FIXING USA ECONOMY AND HEALTHCARE

Creating a Better Financial Environment for Business to Grow

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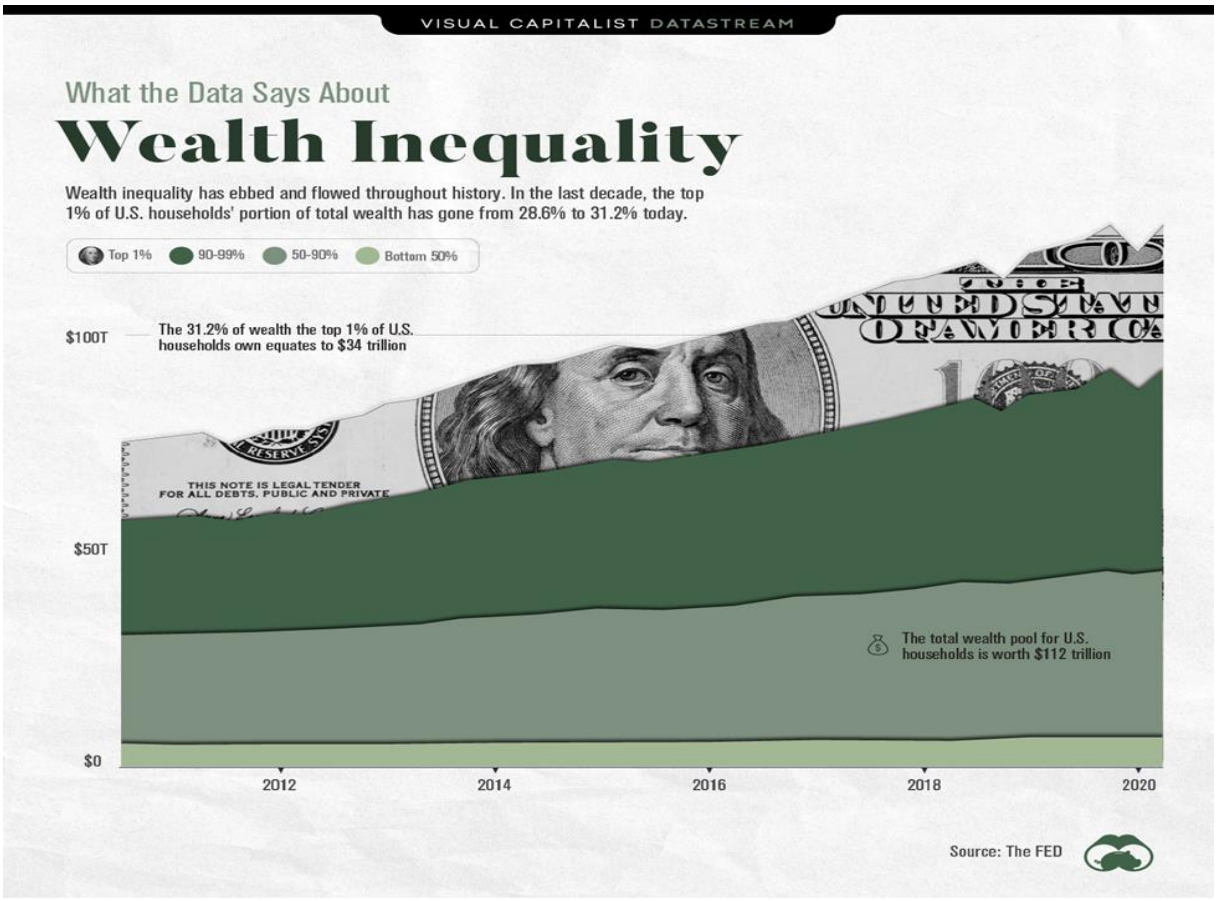
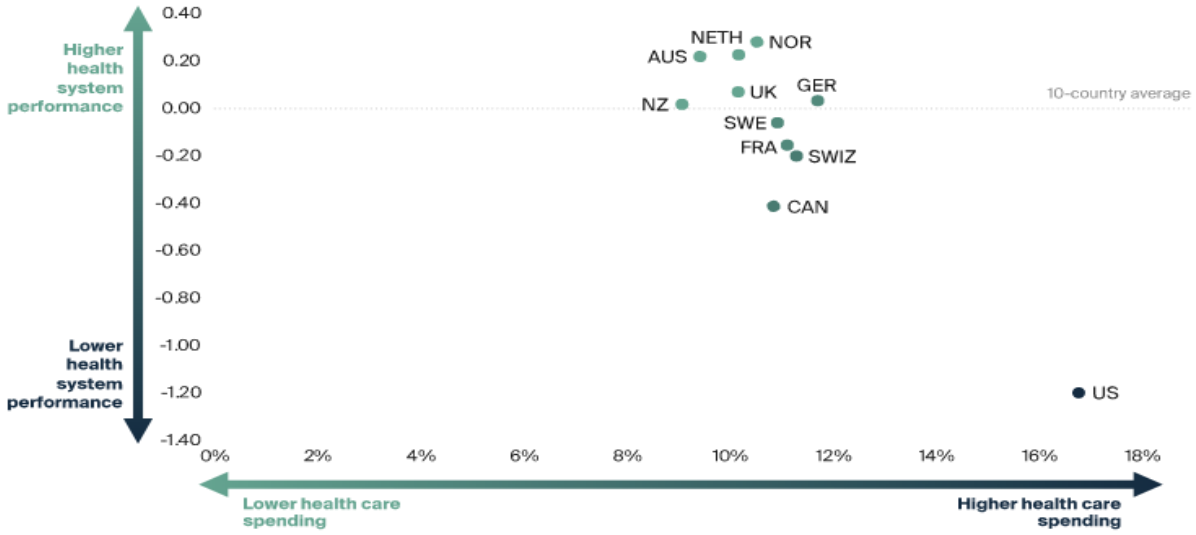
The two major concerns of the USA are the economy and healthcare costs.

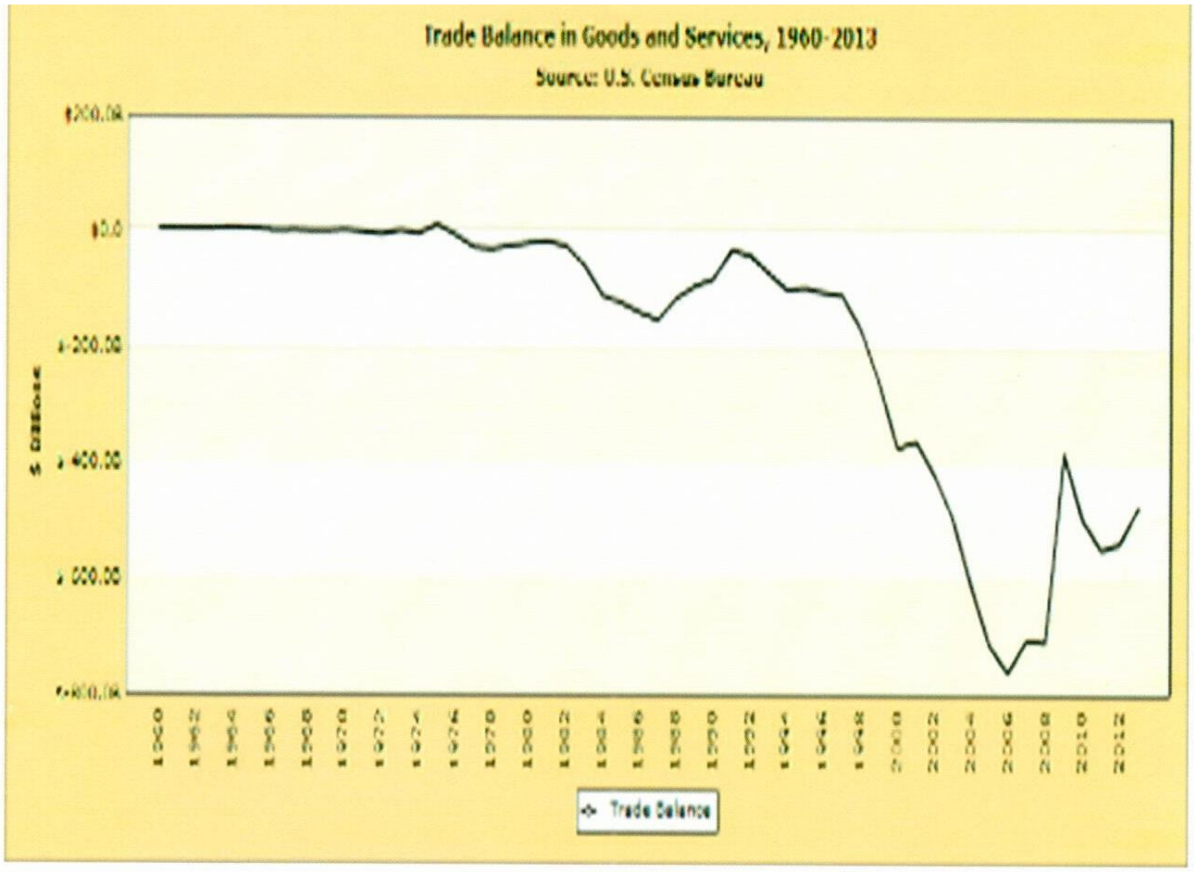
In terms of the economy, there are concerns about income inequality, the national debt, and the future of social security. The wealthiest Americans have seen their income and wealth grow significantly in recent years, while many middle- and lower-income Americans have seen their income stagnate or decline. The national debt has been a source of concern for many years and could lead to inflation or a loss of confidence in the US economy by foreign investors. Social security is facing a funding shortfall in the coming years, which could lead to benefit cuts or tax increases. Proposed solutions include higher taxes on the wealthy, increased public investment in infrastructure and education, and market-based solutions such as deregulation and tax cuts for businesses.



