NJ would reimburse the hospital for the 60% portion covered by Charity Care at agreed upon discounted rates.

RECAP: To qualify for charity care, patients must jump through numerous hoops - often spending **at a minimum** 30% of their income on medical bills - in order to satisfy a hospital bill that may be inflated by as much as one thousand percent.

XII. The Collection Process

In fact, not only are these nonprofit hospitals forcing people into endless debt, the stress they are infusing into already over-burdened lives is unconscionable.

I recently spoke to a couple whose young child is undergoing cancer treatment, and I cannot fathom how these parents keep it together. Not only do they each have to continue working - in order to maintain their health insurance – in between hundreds of hospital visits a year, chemotherapy, radiation, but they also have to deal with confusing, contradictory, and inflated hospital bills. It is no wonder families end up frightened and tapping into pension plans, 401(k)s, equity lines, savings, college deferment plans, *anything* to help pay for bills which they don't understand in the first place and which are *inflated by as much as 1,000 percent*!

So, what do *nonprofit* hospitals do when the uninsured or those with limited insurance can't pay? They aggressively pursue patients – *for the exaggerated billings* – by contracting with collection agencies that use any tactic available to secure payment. Many patients end up with ruined credit ratings, garnished wages, liens placed against their homes, high-interest rate credit card debt, or bankrupt.

According to CNN.com (6/5/09), over 62% of bankruptcies filed last year were due to high medical bills, three-quarters of those people had medical insurance: "Unless you're a Warren Buffet or Bill Gates, you're one illness away from financial ruin in this country" said Steffie Woolhander, M.D. of the Harvard Medical School.

Getting back to the hospital bill, the bottom line is: If you can afford to buy health insurance, you'll pay $2,739 for that hospital bill. If you're too poor to afford insurance, you'll end up paying more, like $16,808.

Now that's sick

XIII Re-Visiting the Criteria for Nonprofit Status

By charging different rates for services rendered to those who can afford health insurance versus those who cannot, hospitals have clearly demonstrated contrary to their IRS-authorized license to operate as a tax-exempt entity **discrimination** based on the patients' ability to pay

OK so going back to the criteria for establishing and running a nonprofit 501(c)(3) entity, how does forcing people into poverty or insolvency by insisting on payment for a *puffed up* hospital bill *advance* the welfare of the public?

XIV LET'S BE FAIR: WHAT ABOUT NONPROFIT HOSPITALS' EXPENSES?

Labor is the largest portion of any hospital's budget as they must employ not only doctors and nurses, but also administrative, custodial, laundry, maintenance, and security personnel. However, the compensation paid to the very few at the top is so grossly disproportionate, it is shocking and irresponsible. It's an authentic good old boys club of perks (forcing the poor and taxpayers to foot the bill).

XIV.A. Outrageous Compensation Packages

The following is a review of Form 990s from across the nation, a sampling of how hospitals spend money on top administration:

Among just *ten* hospitals' Form 990s compensation in 2008 to highly salaried personnel totaled over $55 million.

Monmouth Medical Center lists 19 listed highly compensated individuals, 12 are vice presidents (all but one, non-medical), and the top seven earned over $1.3 million in 2008 despite the fact the hospital has a *negative* fund balance of $48 million.

Here's something of note when my family member was hospitalized: Stuck to Monmouth Medical Center's hospital room pegboard was a notice to patients which stated they were on a "cost cutting mission" and had "partnered with doctors in a profit-sharing measure" (not sure how a nonprofit has profit sharing). The mission included several critical modifications to their policies – like not changing patients' bed linens daily unless they were soiled. Just thinking out loud here but aren't hospital infections one of the largest problems of staying in the hospital? In fact, they are. According to a front page report in *The Star Ledger* 1/15/2011 regarding hospital infection:

> "Health care-associated infections – infections patients incur after being admitted to a hospital or health are facility – are regarded as one of the top causes of unnecessary illnesses and deaths in the United States. Approximately 1.7 million such infections occur nationwide annually accounting for almost 100,000 deaths."

Chief Operating Officers and top personnel at nonprofit hospitals are given extremely generous employment packages.
I suggest you buckle your seat belt, because it's a shockingly outrageous ride on the "Roller Coaster of Executive Privileges, Premiums, and Perks".
Hang on!
(Here's hoping you don't get nauseous)

The following is only a sample of 2008's highly-compensated personnel:

Catholic Health West, San Francisco, CA	
President	$10.0 million
Top next 8 personnel (all non-medical)	$15.4 million
Top next 8 personnel (all non-medical)	$ 8.3 million
Top next 16 personnel (all but 4 non-medical)	$11.5 million
Top 33 employees rake in (Average $1.3 million)	$45.2 million
Average salary of its 52,287 employees	$52,000
University of Chicago, Chicago IL	
President	$1.6 million
Chief Financial & Strategy Officer	$1.2 million
Top next 3 vice presidents	$1.20 million
Top 5 officers rake in (Average $800,000)	$4.0 million
Average salary of its 7,240 employees	$50,500
Catholic Health Systems East	
President	$2.5 million
Executive VP	$2.3 million
Top next 20 employees	$18.5 million
Total top 22 employees rake in	$23 million
Average salary of its 460 employees	$63,000
Meridian Health System, NJ	
President	$1.4 million
Top next 4 other Presidents	$2.3 million
Top next 7 Vice Presidents	$2.8 million
Top 12 officers rake in	$6.5 million
Average salary of its 9,660 employees	$40,000
Robert Wood Johnson Hospital, NJ	
President	$1.5 million
Top next 3 personnel (CFO/CEO/VP)	$1.3 million
Top next 16 VPs	$7.0 million
Top 20 officers rake in	$9.2 million
Average salary of its 5,188 employees	$50,000

Hackensack University Medical Center, NJ

President	$ 3.5 million
Top next 3 personnel (CMO, CEO, CFO)	$ 4.2 million
Top 4 employees rake in	$7.7 million
Average salary of its 8,371 employees	$56,000

Long Island Jewish Medical Center, NY

Section Head	$2.3 million
Top next 4 officers	$5.6 million
Top 5 officers rake in (Average $1.5 million)	$7.9 million
Average salary of its 8,189 employees	$64,500

Orlando Hospital, Orlando, FL

President	$4.4 million
Senior VP	$1.0 million
Top next 3 vice presidents	$2.7 million
Top 5 officers rake in	$8.1 million
Average salary of its 16,047 employees	$36,000

Of course the aforementioned perks often include, but are not limited to:

Form 990, Schedule J, Part II Officers, Directors, Trustees, Key Employees, and Highest compensation Employees:

(1) Base Compensation
(II) Bonus and Incentive Compensation
(III) Other Compensation
(IV) Deferred Compensation
(V) Nontaxable Benefits

But there's more. In addition, they often receive:

(1) Severance Payments
(2) Grossed Up Payments
(3) Tax Indemnification
(4) Maid Service
(5) Charter Jets
(6) Personal Chefs
(7) Personal Car Service
(8) Personal low-interest rate loans
(9) Membership to golf clubs, health clubs or social dues
(10) World (and first!) class travel
(11) Travel for companions
(12) Housing allowance

And even more; they are often guaranteed

(1) Pensions
(2) Basic Life Insurance
(3) Dependent Life Insurance
(4) Long Term Disability Insurance
(5) Fully paid Health Insurance

XIV.B. Extravagant Severance Pay

Children's Medical Center of Dallas		
	Severance payment to two former employees	$541,500
Baylor Health Care System, Dallas, TX		
	Severance payment to one former employee	$554,116
Jersey City Medical Center, Jersey City, NJ		
	Severance payment to one former employee	$752,000
St. Jude's Children's Research Hospital, TN		
	Severance payment to three former employees	$1.2 million
Liberty Health Care System, Secaucus, NJ		
	Severance payment to two former employees	$1.35 million
Holy Cross Hospital, Ft. Lauderdale, FL		
	Severance payment to one former employee	$1.35 million
Robert Wood Johnson Hospital, New Brunswick, NJ		
	Severance payment to two former employees	$1.46 million

Catholic Health System East (2008) which manages hospitals from Maine to Florida
Severance payment to two former employees $1.7 million

Miami Children's Hospital, Miami, FL
Severance payment to four former employees $2.4 million

University of Chicago, Chicago, IL (2006)
Severance payment to three former employees $2.6 million

I've just listed over $13.9 million paid out to 21 former employees of *ten* nonprofit hospitals.

CWH Medical Foundation, Rancho Cordova, CA
Severance policy:
"The organization's officers and key employees participate in a severance plan that provides fair compensation, ranging from payments of *6 months to 2 years* of base compensation, depending on the executive's position, in the event of position elimination or other involuntary termination, in accordance with the guidelines."

I've done hundreds of tax returns for individuals who've given to children's research hospitals. Most of these taxpayers live paycheck to paycheck. I wonder how many of them realize a portion of their donations go to line executive's pockets.

XIV.C. Bonuses

Meridian Health System, Neptune, NJ 2008

President	$500,000
Next two Officers	$200,000
Next 21 Officers	$1.9 million
Total Bonuses to 24 employees	$2.6 million

Centra-State Medical Center, Freehold, NJ, 2008:

"The organization has a System Performance Incentive Program, which is contingent *upon net earnings* and other criteria."

Amount of bonuses: $500,000 to a dozen top employees

Hackensack University Medical Center, Hackensack, NJ 2008

President	$ 391,477
Next four officers	$ 687,400
Total bonuses to five employees	$1,078,877

Fayette Community Hospital, Fayetteville, GA

President	$110,351
Next four officers	$156,780
Subtotal	$267,131

Note: Form 990, 2008. Part III Supplemental Information: Bonuses

"Bonuses are paid on various metrics including net earnings"

Fayette Community Hospital's average *bonus* – not salary but bonus - in 2008 for the top 5 officers ($53,426) was greater than the average *salary* of its 1,240 employees ($47,500).

Orlando Hospital, Orlando, FL

Bonuses paid in 2008 to 23 (of its 16,000) employees $2.2 million

System Performance Incentive Programs exist despite nonprofit status criteria which state: "net earnings shall not benefit any one individual or stakeholder".

XIV.D. Unbelievable Expenditures on *Office Expenses*

Meridian Health Systems, Neptune, NJ
Office Expenses $200 million (20% of total expenditures)

Covenant Medical Center, Saginaw, MI
Office Expenses $100 million (21% of total expenditures)

Atlanticare Regional Medical Center, Atlantic City, NJ
Office Expenses $127 million (23% of total expenditures)

Baptist Memorial Hospital, Memphis, TN
Office Expenses $154 million (25% of total expenditures)

Shore Memorial Hospital, Somers Point, NJ
Office Expenses $ 49 million (26% of total expenditures)

Fayette Community, Fayetteville, GA
Office Expenses $ 40 million (27% of total expenditures)

Office expenses include such items as coffee, flowers, bottled water, partitions, and window treatments – whatever is needed to maintain the office - and are normally not more than 3% to 5% of total expenses.

XIV.E. Contributions to other Affiliated Nonprofits

It is common for nonprofit hospitals be affiliated and provide financial support to other nonprofit entities through contributions which are included in their annual expenses.

The following six hospitals are a part of the St. Barnabas Hospital System:

St. Barnabas Health Care System Foundation
St. Barnabas Medical Center
Clara Maas Medical Center
Community Medical Center
Newark Beth Israel Medical Center
Monmouth Medical Center

According to Form 990 (2008), each of the above contributed the sum of $200,000 to SBHCS Research Institute, a nonprofit entity.

According to the 2007 Form 990, the primary exempt purpose of SBHCS Research Institute located in Livingston, NJ [Statement 3, page 22] – Nature of Activities:

"Research by clinicians on clinical practice to improve the delivery of patient care, to add to the knowledge base on the delivery of patients nationally, to improve the processes and infrastructure supporting the delivery of clinical care."

According to the 2008 Form 990, SBHCS (St. Barnabas Health Care System) Research Institute received revenue of $1.2 million ($200,000 contribution from each of six member hospitals) and **paid out in salaries to *four* employees a total of $1,075,645.**

XIV.F. Related Entities

Meridian Health System, Neptune, NJ (2008) Form 990, Schedule R, Part V – Transactions with Related Organizations - lists 43 related entities involving a total of $120 million.

Lehigh Valley Hospital, Allentown, PA (2008) Form 990, Schedule R, Part I thru Part IV – Related Organizations – lists 24 related entities.

Long Island Jewish Medical Center, NY (2008) Form 990, Schedule R,, Part II

Number of Related Tax-Exempt Organizations = 29
Number of Related Organizations Taxable as a Corporation or Trust = 34
Total Related Entities = 63

Related entities raise questions about hospital's independence with regard to referring patients for services which could be redundant, expensive, or totally unnecessary.

XIV.G. Assets left Unprotected – Staggering Losses

Miami Children's Hospital, Miami, FL (2008)	
"Net unrealized losses on investments"	$92 million (30% of assets)
Robert Wood Johnson Hospital, New Brunswick, NJ (2008)	
"Net unrealized losses on investments"	$85 million (20% of assets)
University of Chicago, Chicago, IL (2008)	
"Hedge Fund Ineffectiveness"	$13 million loss
Loss on worthless securities	$155 million (20% of assets)
Covenant Medical Center, Saginaw Michigan (2008)	
Loss on securities	$33 million (21% of assets)
Jersey Shore Medical Center, Neptune, NJ (2008)	
Change in cash value of hedge instruments	$5 million
Net unrealized loss on investments	$54 million (total 12% of assets)
Saint Joseph's Hospital, Atlanta, GA (2008)	$17.7 million (8% of assets)

Given that hospital executives complain of tight budgets, why would they expose their assets to such overwhelming losses?
Who's watching the money?

XIV.H. Lobbying

Robert Wood Johnson Hospital, NJ	$ 362,000
Orlando Hospital, FL	$ 344,000
Catholic Healthcare West	$1,969,285
Cooper Health System, NJ	$ 714,304
Phoenix Children's Hospital, AZ	$ 223,113

So what are they lobbying for?

Cooper Health System, Form 990 2008, Schedule C, Part IV Supplemental [Lobbying] Information:

"During 2008, the organization paid independent firms $605,515 for lobbying consulting services. In addition, the organization is a member of the New Jersey Hospital Association and the American Hospital Association, both of which engage in lobbying efforts on behalf of their member hospitals. The portion of these dues allocated to lobbying expenditures amounted to $46,557."

XIV.I. Bad Debt that Never Seems to Go Away

Hospitals write-off bad debt – a portion of which is inflated billing:

A listing from Form 990, 2008:

Atlanticare Regional, Atlantic City, NJ	$ 48 million
Meridian Health, Neptune, NJ	$ 47 million
Baptist Memorial Hospital, Memphis, TN	$ 50 million
Holy Cross Hospital, Ft. Lauderdale, FL	$ 25 million
St. Barnabas, New York	$ 20 million
Robert Wood Johnson, NJ	$ 45 million
University of Chicago, IL	$ 51 million
Catholic Healthcare West, CA	$630 million
Orlando Health, FL	$128 million

Total debt written off for *nine* listed hospitals was over $1 Billion which is enough to open at least two additional hospitals.

XIV.J. Continuing Collection Costs

So what happens after hospitals write off bad debt? Well, it doesn't necessarily mean that's the end of the process. Nonprofit hospitals often outsource that debt to collection agencies who know how to use the most aggressive tactics to secure payment. If collection agencies don't collect, they don't get paid so they will pursue patients for the unpaid bills under every nook and cranny, at your home, and at your work.

Many nonprofit hospitals set up their own wholly-owned collection agencies (see "Layers and Layers and Layers of Administrative Shuffling of Money).

New York Presbyterian system of member hospitals has its own collection agency called Network Recovery Services.

Covenant Hospital in Saginaw Michigan paid almost $1 million in collection fees in 2008 to an outside agency.

XIV.K. Loans to Officers and Other Perks

University of Chicago, Chicago, IL Form 990 (2007)
Low-interest rate mortgage loan to Officer: $400,000 4.27% fixed interest
Purpose of Loan: Purchase of personal residence

St. Jude Children's Hospital, TN Form 990 (2008) Schedule L, Part IV Business Transactions Involving Interested Persons:

"Rental of condominium and purchase of condominium as part of transaction described on Schedule J, Parts II and III"
Amount paid on behalf of former Executive VP $1,718,584

XIV.L. But there's a Board of Director's, right?

Covenant Medical Center, Saginaw, MI (2008)
[Explanation of Compensation] Form 990, Part VI – Executive Salary

"Executive salary ranges are established through in depth external market studies and approved by the Compensation Committee. The Compensation Committee of the Board of Directors reviews and approves compensation changes for vice presidents, as recommended by the CEO. The Compensation Committee recommends annually to the Board of Directors a performance rating and compensation changes for the CEO.
The Board of Directors acts on all recommendations from the Compensation Committee."

It's pretty hard to be wrong if you keep answering yourself all the time."

Groucho Marx
Animal Crackers

Phoenix Children's Hospital, AZ (2008)
Form 990, Schedule J, Part III Supplemental Compensation Information:

"Compensation contingent on the net earnings of the organization [for the following individuals as listed who] were eligible for the executive incentive plan in which one of the performance measures was earnings before interest, depreciation and amortization. This incentive plan was approved by the Compensation Committee."

Net earnings for Phoenix Children's Hospital (2008) were $16,198,097. By computing earnings before interest, depreciation and amortization the earning used to calculate executive incentive bonus **increases by $18 million.**

XIV.M. Payments to Wealthy Professional Athletes

According to a 2/22/2010 *New York Post* article, St. Vincent's Hospital – which closed in 2010 due to insurmountable debt of almost $1 billion - paid NFL Giant's Quarterback, Eli Manning, at least $600,000 *in addition to* "first class airfare, lodging, ground transportation, and meals for his family" for media events. Mr. Manning is already independently wealthy with an NFL six-year deal worth almost $100 million and another $5 million a year in endorsements.