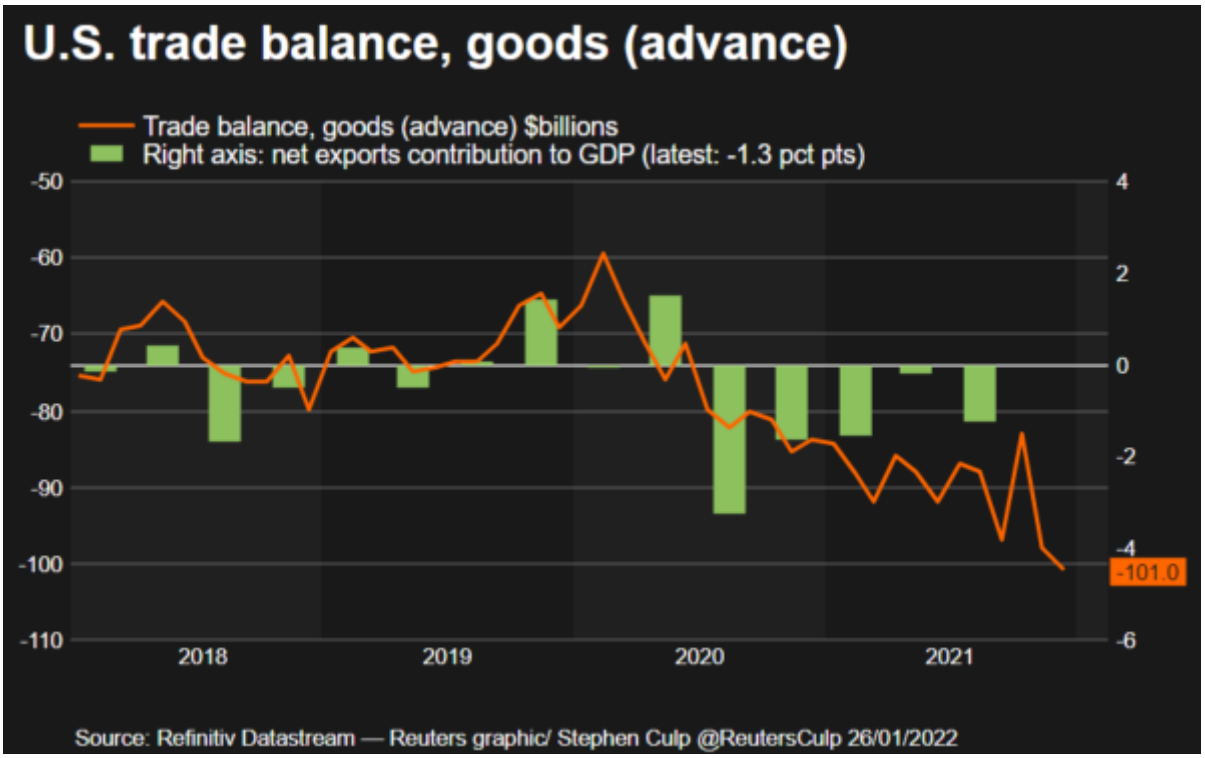
In terms of healthcare costs, the US has one of the highest healthcare costs per capita in the world due to high prices for drugs and medical procedures, administrative costs, and a lack of price transparency. The high cost of healthcare is a barrier to access for many Americans, particularly those without insurance or with high deductibles. There are ongoing debates about how to address these issues, with some advocating for universal healthcare or a public option, while others prefer market-based solutions.



The U.S. trade deficit started in the late 1980s. a short time after Congress changed the payment method for Medicare from a cost allocation basis, which was based on proportion of charges for government business and private-pay business, and adopted the Prospective Payment Plan, which the payments are based on the patients diagnosis, where annual adjustments to Medicare reimbursement were updated annually, mainly based on what the private-pay patients were charged for their services. The Healthcare Industry responded to this change by introducing the secrete kickback scheme and disguising the kickback as a contractual adjustment.



The latest trade deficit is at one trillion dollars.



This article examines the issue of high healthcare costs in the United States, which are more expensive than in other G20 countries. These costs create a burden on employers and affect the competitiveness of the manufacturing industry. The focus of the analysis is to identify the causes of these high costs and to find solutions that reduce costs without compromising the quality or availability of healthcare, with an emphasis on the manufacturing industry. The article suggests various solutions, such as implementing cost-containment measures, and shifting the financing of healthcare and Social Security benefits away from employers. It also highlights the potential benefits of regulatory reform, new technologies, and innovation to reduce costs and improve efficiency. Overall, the goal of the article is to contribute to ongoing efforts to address healthcare costs and their impact on American manufacturing competitiveness.

The Hidden Costs of Healthcare: Kickbacks and their Effects on American Industry and Individuals

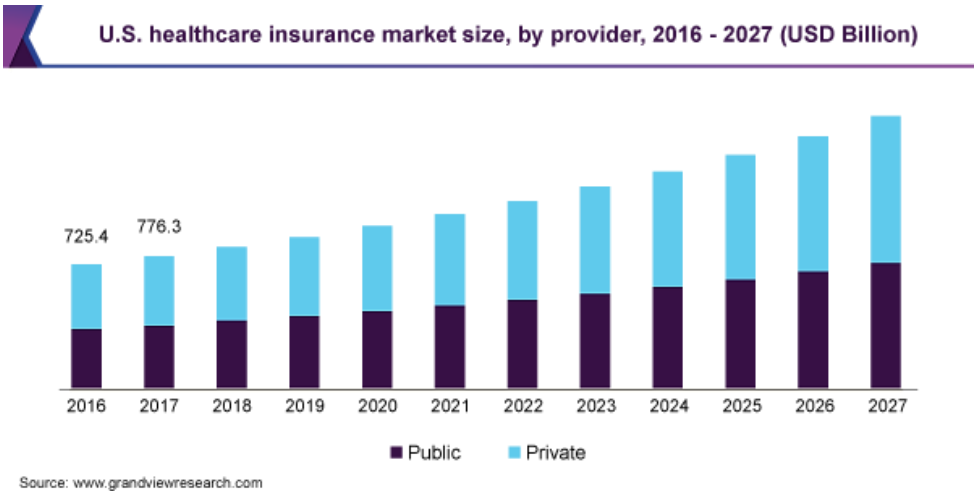
The rising cost of healthcare in America is a multifaceted issue with various factors contributing to the problem. One significant factor is the direct relationship between the quality of healthcare services and their associated costs. Additionally, the illegal exchange of money or favors between healthcare providers and insurance companies, known as kickbacks, has played a crucial role in the escalating healthcare costs. A rampant illegal kickback scheme is currently exacerbating the situation, with law enforcement agencies failing to take any action. Despite attempts through laws and regulations to curb this illegal practice, it continues to thrive and remains untaxed. Consequently, many individuals are finding it challenging to afford the high cost of healthcare, leading to personal bankruptcies. Employers are also facing the brunt of the rising healthcare insurance costs for their employees, adversely impacting the manufacturing industry. Furthermore, the government is spending an increasing amount on healthcare, putting a growing strain on the economy.