An astute St. Vincent's Board member noted "[Eli] Manning's pact was a bad deal at a bad time that could lead to bad publicity".

XIV.N. Layers and Layers and Layers of Administrative "Shuffling" of Money

Baylor Health Care System, Dallas, Texas, Form 990 2008, paid $19 million to HealthTexas Provider Network for "general support". According to Baylor Health Care System's Form 990, they are:

"A faith based supporting organization formed 1981 to provide centralized strategic and management services to an integrated health care delivery system (System). The System consists of a growing network of acute care hospitals, specialty hospitals, primary care physician centers and practices, rehabilitation clinics, senior health centers, ambulatory surgery centers, short stay hospitals, foundations, and other related health care facilities that provide quality patient care, medical education, medical research, and other community services to the North Texas Region."

Despite a 2008 net loss of $74 million, Baylor Health Care System, paid the top three employees over $5 million (total compensation to current officers, directors, trustees and key employees over $11.5 million including bonuses of $3 million), and had transactions with 61 related organizations.

HealthTexas Provider Network's mission, Form 990 2008:

"To achieve excellence in the delivery of accessible, cost effective quality health care and demonstrated customer satisfaction that delivers value to patients, payers, and the community in partnership with Baylor Health Care System"

The top six employees at HealthTexas earned $10 million at the same time the System wrote off $12 million in bad debt. Further:

HealthTexas is associated with a Baylor Health Network, Inc, billing and collection agency to which it paid over $11 million in 2008. This collection agency **shares in the organization's revenues** (2008 revenues $290 million). Sharing in revenues is motivation to use aggressive collection tactics against those already too poor to pay.

XIV.O. Hospitals Cry "Wolf" About Financial Distress

A former employee of a hospital at the Jersey Shore told me the hospital had been complaining for years it was losing millions as justification for the numerous layoffs including administrative, nursing, and support staff.

Form 990s filed by this hospital revealed net income each and every year for the past 12 years, ranging from $3.4 million to a high of $12 million.

Cumulative net surplus between 2003 and 2008 totaled $58 million.

By the end of 2008, this hospital's fund balance was in excess of $130 million (42% of assets). Interestingly enough, the hospital also had a "system performance incentive program" for certain top employees based on net earnings of the facility.

XIV.P. A Tale of Two Hospitals who Closed or Sold – Where's the Fire?

Number One – Meadowlands Hospital

Nonprofit Meadowlands Hospital in Secaucus, NJ was sold to private equity investors in 2010.

Let's look for the fire - the disastrous financial events – leading up to the sale.

"According to the *Hudson County News* 8/14/2010:

"State officials have questioned the fairness of LibertyHealth's deal with a private investment group to sell Meadowlands Hospital in Secaucus, [NJ], converting it from a nonprofit to a for-profit institution….The State [of NJ] has raised questions about the low purchase price [$15 million] and about why there was no public bidding before the deal was announced."

Over the past 5 years fifteen hospitals in NJ have either closed their doors or privatized, among them (1) Bayonne Medical Center – filed bankruptcy 2009; (2) Irvington General Hospital; (3) Lourdes Medical Center of Burlington County; and (4) Muhlenberg Hospital, Plainfield.

The *Hudson County News* report continues

"Meadowlands Hospital sustained losses of $500,000 to $700,000 a month [at least $6 million] in the past year, said Mark Rabson, a spokesman for LibertyHealth, which operates the facility. Several potential buyers came forward to help infuse money into the facility, he said. 'If we don't buy this hospital, it's going to close,' William Maer, spokesman for MHA [proposed buyer] said."

A historical look at the hospital's revenue:

1998 Form 990	Net Program Service Revenue over Expenses	$11 million
1999 Form 990	Net Program Service Revenue over Expenses	$ 6 million
2000 Form 990	Net Program Service Revenue over Expenses	$17 million
2001 Form 990	Net Program Service Revenue over Expenses	$15 million
2002 Form 990	Net Program Service Revenue over Expenses	$22 million
2003, Form 990	Net Program Service Revenue over Expenses	$35 million
2004, Form 990	Net Program Service Revenue over Expenses	$11 million
2005, Form 990	Net Program Service Revenue over Expenses	$14 million
2006, Form 990	Net Program Service Revenue over Expenses	$15 million
2007, Form 990	Net Program Service Revenue over Expenses	$12 million

Recap: Net Program Service Revenue over Expenses between 1998 thru 2007 totaled $158 million

Fund balance 12/31/2007 is **$9.4 million.** OK, so far, no financial crisis.

2008, Form 990 amended and filed 5/18/2010, Meadowland's Hospital reported a total loss of $5.7 million. However, according to page 4, Statement of Program Services:

Total program service revenue	$66,400,704
Total program service expense	$63,673,435
Net program service *income*	$ 2,727,269

In 2008, the hospital had $2.7 million net income on services provided for its stated purpose, but other costs such as "Management Expenses" ($12 million) dragged the hospital into red ink.

The Record of North Jersey stated 8/13/10 with regard to Meadowland's finances:

"[NJ Deputy Attorney General Jay A.] Ganzman also questioned whether the hospital's trustees sought legal advice in deciding to sell without soliciting bids. He called a four-page organization chart on the 59 affiliates [of the prospective buyer] 'convoluted'. Ganzman also cited the disparity in calculations on the hospital's finances. He noted that, in minutes from a July 27, 2009, meeting of the facility's Hospital Finance Committee, officials projected 'a positive net income result of $22,355 for September' and said that if the trend continued, the hospital 'should break even in September.' Yet…minutes from a

Liberty Health board executive session held 11 days earlier said the hospital 'is not sustainable based on current and forecasted volume and revenue trends."

Interesting how the hospital's finance committee and board of directors aren't on the same page: In 2009, which was it?
Was Meadowlands Hospital projected to "break even" or was it "not sustainable"?

Attorney General Ganzman ordered an independent report on the proposed sale from Navigant Capital Advisors. The reports – Consultant's Report (CR) on the Proposed Sale of the Assets of Meadowlands Hospital Medical Center - dated 8/13/2010 and 11/1/2010 details the valuation, analyzes the proposed financing, and reviews the use of proceeds from the sale of the hospital.

From The CR:

"Meadowland's share of Corporate costs (about 20% of total Corporate shared services costs with no markup [paid to Liberty Healthcare System Inc., the holding company of Meadowlands Hospital]."

Section II
Review of the validity of inter-corporate transfers
between the Hospital and its affiliates, p 11

Nowhere in the Navigant report does it state the composition of these corporate costs which are due and payable to affiliate Liberty Healthcare System, yet it concludes "This policy is reasonable and a common accounting policy in the healthcare industry."
The CR, page 12

This corporate overhead not only adds to the cost of health care, but drains net revenue and should be addressed because it directly affect the valuation of the hospital. I just pointed out that in the years between 1998 and 2008; the hospital had net revenue over expenses for program services (i.e. its stated purpose) *of $158 million*. In 2007, fund balance was $9.4 million on net income of $2.6 million. So where's the financial fire?

Then in 2008, the hospital reports an enormous loss.

Here's the question: What happened between 2007 and 2008 to make the financial situation of Meadowlands Hospital all of a sudden take a nose dive?

The CR does not address this question nor does it point out that this hospital is a nonprofit entity whose sole purpose is to serve the community's health care needs and for that privilege, it pays no property, income, or sales taxes.

Converting this hospital to a for-profit entity **adds** to the cost of health care because the hospital will now have increased costs in the form of property, sales, and income taxes in the millions of dollars.

"The hospital was founded as a for-profit hospital under the name Riverside Hospital in 1976 by a group of doctors led by Dr. Paul Cavalli. It is our understanding that a deed restriction exists related to the hospital's real property that states the property can only be used for "hospital and/or related medical purposes and **shall not be used for any other purpose."**

The Consultant's Report, page 8

Page 37 of the Consultant's Report includes a copy of the restrictive deed covenant - which begs the question: How does converting this facility from a non profit to a for-profit hospital reduce the cost of healthcare?

It doesn't. And again, where's the fire – the financial crisis - that precipitated this sale?

The consultant, Navigant, values Meadowland's hospital for the pending sale:

"The income approach [to valuation for a sale of property] analyzes a property's ability to generate financial returns as an investment. The appraisal estimates a property's operating cash flow, projecting revenue and expenses. Inherent to the income approach is the capitalization of the resulting net operating income. Through an income capitalization procedure, the value of the subject property is calculated. The income approach is often selected as the preferred valuation method for operating properties because it most closely reflects the investment rationale of knowledgeable buyers. This approach, however, is utilized for income producing properties and is not typically relied upon for facilities that are not currently or expected to generate income in the new future *such as the subject* [emphasis added]."