In 2022, the United States recorded a trade deficit of 948 billion dollars, largely due to the fact that it is not manufacturing enough goods domestically. The country's reliance on overseas manufacturing is further exacerbated by the fact that healthcare costs in the United States are significantly higher than in other countries, as the country is the only one that relies on a system where payments are collected through employee FICA taxes, rather than through income taxes. When a tax is imposed prior to the sale of a good or services it increases the break-even point to make a profit, therefore pushes up the selling point of the service or goods price. These higher healthcare costs have a direct impact on the prices of manufactured goods, making them less competitive in the global market. Additionally, it's worth noting that a portion of the interest on the US national debt is going overseas.

The Healthcare Industry: Essential to Modern Society

The healthcare industry is a vital aspect of modern society. It provides individuals with the medical services and support they need to maintain their health and well-being, whether it's to save a life, alleviate pain, or prevent future health problems. However, this industry has become increasingly expensive due to the high demand for medical services.

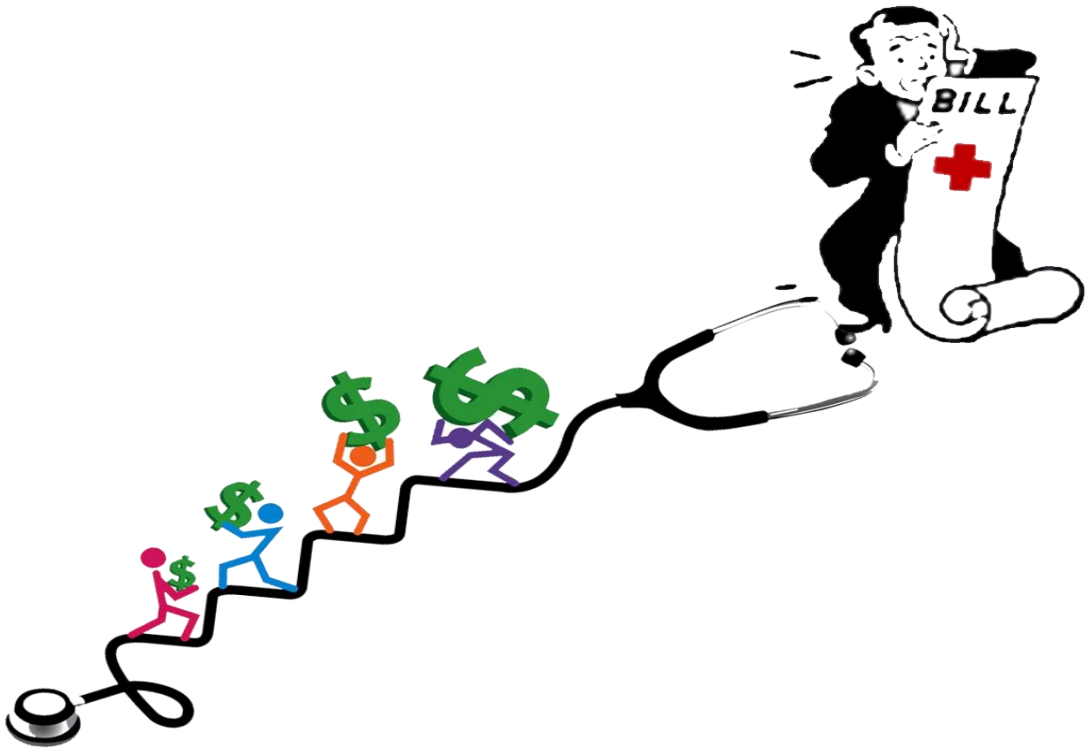
Despite the high cost of healthcare, many people are still willing to pay large amounts of money for medical treatment, even if it exceeds their budget. This demand has resulted in the growth of insurance revenues, profits, and rate of return for some of the largest insurance companies in the United States. These insurance companies have become a major player in the healthcare industry and generate billions of dollars in profits each year.



Insurance companies provide insurance coverage to millions of Americans, allowing them to access the medical care they need when they need it. In exchange, while insurance companies get a steady income stream from premium payments, on the other they receive of kickbacks, which are illegal payments made by healthcare providers to them. This kickbacks income is not taxed, which results in the insurance companies having a tremendous revenue growth.

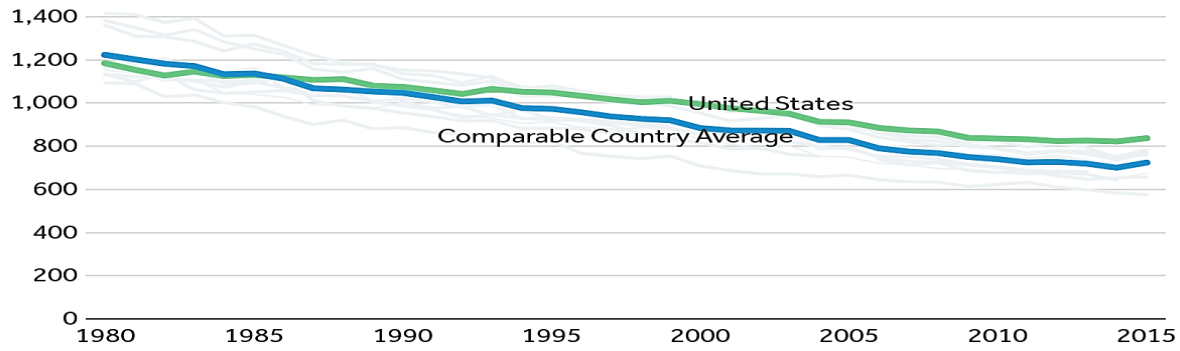
However, this increase in revenue for the insurance companies has led to a rise in healthcare costs, making it increasingly difficult for individuals and employers to afford the cost of medical care. The healthcare industry also employs millions of people, including doctors, nurses, and other healthcare professionals, as well as support staff and administrative personnel.

The High Cost of Healthcare: A Major Contributor to Rising Death Rates in the United States



In recent years, the United States has experienced a concerning rise in death rates, particularly when compared to other countries with different healthcare systems. This increase in death rates has been attributed to a number of factors, one of the most prominent being the high cost of healthcare.