Appraisal of the Full and Fair Market Value of the Assets of Meadowlands Hospital Medical Center as of July 31, 2010, Navigant Consulting, page 16

Wait a minute, according to the Navigant Report (CR) dated 11/1/2010, Summary of Monthly Cash Operating Forecast, the facility is projected to have a *positive* net income just five months after the sale and that positive cash flow is projected for each and every month thereafter through month 24 (page 3):

Months 05 thru 12 cumulative net positive cash flow	$4 million
Months 13 thru 24 cumulative net positive cash flow	$7 million

Ending up with a net fund balance by month 24 of $**9.4 million** which is where Meadowlands Hospital was 12/31/2007 just prior to the so-called financial crisis.

Based on the foregoing information – taken directly from the Consultant's Report - there appeared to be NO financial calamity that caused the sale of this hospital.

Number Two - Temple East, Inc, Philadelphia, PA

Where's the fire?

Temple East Hospital, located in the Port Richmond section of Philadelphia, is in "an economically challenged neighborhood", and according to Form 990, in 2008, the hospital ceased to operate an inpatient hospital. Further Form 990, Part III Statement of Program Service Accomplishments (2008) states:

> "It's Emergency Department serves approximately 44,000 patients each year, many without insurance. Northeastern provides services to many Medicare and Medicaid patients."

A historical look at the hospital's revenue

1998 Form 990	
Net program service revenue over expenses	$ 9 million
1999 Form 990 (109,000 patients treated)	
Net program service revenue over expenses	$7.9 million
2000 Form 990 (110,000 patients treated)	
Net program Service Revenue over expenses	$10 million
2001 Form 990 (over 85,000 patients treated)	
Net program service revenue over expenses	$12 million
NOTE: Fund Balance	$12.1 million (30% of assets)
2002 Form 990 (over 85,000 patients treated)	
Net program service revenue over expenses	$16 million
NOTE: Fund Balance	$12.2 million (25% of assets)
2003 Form 990 (over 85,000 patients treated)	
Net program service revenue over expenses	$18 million
NOTE: Fund Balance	$17.3 million (27% of assets)
2004 Form 990	
Net program service revenue over expenses	$17 million
2005 Form 990	
Net program service revenue over expenses	$9 million

2006 Form 990

Net program service revenue over expenses	$25 million
NOTE: Fund Balance	$19.1 million (30% of assets)

2007 Form 990

Net program service revenue over expenses	$14 million
NOTE: Fund Balance	$12.4 million (20% of assets)

Recap: Net Program Service Revenue over Expenses between 1998 thru 2007 totaled
$138 million

In the 10 years between 1998 and 2007, program service revenue exceeded program service expenses each and every year, which means reimbursement for medical services rendered was greater than the cost of those medical services regardless of the fact that 83% of patients were uninsured or enrolled in Medicare or Medicaid.

By June 30, 2009, this hospital's fund balance went from positive $12.4 million to a negative ($11 million). Included in expenses were $20 million in restructuring fees like "Impairment Loss" $12.3 million and "Restructuring Costs" $8.7 million.

Where was the financial distress that precipitated this hospital's closing? Based on the financial information reviewed, there appeared to be no distress.

When the inpatient hospital closed in 2009, thousands of employees lost their jobs. This "economically challenged" neighborhood became even more depressed.

The sole member of Temple East was Temple University Health System and as of 6/30/2009, Temple University Health System had a Fund balance of $229 million.

XIV.Q. Transactions with Related Persons

Covenant Medical Center, Saginaw, MI 2008
[Explanation of Board Member Transactions] Form 990, Schedule L, Part IV

"The Hospital paid $128,380 for insurance to Saginaw Bay Underwriters, a firm in which [a] Board Member is the Senior Executive. The Hospital paid Martin Chevrolet of which [a] VP is the President $152,620 for company cars and also company car repairs. Fees for all services are at arm's length market rates and are contracted in accordance with the Hospital's conflict of interest policy."

These statements provoke two questions:

(1) Why does a nonprofit hospital need a fleet of company cars?
(2) Why would the nonprofit hospital approve transactions with Board Member's business organizations which, on surface, raise questions of independent status?

University of Chicago Medical Center (UCMC), Chicago, IL (2008)
[Explanation of Board Member Transactions] Form 990, Schedule L, Part IV

A member of Biomet's Board of Directors is a UCMC Trustee. UCMC paid *$1,080,608* to Biomet and its related entities…an officer of Northern Trust Corporation is a UCMC Trustee. UCMC paid $437,506 to Northern Trust Corporation."

XIV.R. OK but Nonprofit Hospitals are Poor, Right?

A sampling of Fund Balances (surplus), Form 990s (2008):

Holy Cross Hospital, Ft. Lauderdale, FL	$100 million
Our Lady of Lourdes Medical Center, Camden, NJ	$112 million
Fayette Community Hospital, Fayetteville, GA	$122 million
Community Medical Center, Toms River, NJ	$192 million
Saint Joseph Hospital, Atlanta, GA	$233 million
Good Samaritan Hospital, OH	$302 million
Meridian Health System, Neptune, NJ	$360 million
Baptist Memorial Hospital, Memphis, TN	$417 million
Robert Wood Johnson Hospital, NJ	$428 million
Yale New Haven Hospital, CT	$620 million
University of Chicago, IL	$822 million
Orlando Health, FL	$842 million
The General Hospital Corp, Boston MA	$1.5 Billion
St. Jude Children's Hospital, TN	$1.9 Billion
The Methodist Hospital, Houston, TX	$2.1 Billion
Catholic Hospital West, CA	$2.5 Billion

Fund Balance for 16 listed hospitals totals $12.5 Billion. We're talking liquid assets while hospitals pursue the un- and underinsured for inflated hospital bills.

XV THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) – a 2,000-plus page document (no one knows for sure) - which contains:

22 new bureaucracies,
59 new grant programs,
26 new demonstration and pilot programs,
17 new insurance mandates,
19 new special-interest programs,
04 new regulatory programs,
04 new loan repayment and forgiveness programs

> "The President of United Health Care made so much money that $1 in every $700 that was spent in this country on health care went to pay him."
>
> Elizabeth Edwards
> 5/21/09
> The Daily Show

That comment was made before PPACA. The new health care legislation forces – strike that – *mandates* citizens purchase for-profit health insurance, an enormous portion of it paid by taxpayer dollars. Not only is it a windfall for United Health Care, it's called corporate welfare.

I attended a Healthcare Conference last year presented by the NJ Society of Certified Public Accountants. The first speaker, a PhD from Deloitte Center for Health Solutions, presented highlights from the Patient Protection and Affordable Care Act. Apparently, one of the Plan's purposes is to move from a physician-based-decision-of-patient-care-system to one that promotes patients research their own symptoms and illnesses by looking at the 82 randomized control studies published every day in this country which, thanks to $34 billion in PPACA funding (through 2019), will be made "ubiquitously" available to all citizens so that when they meet with their doctor, they'll be able to deliver their own, personally investigated and compiled report on what treatment options to consider. Basically the patient does all the leg work, and the doctor gets paid.

Now I ask: Can it get any more ludicrous?

Yes it can.

The PPACA was modeled after the Massachusetts health insurance plan implemented in 2006 which, despite being touted as universal coverage for its residents, still leaves many uninsured and subject to costly tax penalties. On top of that, a large number of insured residents continually bounce in and out of plans because eligibility and affordability are based on income. This system fails to recognize the instability and complex financial situations of the working class and poor. The stress of having to fill out new paperwork when income changes – be it once a year or more – is daunting as is being shifted from one plan to another which leaves residents with premium and cost-sharing changes while some must find new doctors and others can't find a doctor in their area who will take residents in Medicaid or in the subsidized plans.

The Massachusetts Health Plan includes

(1) An individual mandate (penalizing residents 18 and up who don't have insurance);
(2) An employer mandate - 11 or more employees (known as pay-or-play);
(3) A "Health Insurance Connector Authority" through which uninsured residents can purchase for-profit health insurance (a quasi state agency operated by politicians and highly paid, unelected political appointees and is influenced by business executives from the private insurance industry. This arrangement means the plans offered will not upset any special interests and profits will be assured);
(4) State subsidies for residents with incomes up to three times the federal poverty level.

According to Connector documents, between April and July 2008, the subsidized plans had 60,681 enrollments and 62,672 disenrollments, for a net loss of 1,991 members. There were 45,803 terminations in the four months prior to June 2009.