Overall age-adjusted mortality rate per 100,000 population, 1980-2015

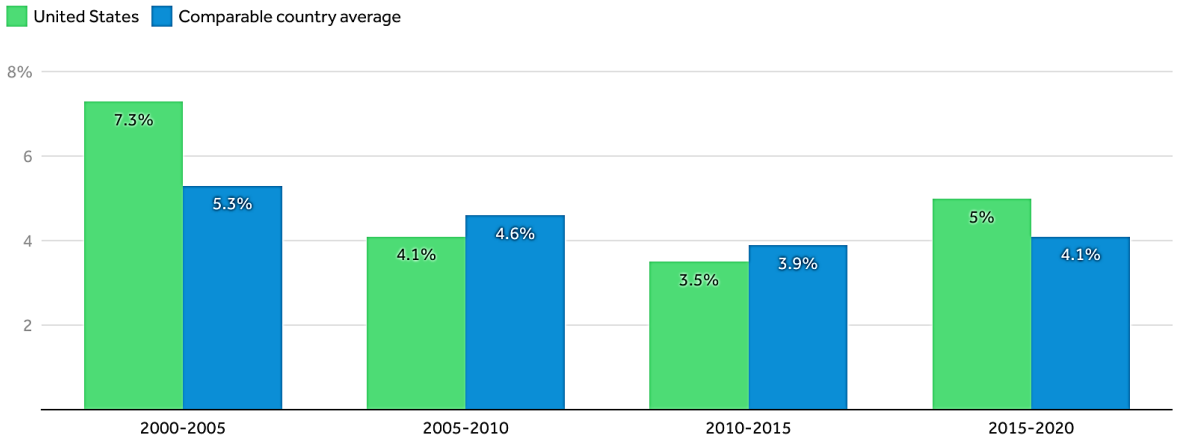


Notes: Break in series in 1987, 1995 and 1997 for Switzerland; in 1996 for Netherlands; in 1998 for Australia, Belgium, and Germany; in 1999 for United States; in 2000 for France; 2001 in the United Kingdom; and in 2015 for France. All breaks in series coincide with changes in ICD coding.

Source: KFF Analysis of OECD Health Statistics (Database)

According to the World Health Organization (WHO), the United States ranks 37th in overall health performance, despite having the highest healthcare spending per capita among developed countries. In 2017, the total healthcare spending in the United States reached $3.5 trillion, accounting for nearly 18% of the country's gross domestic product (GDP). This figure is more than double the average spending of other developed countries, such as the United Kingdom ($4,192), Canada ($4,753), and Australia ($4,781).

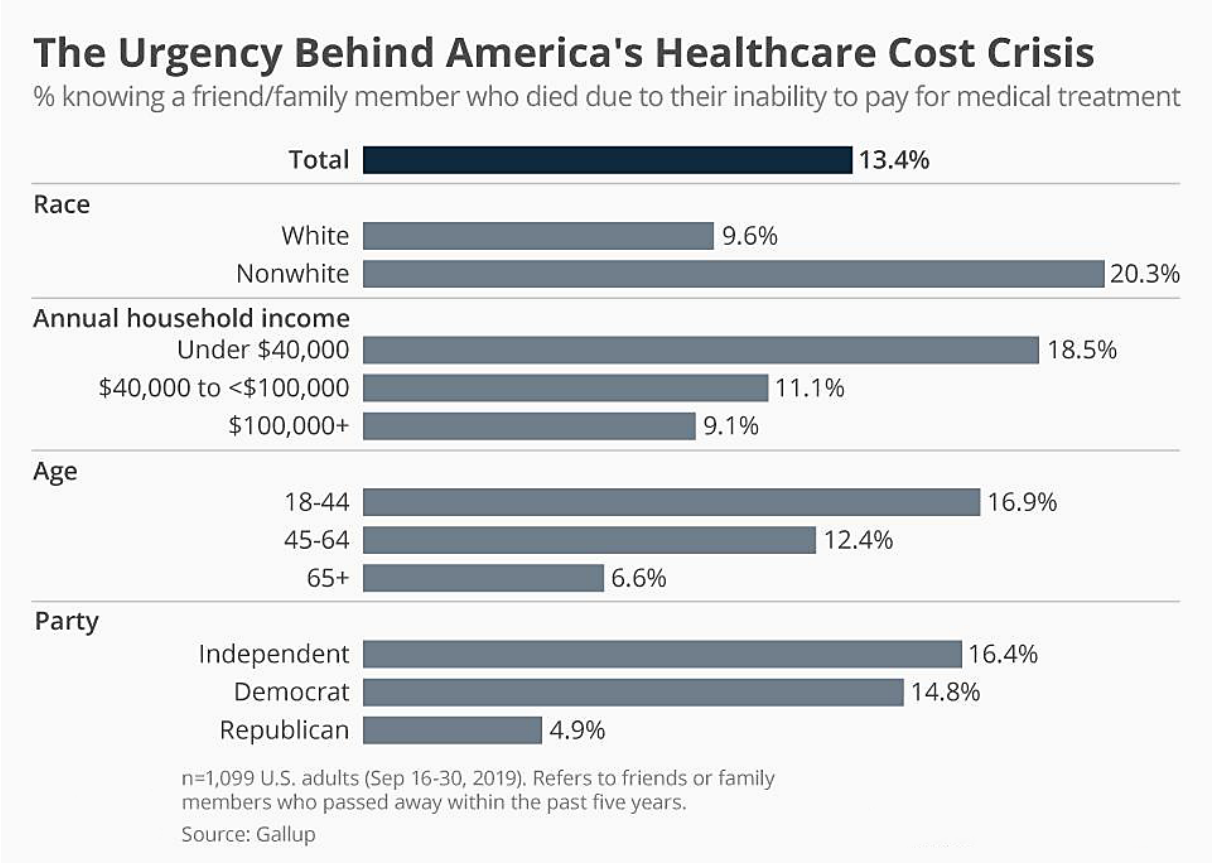
Average annual growth rate in health consumption expenditures per capita, 2000-2020, U.S. dollars, PPP adjusted



Notes: U.S. value obtained from National Health Expenditure data. The 2020 comparable country average used to calculate growth rate only includes data from Austria, France, Germany, Netherlands, Sweden and the United Kingdom. 2020 France data is estimated. 2020 data for Austria, Germany, Netherlands, Sweden and the United Kingdom are all provisional. Difference in methodology for Australia in 2000, 2005, 2010, and 2015. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of National Health Expenditure (NHE) and OECD data

This high cost of healthcare has had a significant impact on the health and well-being of the American population. Many individuals, particularly those with lower incomes, cannot afford the cost of medical services, leading to a lack of access to adequate care. This, in turn, has contributed to higher death rates, particularly for conditions that could have been prevented or treated with early intervention.



For example, a study published in the Journal of the American Medical Association (JAMA) found that the mortality rate for individuals without health insurance was nearly 25% higher compared to those with insurance. This means that individuals without health insurance are at a significantly increased risk of dying prematurely, simply because they cannot afford the cost of medical services.

Susan Finley was found dead in her apartment after avoiding going to see a doctor for flu-like symptoms.

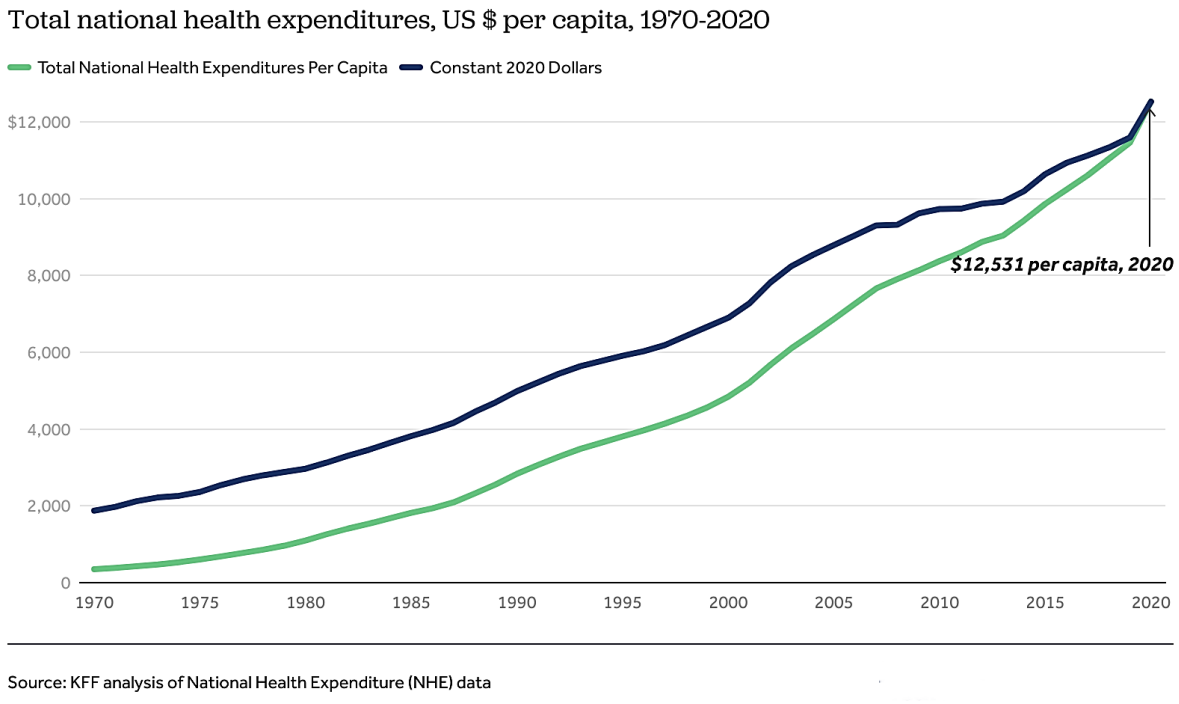
Photograph: Courtesy of the family

Additionally, a study by the Commonwealth Fund found that the United States has the highest rate of preventable deaths among 11 developed countries, including Canada, the United Kingdom, and Australia. In 2013, the preventable death rate in the United States was 45 deaths per 100,000 population, compared to an average of 29 deaths per 100,000 population in other developed countries.

The Increase in Healthcare Spending in the US: A Look at the Numbers

Healthcare is one of the most essential components of modern society, and it is crucial for people to access high-quality medical services when they need them. However, the cost of healthcare has been increasing rapidly in recent decades, and this has become a major concern for many people in the US.

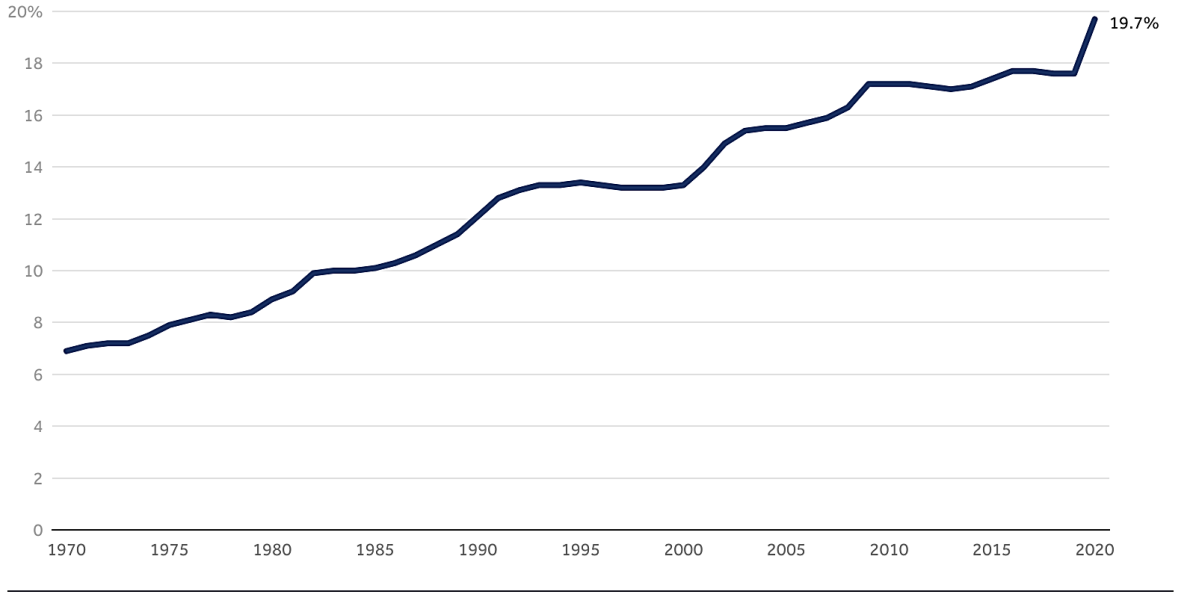
One way to examine the increase in healthcare spending is to look at the per capita basis. According to data from the Centers for Medicare & Medicaid Services (CMS), the per capita health spending in the US has increased from $353 in 1970 to $12,531 in 2020. This represents a 36-fold increase in just four decades.



Source: KFF analysis of National Health Expenditure (NHE) data

Another way to examine spending trends is to look at what share of the economy is devoted to health. In 1970, only 6.9% of the gross domestic product (GDP) was spent on healthcare in the US. This number has increased significantly over the years, and by 2020, it had reached 19.7% of the GDP. It is worth noting that health spending as a share of the economy often increases during economic downturns and remains relatively stable during expansionary periods.

Total national health expenditures as a percent of Gross Domestic Product, 1970-2020

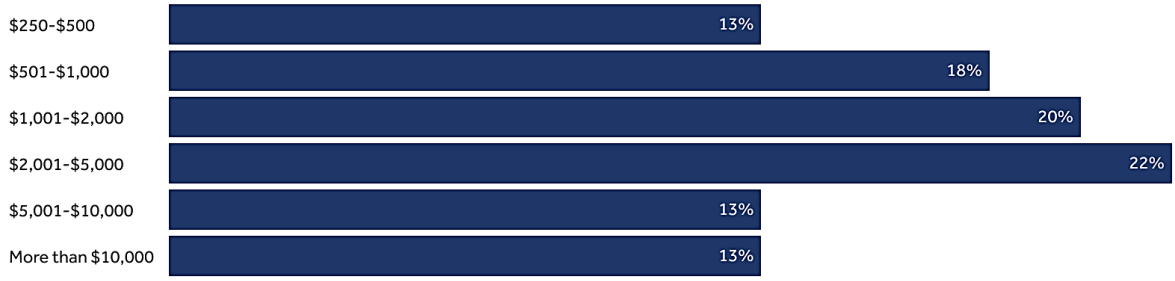


Source: KFF analysis of National Health Expenditure (NHE) data

The Collection of Unpaid Medical Bills: An Additional Financial Burden

In the United States, the cost of medical care continues to rise, and as a result, many people are struggling to keep up with their medical bills. Unfortunately, a significant portion of these bills go unpaid, creating a major financial burden for healthcare providers. This burden is further exacerbated by the cost of collecting these debts, which can be substantial.

Share of adults with medical debt, by the amount of debt they owe, 2019



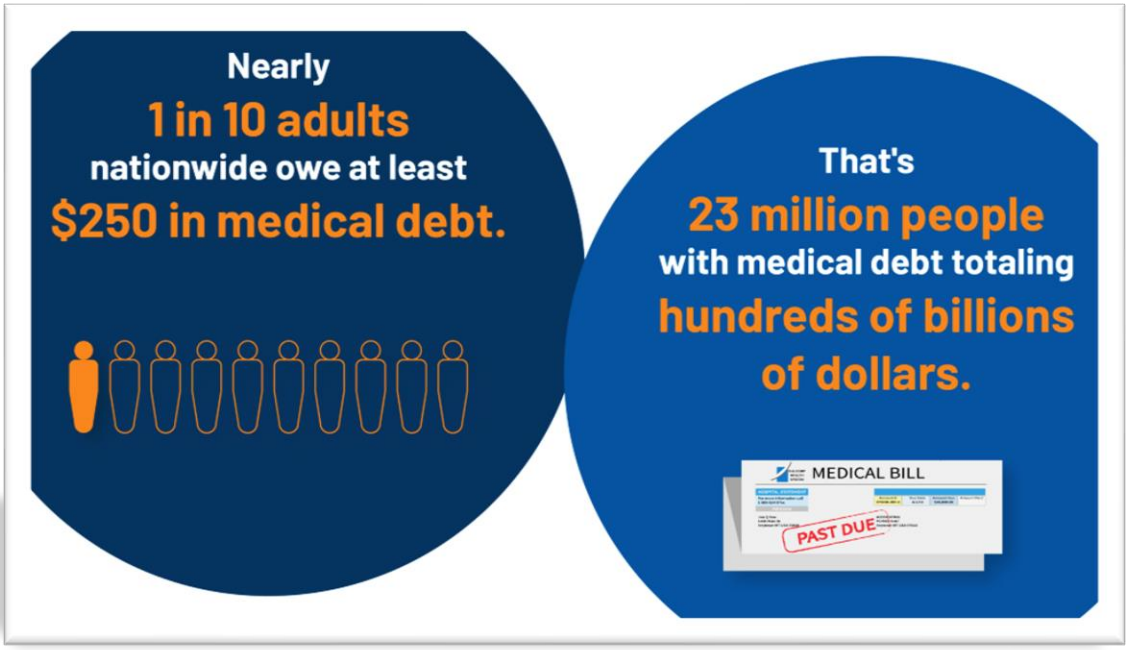
Note: This analysis is limited to adults owing over $250 in medical debt.