From the beginning, the Massachusetts plan was fraught with problems:

"Massachusetts health program, model for Obama's reform, strains state budget. Rapidly rising health-care costs are the central problem with the plan. Since 2006, the cost of the state's insurance program has increased by 42 percent [and] in the absence of policy change, health care spending in Massachusetts is projected to nearly double to $123 billion in 2020. Meanwhile, the cost of insurance premiums in the state is the highest in the nation, and double-digit rate hikes are expected again in 2010 [and] will overwhelm the state's budget. Already it has forced service cuts…In 2009, the state announced plans to drop coverage for 30,000 legal immigrants [to] cut $130 million"

dailycaller.com
1/10/2010

The Boston Globe reported (2/5/07):

"The Connector's policy committee decided in November that the minimum plans should provide comprehensive coverage, including prescription drugs, and hired an actuary to model a minimal plan. It came back with a $260 average premium and a fairly high deductible, which applied to hospital benefits [uh, oh, those inflated hospital bills – up by as much as one thousand percent]. But when the board sought bids from insurers, many came in substantially higher…monthly premiums ranging from $250 for a 28-year-old to $500 for a 56-year old [with a monthly average premium of $380]."

The *Boston Globe* reported 2/10/11 (excerpts):

"Plans steer patients to lower-costs hospitals.
Hundreds of small businesses have signed up in the past month for a new Blue Cross Blue Shield health insurance plan that charges employees hefty fees for seeking care at more expensive hospitals, in an effort to steer them to lower cost care.

The popularity of the plan – Blue Cross Blue Shield of Massachusetts says it is the fastest launch ever of a new product – is the latest sign that the once radical idea has been embraced as a way to control soaring health care cots, even as pricier hospitals warn of a possible backlash and cuts in services.

Other Massachusetts insurers also report brisk business in plans that offer lower premiums in exchange for limits on use of high-cost care. The plans either charge consumers extra for receiving care from popular but expensive hospitals or doctors, or bar them altogether from seeking treatment at those institutions and practices.

…at 15 higher-cost hospitals, including Massachusetts General and Brigham and Women's hospitals [combined fund balances 2008 **over $2 billion**], Children's Hospital Boston [fund balance **$1.6 billion**], and UMass Memorial Medical Center in Worcester.

…But executives at Partners HealthCare, the parent organization of Massachusetts General and Brigham and Women's, said that while these new policies are making providers more sensitive to price, they have pitfalls.

Dr. Thomas Lee, head of Partners' physician group, said some people will become seriously ill and realize they can't go to, or can't afford, their first-choice hospital."

The Boston Globe 2/10/11

Boston AP reported 2/11/11 (excerpts):

"Mass seeks health insurance rate cuts.

The agency that oversees the Massachusetts health insurance law is asking insurers to cut rates for 160,000 low- and moderate-income residents who receive state-subsidized care.

The Connector Authority is facing soaring costs, vanishing resources, and an expected jump in enrollment.

With projected $82 million gap, the authority's board on Thursday approved a major change in how it will do business with insurers in the Commonwealth Care program…

…Health care advocates are concerned that rate cuts would probably mean insurance plans with a narrower choice of hospitals and physicians and more restrictions on the use of specialists."

Boston AP 2/11/11

Don't forget those monthly premium numbers include high deductibles, co-pays, co-insurance and the ever-lovin', flat-out denial of medical care by the for-profit insurance companies. Nothing in the Massachusetts or PPACA (Obama plan) protects a patient from these abuses.

Other major problems with the Massachusetts plan include:

(1) In order to avoid paying for health insurance, employers offer expensive plans so employees have no choice but to opt out. This strategy saves the employer from paying bulky fines but leaves employees without coverage. Citizens without health insurance face expensive penalties enforced by the Massachusetts Dept. of Revenue as income tax evasion if not paid in full and on time with their state tax return…in addition to being uninsured.

(2) The bureaucracy of obtaining health coverage for those who lose their jobs is enormous. A state subsidized plan is only available to those who have already applied and been turned down for unemployment health coverage.

(3) For many citizens, income varies from year to year. Part time workers, the self-employed, and those who move in and out of the state find it difficult to "fit" into a particular income level which is important because health insurance premiums are based on income. A citizen has 10 days to report a change in income.

(4) Because the low-income (subsidized) plans are administered by the Massachusetts Office of Medicaid, some residents refuse to enroll in either Medicaid or a subsidized plan because of the federally-required estate recovery program which mandates (and allows) all states that receive federal Medicaid funding to recover assets upon death of

Medicaid members who used Rx and hospital benefits at age 55 and up. However a state **can** recover assets for any and all medical benefits used. The age in some state may be lower, but higher than age 55 is not permitted by the federal regulation.

The estate recovery clause is on the signature page of the forms that must be submitted when applying for Medicaid (MassHealth in Massachusetts) and the state-subsidized insurance plans. Federal regulations stipulate that all applicants be notified about estate recovery upon application and re-determination, and the disclosure/signature page must be signed by all applicants and also for annual re-determinate (to verify income).

The state keeps a running tab of the benefits used and also has the power to lien property and assets. When you die, it takes your estate (your assets) – dollar for dollar – for the benefits on your tab. It is not known if fees and state attorney costs are also added to the tab, and if you can check periodically to even see the figures on your own tab.

Two years into the Massachusetts plan after some shouting by the private sector, text was added to the estate recovery clause on the signature page which stated that *under current practice,* estate recovery does not apply to Commonwealth Care (subsidized plans). Most likely, residents will not know when or if current practice has changed unless they do some investigating. If it has changed when they sign, but the language on the form has not been modified to clarify this, or they are given an outdated form, they will never know. Neither will their heirs who, for starters, can kiss the family home goodbye. It appears that Massachusetts has left the door wide open for use of estate recovery in the state-subsidized plans.

It must be noted that under PPACA (Obama plan), Medicaid has been expanded to 133 percent of the Federal Poverty Level, the age limitation has been increased to 64, childless adults will be allowed, and **the asset test was dropped**. This means that when the expansion of Medicaid is implemented under PPACA, millions of citizens age 55 and up who are eligible for Medicaid will be subject to this *federally-required* estate recovery program which is administered by each state. If they are not auto-enrolled in Medicaid and refuse to apply, they will be penalized unless they can afford to purchase health insurance on the open market. Citizens who are found eligible for Medicaid will be "encouraged" to enroll in this plan and will be offered assistance when they try to "shop" at the Exchange for a plan. Either they will not be allowed to apply for a subsidized plan or there will be no plans in the Exchange that are affordable for this segment of the population. Plans in the Exchange are for citizens who earn over 133 percent to 400 percent of the Federal Poverty Level.

Oh, but to be fair, residents in Massachusetts do have some options available to them if they can't afford the insurance that the state decided they could afford:

(1) They can file for an appeal and request an exemption if they qualify for at least one financial hardship event (basically proving they've so depleted the family's income that they're unable to pay for the plan they "can afford". Exemptions come with an expiration date, so you have to clean up your act very quickly!

Exemption circumstances include homelessness, eviction or foreclosure notices, utility shut-off notices, domestic violence-related medical trauma, major long-term illness of a child, death of spouse or partner, fire, flood, natural disaster or human-caused event. (What, no witness protection program exclusion?). And my personal favorite:

> "[If] you can establish that the expense of purchasing health insurance that meets minimum ***credible*** [state-mandated] coverage would have caused you to experience serious deprivation of food, shelter, clothing, or other necessities."

This is a joke, right?

The PPACA (Obama plan) is also an expensive, bureaucracy-laden, class-based system, and like the Massachusetts plan, is designed to control your finances and health care choices while it rations and restricts access to care for the very people we are told it will help. Both plans discriminate and exploit the working class and poor who do not have the resources to defend themselves.

"We have 900 billing clerks at Duke (medical system, 900 bed hospital). I'm not sure we have a nurse per (each) bed, but we have a billing clerk per bed…it's obscene."

Uwe Reinhardt, Hearing on Health Care Reform
US Senate Finance Committee
November 19, 2008

The Patient Protection and Affordable Care Act does nothing to address the cumbersome and burdensome administrative costs of hospitals; in fact it enables this dysfunction by adding new requirements and mandates and forcing more people into it. The PPACA does nothing to stop The Health Care War Economy shell game. It does nothing to curb administrative costs and profits at insurance companies which can be as high as 35%. It does nothing to reign in costs or the threat by insurance companies of 20 to 40% increases from year to year. It does not guarantee universal coverage.

Health care costs are 21% of every State budget and16% of household discretionary spending. PPACA does zilch to lower these staggering percentages and as the Massachusetts plan has proven in its 4 year existence: it targets the poor and uninsured (even dumping people from the plan in dire cost saving measures) by penalizing them for not having health insurance and by attaching (i.e. financially seizing) their assets

XVI UNIVERSAL SINGLE-PAYER HEALTH CARE

The first thing Universal Single-Payer Health Care (USPHC) – also known as improved and expanded Medicare for all - will do for Americans is simplify their lives.

Universal Single-Payer Health Care is uncomplicated, comprehensive, patient-centered care which is publicly administered and privately delivered.
It is a Public-Private Partnership

How it works

(1) Universal - because everyone would be covered regardless of race, age, sex, employment or ability to pay. Everyone in; no one out;

(2) Single-Payer – because funding would originate from a single source, a small, fixed tax (payroll or income) as a percentage of wages or income which would be much smaller than what the majority of Americans now pay in insurance premiums.
Full disclosure: LeBron James and Paris Hilton would pay more;

(3) Health Care – because what we now have is *sick* care. Universal Single-Payer would be accounting-determined-cost-controlled care without playing The Health Care War Economy shell game where citizens are exploited by hospitals, profit-driven insurance conglomerates, and the pharmaceutical industries who artificially inflate costs.

Under USPHC there would be **NO**
(01) Deductibles
(02) Co Payments
(03) Co Insurance
(04) Donut Holes
(05) Out-of-Pocket Expenses
(06) Need to fight with hospitals over payment of invoices
(07) Aggressive collection tactics
(08) Need for Workman's Compensation Insurance for medical expenses (hence reducing the cost of Workman's Comp Insurance which is always passed on to consumers)
(09) Need for Medical Expense clause in Auto policies resulting in lower auto insurance rates
(10) Need for Medical Expense clause in Homeowner's policies resulting in lower homeowner's insurance rates.

If you hate socialized medicine, you'd better run down to your local congressman's office and demand a change in how we administer medical care and treatment to our men and women in uniform.
The Veteran's Administration **is** socialized medicine.

Additionally, there would be **NO**

(01) Referrals;
(02) In or out-of-network options;
(03) Participating versus nonparticipating regarding specific insurance companies;
(04) Receipt of cumbersome, contradictory, and costly paperwork from insurance companies notifying insured of

Claim Filed
Claim Pending
Claim Being Processed
Possible Participant's Obligation
Claim Denied

And most importantly,

(05) NO need to sweat out how much *your* portion of the health insurance policy (you desperately need) will cost from year to year.

Expanded and Improved Coverage

Universal Single-Payer Health Care is not socialized medicine. It is a public-private partnership which would include coverage for all medically necessary services with patient free choice, all owned and operated privately (or nonprofit i.e. hospitals).

According to HR676 – a bill to provide comprehensive health coverage for United States residents - introduced January 2009 into The House of Representatives by Congressman John Conyers, the bill's sponsor, Section 102. Benefits and Portability include:

Primary care and prevention
Inpatient care
Outpatient care
Emergency care
Prescription drugs
Durable medical equipment
Long-term care
Palliative care
Mental health services
Dental services
Substance abuse treatment services
Chiropractic services
Vision care
Hearing services including hearing aids
Podiatric care

How is That Possible?

Under USPHC, there is a single source of revenue – i.e. a small payroll or income tax, a fixed percentage of wages or income which, in the case of a payroll tax would be paid by the employee and matched by the employer – similar to the way Medicare currently operates (Medicare is also currently paid by the self-employed through the filing of income tax returns). The majority of Americans would be paying less through this tax than what they now pay in insurance premiums, out-of-pocket expenses, and fights with hospitals over inflated billing.

According to a 7/28/2010 article, "RX on Medicare's Birthday: Expand it to All", by Dr. Quentin Young, which can be found on the website of Physicians for a National Health Program, an organization of 15,000 member physicians advocating for a Single-Payer system:

"Medicare stands like a rock in a troubled sea of waste, inefficiency and disarray in the rest of our health care system, dominated as it is by big, corporate insurers whose paramount goals is to maximize profits, often by enrolling healthy, avoiding the sick, raising premiums and denying claims. By replacing our crazy-quilt, inefficient system of private health insurers with a streamlined, publicly financed single-payer system, we would reap enormous savings. First, we would save about $400 billion annually that is presently wasted on excess paperwork and bureaucracy. That's enough money to cover everyone who is currently uninsured and to upgrade everyone else's coverage without increasing overall US health spending by a single penny. Patients could go to the doctor and hospital of their choice. Second, we'd acquire powerful cost-control tools like the ability to purchase medications in bulk, negotiate fees, develop global budgets for hospitals, and coordinate capital investments. Such tools would rein in costs and help assure the program's sustainability over the long haul."

Under our current systems, for-profit insurance companies set the rates they are willing to accept to provide coverage. The average family policy is $15,000 – and don't forget this increases by as much as 12% to 25% each year.

Current Health Care System Cost

Our current system of paying for health care is a regressive tax.

Assume insurance premium payment for family coverage is $15,000

Employee salary @ $125,000 = total cost of premium is 12% (125,000/15,000 = 12%)
Employee salary @ $80,000 = total cost of premium is 18.75%
(80,000/15,000 = 18.75%)
Employee salary @ $45,000 = total cost of premium is 33.33%
(45,000/15,000 = 33.33%)

Universal Single-Payer Health Care System

Under Universal Single-Payer, assuming a fixed payroll tax of approximately 3.3% - contributed by both employer and employee - health care costs would be:

Employee Salary @ $125,000 X 3.3% = $4,125 employee and $4,125 employer for total cost of $8,250 – savings equal $6,750 ($15,000 less $8,250)

Employee Salary @ $80,000 X 3.3% = $2,640 employee and $2,640 employer for total cost of $5,280 – savings equal $9,720 ($15,000 less $5,280)

Employee Salary @ $45,000 X 3.3% = $1,485 employee and $1,485 employer for total cost of $2,970 – savings equal to $12,030 ($15,000 less $2,970).

But What About Charity Care, Wouldn't We Lose it?

Under USPHC, charity care - which is funded by taxpayers - would be unnecessary because all citizens would already have comprehensive health coverage.

As stated earlier, charity care is problematic in that its funding burdens cash-strapped States. Further the program's administrative paperwork is cumbersome, subject to outside audit, and the approval process is timely and invasive. Many patients are reluctant to complete the application for fear of disclosing personal financial and employment information.

What's worse is that low-income patients who don't qualify for 100% of charity care are still left to pay the balance of an inflated hospital bill.

Wait a Minute. Who's Going to Manage the Funds?

> "There is a myth that with national health insurance the government will make the medical decision. But in a public financed, universal health care system, medical decisions are left to the patient and doctor as they should be. In a public system, the public has a say in how it's run. Cost containment measures are publicly managed at the state level by elected and appointed agencies that represent the public. This agency decides on benefit packages and hospital budgets. It is also responsible for health planning and the distribution of expensive technology. Thus the total budget for health care is set through a public, democratic process. But clinical decisions remain a private matter between doctor and patient."
>
> www.pnhp.org "frequently asked questions"

Universal Single Payer Health Care funding would work similar to the way Medicare is now managed. **Further, Medicare's overhead costs are between 2 to 5% - a mere pittance compared to the 25 – 35% expended in the for-profit insurance industries**

The following countries have universal health care plans:

Country	How Long the US has been lagging behind other countries
Australia	Since 1975
Bahrain	Since 1957
Brazil	Since 1988
Brunei	Since 1958
Canada	Since 1966
Cuba	
Cyprus	Since 1980
Denmark	Since 1973
Finland	Since 1972
France	Since 1974
Greenland	
Hong Kong	Since 1993
Iceland	Since 1990
Ireland	Since 1977
Israel	Since 1995
Iraq	
Italy	Since 1978
Japan	Since 1938
Kuwait	Since 1950
The Netherlands	Since 1966
New Zealand	Since 1938
Norway	Since 1912
Portugal	Since 1979
Russia	
Singapore	Since 1993
Slovenia	Since 1972
Spain	Since 1986
Sweden	Since 1955
United Arab Emirates	Since 1971
United Kingdom	Since 1948

The Iraqi constitution, as drawn up by the administration of George W. Bush in 2005, specifically says:
Every [Iraqi] citizen has the right to health care

From *The Huffington Post* 9/9/2009 "Guaranteed Health Care in Iraq - But Not for You", Mark Dorlester:

"Article 31 of the Iraqi Constitution, drafted by your right-wing Bushies in 2005, and ratified by the Iraqi people, includes state-guaranteed (single payer) healthcare for life for every Iraqi citizen."

The Iraqi Constitution, Article 30:

"First: The state shall guarantee to the individual and the family – especially children and women – social and health security, the basic requirements for living a free and decent life, and shall secure for them suitable income and appropriate housing.

Second: The State shall guarantee social and health security to Iraqis in cases of old age, sickness, employment disability, homelessness, orphanhood, or unemployment, shall work to protect them from ignorance, fear and poverty, and shall provide them housing and special programs of care and rehabilitation, and this shall be regulated by l aw."

The Iraqi Constitution, Article 31:

"First: *Every citizen has the right to health care.* The State shall maintain public health and provide the means of prevention and treatment by building different types of hospitals and health institutions.

Second: Individuals and entities have the right to build hospitals, clinics, or private health care centers under the supervision of the State, and this shall be regulated by law."

How Would Single Source Affect Hospitals?

As stated earlier, currently hospitals must secure payment from a multitude of sources, including, but not limited to:

(01) Medicaid
(02) Medicare
(03) For-profit insurance companies (there are at least 1,300 across the nation each with their own set of policies, procedures and paperwork)
(04) TriCare (the civilian portion of veteran's benefits)
(05) Charity Care
(06) SCIP (State Children's Insurance Programs)
(07) Workman's Compensation Insurance
(08) Liability Insurance
(09) Homeowner's Insurance
(10) Auto Insurance
(11) Collection Agencies
(12) Attorneys
(13) And a host of other revenue streams

Imagine, you are taking a trip and need to go from New Haven, Connecticut to Spencer, Iowa, and that 1,320 mile excursion mandates you take at least THIRTEEN different cars, changing every 100 miles or so.