Source: KFF Analysis of U.S. Survey and Income and Program Participation (SIPP) data

One of the primary causes of unpaid medical bills is a lack of insurance coverage. While the Affordable Care Act (ACA) has made it easier for people to get insurance, many still remain uninsured. Additionally, even those with insurance may have coverage that does not fully cover the cost of their medical care.

For healthcare providers, the collection of unpaid medical bills can be a time-consuming and costly process. They must first attempt to collect the debt from the patient, and if this is unsuccessful, they

may need to turn to a collections agency. This process can take months or even years, and the provider must bear the costs of hiring a collections agency, which can be substantial.

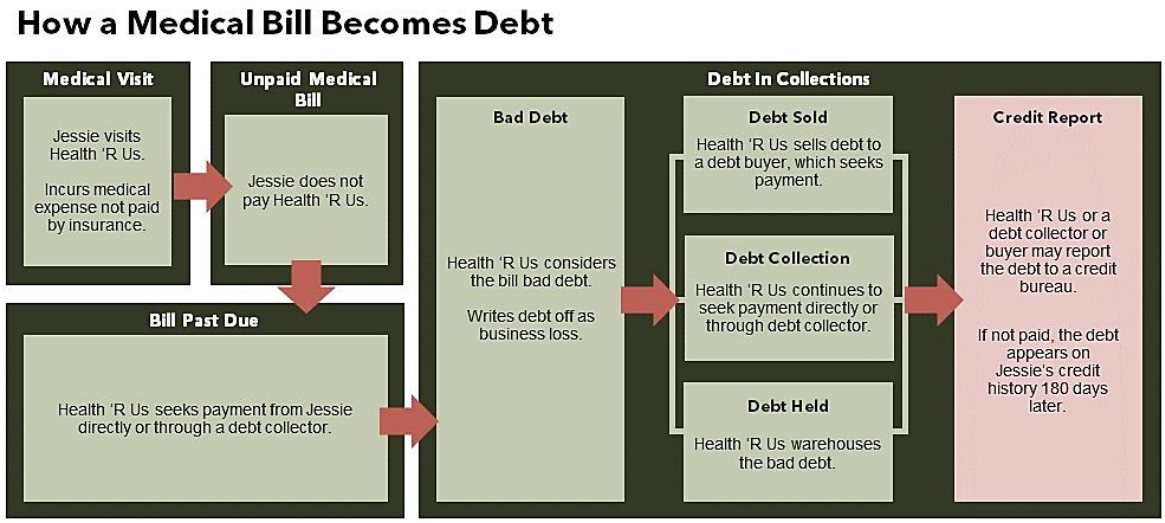


The collection of unpaid medical bills also creates an additional financial burden for healthcare providers. The costs associated with the collection process are passed on to patients in the form of higher prices for medical services. This, in turn, makes it even more difficult for patients to pay their medical bills, perpetuating the cycle of unpaid debts.

It is difficult to determine the exact portion of medical expenditures spent on collection of unpaid medical bills in the US. However, according to some estimates, healthcare providers spend billions of dollars annually on the collection of outstanding medical debt, with some estimates suggesting that as much as 25-30% of a healthcare provider's revenue may be dedicated to this purpose.

Additionally, a study by the Commonwealth Fund found that the average hospital spends over $600,000 annually on debt collection activities, representing a significant portion of their operating expenses. The burden of unpaid medical bills affects not only healthcare providers but also patients, as it can result in negative impacts on their credit scores and financial stability.

However, it has been reported that healthcare providers often hire collection agencies to collect on past due balances, and the cost of these collection efforts can be substantial. According to a report by the American Hospital Association, the cost of collecting payments from patients accounts for an average of 6-7% of a hospital's operating expenses. Additionally, it is estimated that in 2019, the total cost of bad debt and charity care for US hospitals was $57.5 billion. This shows the significant financial impact that the collection of unpaid medical bills can have on the healthcare industry.



Source: Adapted from Urban Institute

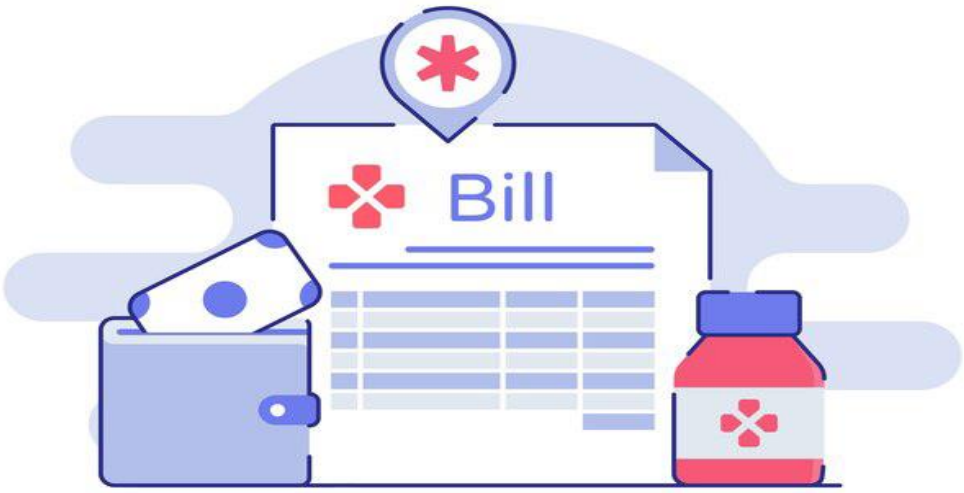
In addition to the financial burden, the collection of unpaid medical bills can also create emotional stress for patients. They may feel guilty about not being able to pay their bills, and the constant collection calls and letters can be overwhelming. This can lead to further health problems, as patients may avoid seeking medical care due to the fear of incurring additional debt.

To alleviate the financial burden of unpaid medical bills, healthcare providers and policymakers must work together to find solutions. One option is to increase access to affordable insurance coverage for all Americans. This would reduce the number of uninsured patients and make it easier for patients to pay their medical bills.

Unlawful Kickbacks in the Healthcare Industry

In the United States, the majority of patients are covered by private health insurance paid by their employers. Health care providers deliver medical services and goods, and insurance companies pay for these services based on contracts.

Providers bill patients for the services, and the recognition of income is based on the accrual accounting method, which recognizes income when a bill is issued, regardless of when payment is received or from whom.



Insurance companies spread the risk of an individual's large medical expenses among many individuals and pay for these expenses, primarily from employers, as medical benefits. When an insurance company receives a bill for an insured member, it recognizes the debt as an expense and is responsible for the full amount, with the insured member responsible for co-payments and deductibles.

Through business agreements, insurance companies often have providers collect these co-payments and deductibles from insured patients, creating a tax problem when the co-payments and insurance company payments are less than the amount billed. This uncollected amount cannot be written off as bad debt, leading to a cancellation of debt for the provider and forgiveness of debt income for the insurance company.

However, a close examination of these contracts reveals that the provider is paying the insurance company to steer insured members their way, which is legally defined as a kickback payment. In the healthcare industry, kickbacks are illegal and cannot be deducted from gross income, even for not-for-profit corporations. The Tax Code recognizes the provider's income when services are performed and a bill is issued, and when an insurance company is utilized, the full amount of the bill is transferred to the insurance company, who has the power to steer patients to providers. To gain access to privately insured members, providers often pay kickbacks in the form of partial cancellation of debt, which is illegal and not recognized as a legitimate deduction by the Tax Code. These kickbacks are often recorded as "contract adjustments" but are not recognized as a legitimate deduction from gross income. Not-for-profit hospitals, which normally have tax-exempt status, must pay taxes on these illegal kickbacks and have their tax-exempt status revoked.

The Healthcare Industry and Kickbacks: A Costly Reality

Kickbacks in the healthcare industry are a major concern for policy makers, healthcare providers, and consumers alike. They are illegal because they increase the cost of healthcare services and defeat the purpose of the law. The purpose of making kickbacks illegal is to keep costs as low as possible, which is important for the functioning of the healthcare system.

The rise in healthcare costs due to kickbacks has far-reaching consequences for society. One of the biggest impacts is on the manufacturing industry, which becomes less competitive as a result. This is because in the cycle of manufacturing, each step of producing a good adds indirect healthcare costs, such as employee benefits, to the finished product. These costs make it difficult for manufacturers to sell their products at a competitive price, which can negatively impact the entire industry.

To stay in business, each group in the manufacturing process must sell their products above their break-even point of costs, which includes indirect healthcare costs, profits, and taxes. In contrast, international competitors have eliminated employer-paid healthcare costs, making their final products more competitively priced. In order to compete with these countries, the United States must eliminate employer-paid healthcare insurance costs.

Eliminating the Affordable Care Act will not solve the problem of rising healthcare costs due to kickbacks. Instead, it will increase the cost of healthcare in the country and overwhelm Medicaid programs. It is estimated that if the Affordable Care Act were eliminated, an additional twenty million individuals would be put back on Medicaid. This would also result in an increase in the number of personal bankruptcies caused by medical claims, which would revert back to 1.5 million from today's half a million.

Benefits for Women

Providing insurance options, covering preventive services, and lowering costs.

Young Adult Coverage

Coverage available to children up to age 26.

Strengthening Medicare

Yearly wellness visit and many free preventive services for some seniors with Medicare.

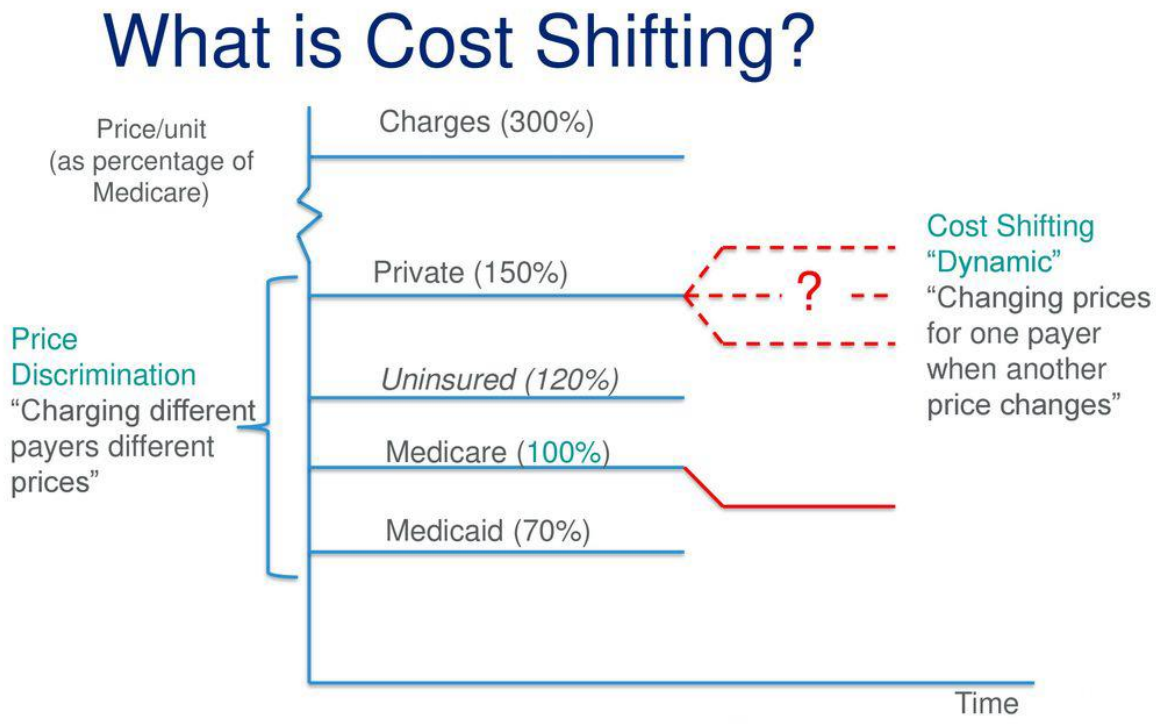
Holding Insurance Companies Accountable

Insurers must justify any premium increase of 10% or more before the rate takes effect.

The solution to this problem could be to go further than the Affordable Care Act and cover every man, woman, and child in the country with comprehensive healthcare coverage. This could be paid for with income tax revenues. Additionally, supervisory government agencies should create specific inspection units to monitor and prevent the application of kickbacks. This could help to ensure that healthcare services are accessible and affordable for everyone, and that the healthcare system is functioning as it should.

Uncovering the Illegal Kickback Practices in the Healthcare Industry: The Dark Side of Healthcare Pricing Strategies

There is a prevalent concept of price discrimination in the healthcare industry, with different amounts being collected from private-pay patients, insured vs uninsured patients, and different insurance companies. The amount collected is also different for different services, which is referred to as cost shifting. The charges often reflect the demographics of the insured members and not the average cost to price ratios of each service, especially when it comes to charges for the elderly, where the government picks up the charges.



Source: Author approximations of Cooper et al. (2015), Hadley (2003), Kaiser (2017)

Due to these kickbacks, the amounts collected from different insurance companies are different, which helps insurance companies get their insured members and boycott competitive providers. The kickbacks are considered trade secrets and are hidden from competitors, even though the latter may be lower in price. The charges do not reflect the actual price, except for uninsured patients. The contracts are not available to anyone, except in California. Although the IRS is capable of examining these contracts, it does no good because the auditors are not trained in contract law. This is what everyone sees:

[5.]

[redacted]

You have asked for our advice. [redacted]

[redacted][1][redacted]

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Every year, the Centers for Medicare/Medicaid Services (CMS) are required to increase the rates of compensation for medical services. To determine the amount of the increase, CMS relies on the charges listed on the bills of beneficiaries. These charges were intended to reflect the actual amount collected for services provided to private-pay patients. However, the charges listed on the bills were based on standard rates that were six times higher than the actual amount collected.