Each car has a separate insurance policy, repair/maintenance log, depreciation expense, and consumes irregular (and unknown) miles per gallon…none being equal.

Each time you switch cars, you have to take everything out of the car you're in, place it in the next mode of transportation; fill up the tank, and go.

Not only would this absurd inconvenience lengthen your trip, but it would certainly add a level of frustration – not to mention *cost* – which would render your journey almost prohibitive.

That analogy is exactly how our current for-profit health care system – including nonprofit hospitals – operates.

Hospitals must run their "vehicles" under those unbelievable situations every single day, constantly changing "carriers" from patient to patient in order to advance their mission.

But under Universal Single-Payer, there would be ONE funding source paid to hospitals. And that one funding source would be negotiated with hospitals so they would be paid ONE amount equal to their annual operating costs.

As a result, hospitals would have **no** need for:

(01) Billing
(02) Filing of claim forms
(03) Collection costs
(04) Writing off bad debt
(05) Extensive paperwork tracking of each separate billing entity's processing, procedures, *and* tracking deadlines.

Bonus by-products of a Universal Single-Payer System are that hospitals would have **no** need for:

(01) Lobbying
(02) Colorful glossy brochures
(03) Advertisements – bulletin boards, radio spots, computer ads, or full and half-page colorful advertisements such as Holy Name Hospital and Meridian Health System have recurring in *The New York Times* on Sundays which cost hospitals millions of dollars.

But Wait There's More

The cost savings under a Universal Single-Payer System are enormous.

A synopsis of approximate savings for **NJ**:

566 municipalities	AVG ANNUAL SAVINGS	$900 Million
600 plus School Districts	AVG ANNUAL SAVINGS	$1.8 Billion
21 Counties	AVG ANNUAL SAVINGS	$600 Million
Subtotal in Projected Annual Savings		$3.3 Billion

Specific examples of independent annual entity savings (2008 calculations) for NJ:

Asbury Park	Annual Savings $4.7 million (11.6% of budget)
Brick Township, Ocean County	Annual Savings $8.2 million (10% of budget)
Old Bride Twp	Annual Savings $7.3 million (12% of budget)
Matawan-Aberdeen	Annual Savings $6.0 million (10% of budget)
Asbury Park School District	Annual Savings $5.2 million (7.7% of budget)
Ocean Township School District	Annual Savings $6.3 million (10% of budget)
Gloucester County	Annual Savings $16.0 million (7.5% of budget)
Monmouth County	Annual Savings $30.0 million (6.0% of budget)

But Wait There's Even More

Add to that number:

(01) Local Authorities (like transportation, utilities, and sewerage)
(02) Fire Districts
(03) State Government

and most importantly:

(04) NJ's **un**-funded Post-Retirement Health Benefit Obligation projection of

$57 Billion

would disappear!

Under Universal Single Payer Health Care, NJ's unfunded post-retirement health benefit obligation to its state/county/municipal/school/authority/district employees of approximately $57 billion
would disappear with the stroke of a pen.

Bloomberg News reported 1/14/11 "[NJ Governor Chris] Christie, a first-term Republican, said health-care spending 'will bankrupt' the state unless it requires its workers to pay more for medical coverage. NJ will spend $4.3 billion on employee and retiree health insurance this year, and that cost will rise *40 percent* within four years".

Hello, NJ Governor Christie? Here's your answer!

But Wait There's Even More…

The above mentioned savings are calculated for the public sector. Now, imagine the savings for the *private* sector. Business could expect similar cost reductions since they would no longer have to be slaves to for-profit insurance company's demands for (ever increasing) premiums – but instead pay a fixed percentage of tax which would be progressive.

So How Would That Specifically Work? I Need Examples

Assume the following for clarification of how USPHC would work in the private sector. Assume a payroll tax – employee and employer matching – of 3.3%

Company X has 12 full time employees, salary expense is $750,000. Health care premiums for 8 employees totaled $118,000 (118,000/750000 = 16%) for this high deductible plan.

Under USPHC costs would be

Salary expense	$750,000
Fixed progressive tax (approx)	3.3%
Total health care cost *for the employer*	$24,750

Savings to employer = $93,250 ($118,000 less $24,750).

Because the private sector would have enormous savings in health care costs, an expected savings can be seen in almost every area of consumer spending.

Savings can be translated to the following insurance costs simply because under Universal Single-Payer Health Care, there would be no need for medical insurance coverage:

Auto Insurance
Workman's Compensation Insurance
Liability Insurance
Homeowner's Insurance

I'm Not Done: There's Even More Savings

Under USPHC there would be **no** need for:

(1) Veterans Administration – health care portion – all service members would be covered
(2) Charity Care
(3) State's Children's Health Plans
(4) State health care paid to for-profit insurance for employees
(5) State health care paid to for-profit insurance for retirees
(6) Federal health care paid to for-profit insurance for employees
(7) Federal health care paid to for-profit insurance for retirees
(8) TriCare

Most importantly, under universal single-payer health care, there would be no tricky asset recovery clause where your assets are seized by the state to settle medical and hospital costs.

XVII SPECIFIC DIFFERENCES BETWEEN (1) THE NEWLY ENACTED HEALTH CARE LEGISLATION – THE PATIENT PROTECTION AND AFFORDABLE CARE ACT - AND (2) UNIVERSAL SINGLE-PAYER HEALTH CARE

The following are highlights of specific major differences of provisions of
The Patient Protection and Affordable Care Act (PPACA)
and
Universal Single-Payer Health Care.

XVII.A. Penalties for non-compliance

PPACA

PPACA specifies that all US citizens and legal residents must have health insurance by 2014 or pay a penalty which starts at $95, or 1% of income (whichever is more), and rises to $695 or 2.5% of income in 2016 (whichever is more). The penalty can only be avoided if you have (a) Employer-sponsored health care, (b) Individual health care, (c) Medicare, (d) Medicaid, (e) State's Children's Health Insurance Program (SCHIP), (f) Tricare (coverage for military personnel treated in civilian facilities), (g) Tricare for Life (Medicare-type coverage for military retirees, or (h) veteran's health benefits.

Universal Single-Payer Health Care

All citizens would be covered so there are no penalties (also avoids redundant health care programs as itemized above – and see also annual savings mentioned earlier).

XVII.B. Small Business Health Care Tax Credit

PPACA

PPACA gives a tax credit to small employers with less than 25 full time employees (FTE) with annual average wages of not more than $50,000 but really not more than $25,000 (because phase out begins at compensation over $25,000); further the premiums paid must be under a "qualified arrangement" meeting certain requirements which include, but are not limited to, the fact that premiums paid must be less than the average premium as determined by the Department of Health and Human Services (Revenue Ruling 2010-13) which sets forth the average premium rates for the small group market for areas within some states (sub state rates).

The IRS explains the calculation of the credit on their website:

"If the number of FTEs exceeds 10 or if the average annual wages exceed $25,000, the amount of the credit is reduced as follows: If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15. If average annual wages exceeds $25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed $25,000 and the denominator of which is $25,000. In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled. For an employer with both more than 10 FTEs and average annual wages exceeding $25,000, the reduction is the sum of the amount of the two reductions. This sum may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual wages of less than $50,000."

IRS.gov Small Business Health Care Tax Credit: Frequently Asked Questions

Oh and by the way, the credit is *only* applicable against an actual income tax or AMT (Alternative Minimum Tax) liability, so if there is no liability, the credit cannot be taken in that year (which is possible if a small business employer spends $100,000 plus on health insurance premiums).

Universal Single-Payer Health Care

All citizens are covered.
Period.
Further there's no need for tax credits and complex calculations because the cost of Universal Single-Payer Health Care is *tremendously less than* the computation of the charge of for-profit premium payments *minus* the tax credit.

XVII.C. Closing the Donut Hole

PPACA

For Medicare D prescription drug beneficiaries, the donut hole will eventually be reduced. In general, here's how the donut hole currently works (Medicare D is managed by the for-profit insurance companies who offer tens of dozens of complicated plans):

Medicare D:
Seniors pay a monthly premium for coverage, deducted from Social Security.
Seniors pay 100% of cost of drugs until deductible of $310 is met.
Seniors then pay 25% of cost of drugs until they reach $2,800.
Seniors have hit the "donut hole" and pay 100% of cost of drugs until they've reached $4,550.
Seniors who hit $4,550 still pay 5% cost of drugs.

So seniors currently are obligated to pay, annually, under Medicare D:

Premiums (avg)	$ 450.00
Deductible	$ 310.00
25% co pay up to $2,800	$ 622.50
Donut Hole	$1,750.00

Total out-of-pocket costs for seniors before paying 5% remaining cost of medication is **$3,132.50**

Under PPACA, those caught in the donut hole will receive a $250 rebate in 2010. In 2011, seniors in the donut hole will be eligible for a 50% discount only *on brand name drugs* with further reductions promised until the year 2020 when the donut hole is supposed to be closed. But 8 years from now when the donut hole is promised to be closed, seniors will still pay 25% of the cost of their drugs.

Universal Single-Payer Health Care

There is no need for redundant, bloated, confusing, and expensive Medicare D programs. Under USPHC, all prescription drugs *would be fully covered*.

XVII.D. Preventive Services

PPACA

All health insurance plans will have to cover checkups and preventive services without co pays – *by 2018.*

Universal Single-Payer Health Care

No waiting period for checkups and preventive care; proactive health initiatives are already included

XVII.E. Access to out-of-network Emergency Room Services

PPACA

From the US government's website promoting The Patient Protection and Affordable Care Act:

"In the past, some health plans would limit payment for emergency room services provided outside a plan's pre-selected network of emergency health care providers, or they would require that you get your plan's prior approval for emergency care at hospitals outside of its networks."

www.Healthcare.gov

Hold on, now; wait a minute, you have a medical emergency and you must stop and take the time to obtain your insurance company's permission to obtain critical care services? That doesn't sound like a good idea to me.

There's more:

"This could mean financial hardship if you get sick or injured while away from home. *The new rules prevent* health plans from requiring higher co-payments or co-insurance for out-of-network emergency room services. The new rules also prohibit health plans from requiring you to get prior approval before seeking emergency room services from a provider or hospital outside your plan's network."

www.Healthcare.gov

Whew! That's much better. Wait, we'd better check the fine print:

"These rules apply to all group health plans and individual health insurance policies *created or issued after March 23, 2010*. These rules *do not apply* to 'grandfathered' health plans…Please note that you still may be responsible for the difference between the amount billed by the provided for out-of-network emergency room services and the amount paid by your health plan."

www.Healthcare.gov

OK so if you're grandfathered into an existing plan, you are not afforded the new coverage.

Let's put that section of The Patient Protection and Affordable Care Act to the test.
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Let's say you live in NY or Kansas or Wisconsin and your family goes on vacation in another part of the country – say, Arkansas, Tennessee, or Wyoming - and you are having a wonderful time with the other vacationers and then your son, who is riding bicycles with a couple of friends he just met, perhaps doing "wheelies" has an accident. So you run out to see what happened only to observe the bone in his arm broken to the point that it is sticking out of his skin. So under the grandfathered clause in the new legislation – the Patient Protection and Affordability Care Act – in order to avoid penalties from your insurance carrier, you must have the presence of mind to (a) run and get your insurance ID card, (b) hold it steady in your hand so you can actually read the number on the back in order to place a call, and (c) ask your insurance provider – after going through about 3 minutes of prompts hoping to get a live person on the phone – "where is the nearest participating hospital in my plan?" who might tell you "Oh you must bring your child to Hospital X" which is a one hour ride from where he broke his arm.

Universal Single-Payer Health Care

All medically necessary hospital services – including critical care - are covered without jumping through rotating hoops.

XVIII CONCLUSION

The Patient Protection and Affordable Care Act of 2010 is costly, redundant, complicated, and forces more taxpayer dollars into the coffers of the for-profit insurance industry, while doing little to protect citizens against the abuse of hospital billing practices, enormous out-of-pocket expenses, or the fear of expulsion from any given plan, especially when you need it the most.

OK But What's the Possibility of This Getting National Attention? How Can I Become Involved?

In order for the citizens of America to pursue a successful campaign for Universal Single-Payer Health Care**, we will need to mobilize state by state**, which is how the woman's suffrage movement gained momentum (hopefully, it won't take as long – *72 years* - the suffrage movement was an outgrowth of the Seneca Falls Convention of 1848).

The following is a synopsis of what's happening state-by-state:

California

As the world's 8th largest economy, thanks to groups like

California Nurses Association,
California School Employees Association
Health Care for All California
California Physicians Alliance
California Teachers Association
California Council of Churches,
League of Women Voters
California Health Professional Student Alliance
California Consumer Federation
California Alliance for Retired Americans
Single Payer Now
Progressive Democrats of America

In June of 2010 the Assembly Health Committee approved the California Universal Health Care Act which guarantees all Californians comprehensive, universal health care.

According to the 6/30/2010 *California Chronicle* article

"Our State is being bankrupted by out-of-control health care cots, and small businesses and families are struggling to pay premiums that rise as much as 40% every year,' said Senator Leno [sponsor of the bill]. 'California's single payer plan remains the gold standard for health care reform, and is the only proposal that will truly contain health care spending and provide universal coverage for all."

The bill – SB 810 – known as The California Universal Health Care Act, would replace private insurance companies by one non-profit health insurance fund and would create a public-private partnership to bring Universal Single-Payer which would include

Medical
Dental
Vision
Hospitalization
Prescription Drugs

Further, according to the *Chronicle*:

> "California currently spends $200 billion annually on a fragmented, inefficient health care system that wastes 30% of every dollar on administration. With Senate Bill 810, that wasteful spending is eliminated. The bill creates no new spending, and in fact, studies show that the state would save $8 billion in the first year under this single-payer health care plan."

Twice in recent years, advocates for Universal Single-Payer in California were successful in getting a referendum on the ballot, where it was overwhelming approved by popular vote and subsequently moved forward in Congress, only to be vetoed each time by then Governor Arnold Schwarzenegger.

For more information go to www.calnurses.org

Vermont

Independent Senator Bernie Sanders has been an untiring advocate of Universal Single-Payer, and along with Vermont's Labor Center (from which the below information was obtained), together have been working to move forward a single-payer agenda.

The following is from S.88, 3/8/2010, presented to the Vermont Senate regarding the need for Universal Single-Payer Healthcare:

Section 2. Principals for Health Care Reform

(1) Every person is entitled to comprehensive, quality health care.
(2) Systemic barriers must not prevent people from accessing necessary health care.
(3) The cost of financing the health care system must be shared equitably.
(4) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves.

(5) As a human right, the health care system that satisfies these principles *is the responsibility* of the government to ensure.

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Section 3.Goals of the Health Care Reform

(1) Vermont's nonprofit community hospital system will be preserved through a system of negotiated payments that are drawn from public revenues and which are based on annual global budgets.

(2) Vermont's primary care providers will be adequately compensated from public revenues through a uniform payment system that eliminates multiple insurers and reduces administrative burdens on providers.

(3) Health care in Vermont will be organized and delivered in a patient-centered manner through community-based systems

For more information, go to www.workerscenter.org

Other states actively campaigning for Universal Single Payer Health Care:

New Jersey NJ One Plan www.njoneplan.org

Minnesota The Minnesota Health Act www.mnhealthplan.org

Pennsylvania The Family and Healthcare Security Act www.healthcare4allpa.org

Wisconsin Wisconsin Health Security Act www.wisconsinhealth.org

Organizations advocating for Universal Single-Payer Health care:

Physicians for National Health Program

Physicians for a National Health Program, a nonprofit educational organization with over 18,000 physician-members, is dedicated to enacting single-payer national health insurance (as introduced by John Conyers in House Resolution 676 – known as HR 676). This legislation is also referred to as Expanded and Improved Medicare for All.

Supporters of H.R. 676 include:

California Democratic Party
Hawaii Medical Association
Kentucky State Legislature
New York State Legislature
New Hampshire State Legislature
Maine State Legislature
US Conference of Mayors

Resolutions passed in support of Universal Single-Payer Health Care include:

Chicago, IL
Austin, TX
Ithaca, NY
Louisville, KY
Bloomington, IN
Indianapolis City Council
Baltimore, MD
Lorain, OH
Warren, TN
Allegheny, PA

You can find out more at www.pnhp.org

Health Care Now

Health Care Now, a national advocacy non-physician group, also campaigns for HR 676 and consider health care as a human right and not a privilege based on the ability to pay. Their grass roots activism has done so much to bring the need for universal single-payer into the spotlight so much so that the League of Women Voters, a nonpartisan organization with over 150,000 members and active in all 50 states, overwhelming passed a resolution at their national convention in June 2010 to "advocate strongly for bills that legislate for improved Medicare for all (aka Single-Payer)."

You can find out more at www.healthcare-now.org

Universal Single-Payer Health Care is an affordable, common-sense solution to America's health care crisis. It's been successful in dozens of other countries and is progressive, equitable, and non-discriminatory.

"[For profit] health insurance premiums have consistently grown faster than inflation or worker's earnings in recent years. Between 2002 and 2007, the cumulative grown in health insurance premiums was **78%** compared with cumulative inflation of 17% and cumulative wage growth of 19%"

Kaiser Family Foundation, Sept 2007

It is time for every citizen to passionately advocate for a change to our current delivery of health care.
We the People desperately need Universal Single-Payer Health Care.

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