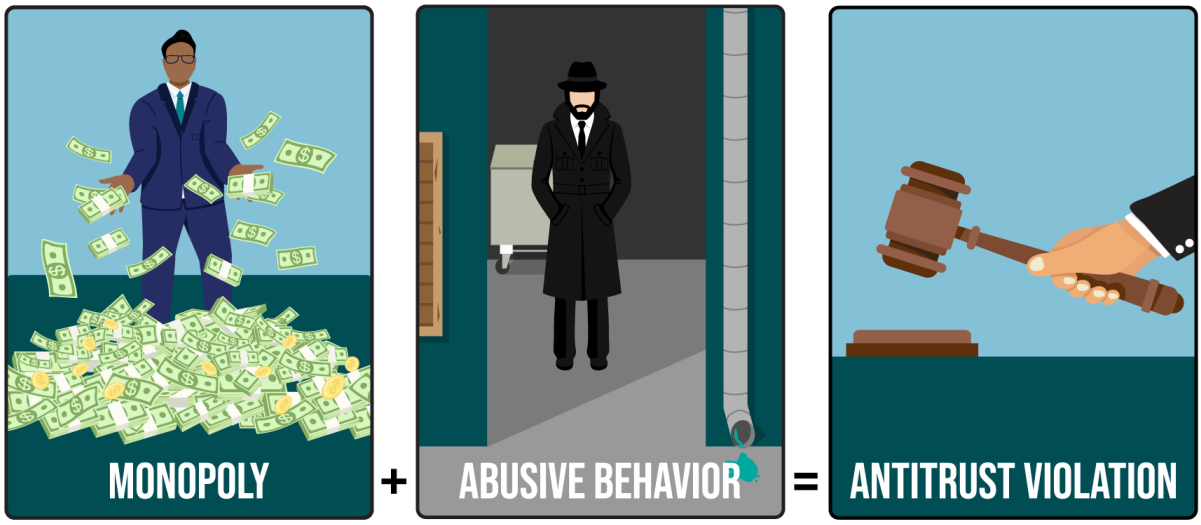
Unfortunately, the CMS was prohibited by the Medicare/Medicaid law from investigating the administrative practices of medical service providers. As a result, they were unaware that the charges listed on the beneficiaries' bills were inaccurate. This means that the Medicare payments for medical services were artificially inflated.

The healthcare industry and insurance companies worked together to increase the billed amounts, thereby shifting the payment of healthcare costs to the government. This was done by partially cancelling debt, which is recorded as a contract adjustment instead of cancelled debt, which would be a violation of price discrimination statutes.

In order to access insured members, insurance companies require providers to give them a kickback in the form of a partial cancellation of debt. This practice of referring patients for cash or cash equivalents is barred by anti-kickback statutes and Stark laws. The insurance companies also created a list of approved providers, known as in-network providers, and imposed financial penalties on insured patients if they sought services from an off-network provider. This led to financial coercion and restraint of trade, which is illegal.

	STARK LAW	ANTI-KICKBACK STATUTE
Prohibits	Physicians from referring Medicare patients for designated health services to an entity in which the physician (or family) has a financial interest.	Any person from offering, paying, soliciting, or receiving anything of value to induce or reward referrals or induce referrals for federal healthcare
Referrals	From physicians	From anyone
Items/Services	Designated health services	Any items or services
Penalties	Civil: overpayment obligation, False Claims Act Liability, civil monetary penalties and program exclusion for known violations, fines up to $22,000 per violation or up to 3x amount	Criminal: fines up to $25,000 per violation or up to five-year prison sentence Civil: False Claims Act Liability, civil monetary penalties and program exclusion, potential $50,000 fine per violation, civil assessment up to 3x amount
Exceptions	Mandatory exceptions, must have all elements met	Voluntary safe harbors
Federal Health Programs	Medicare/Medicaid	All federal programs
Intent	No intent required except when assessing civil monetary penalties for knowing violations	Intent must be proved

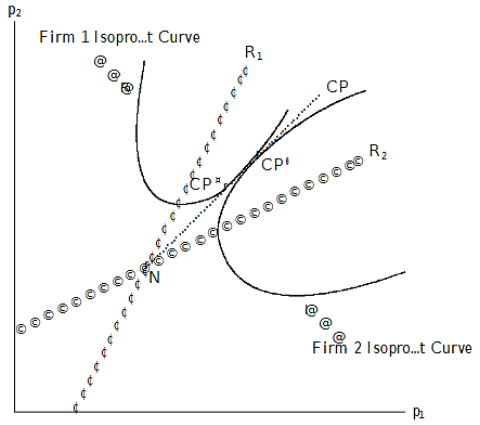
The providers began increasing the billed amount of insured patients and the public beneficiaries, leading to a difference between the billed and collected amounts that is now greater than 89%. This has led to a sharp increase in prices and a corresponding increase in the contribution to GDP.



The healthcare industry operates under an oligopoly structure, which leads to conscious parallelism, a pricing strategy among competitors in an oligopoly that occurs without actual agreement. This can result in consumers being forced to pay monopoly prices for goods, but it is hard to prosecute as it may occur without any collusion between the competitors. However, a violation of antitrust laws can be shown if "plus factors" occur, such as firms being motivated to collude and taking actions against their own economic interests.

In the healthcare industry, there have been instances of conscious parallelism and anti-competitive behavior. For example, in 2018, several large health insurance companies, including Aetna and

Humana, were accused of coordinating their actions to avoid competing on price in certain markets. The companies reportedly used tools like rate setting software to monitor each other's prices and ensure that they were not undercutting each other's prices. Another example is the case of pharmaceutical companies conspiring to keep generic drugs off the market, which has resulted in artificially high drug prices for consumers. In some cases, brand-name drug companies have paid generic drug companies to delay launching their cheaper alternatives, a practice known as "pay-for-delay." These instances illustrate how parallel consciousness and anti-competitive behavior can occur in the healthcare industry, leading to higher prices and reduced access to care for patients. Conscious parallelism can be illegal if it results in anti-competitive behavior, such as price fixing, market division, or limiting output, which can harm consumers by driving up prices and reducing choice.

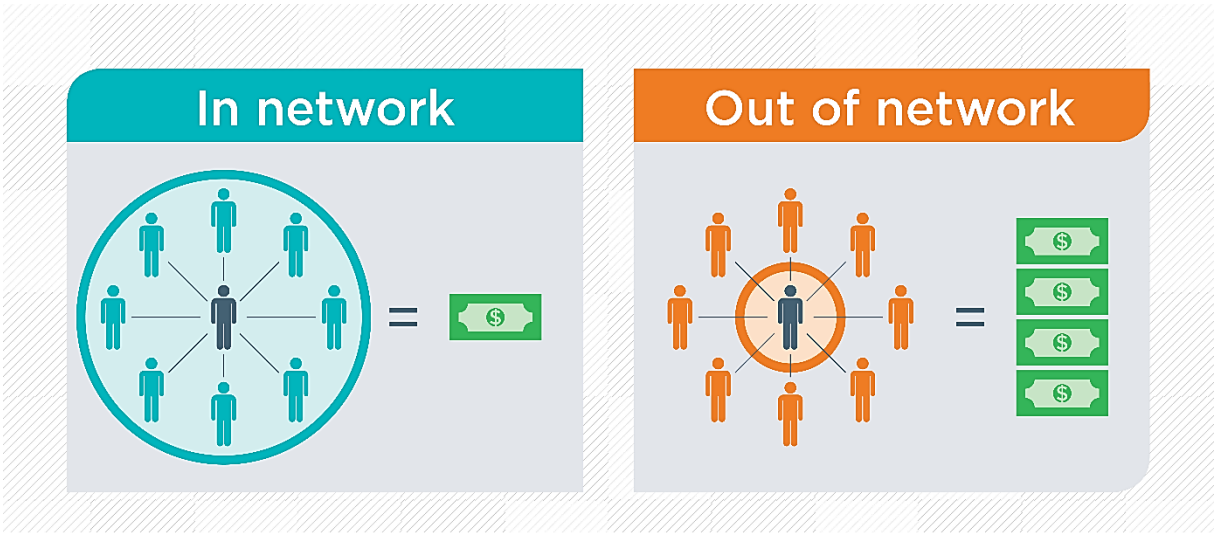


The Conscious Parallelism Equilibrium
N as the origin. It shows all possible conscious parallelism prices. The conscious parallelism prices preferred by …rm 1 and …rm 2 are found where isopro…t curvesare tangent to the CP line: …rm 1 prefers prices corresponding to CP¤, while…rm 2 could still gain from a further price increase to CP0– given that this pricewould be matched by …rm 1. Since …rm 1 is worse o¤ at point CP0, it does notmatch this price increase and CP¤is the conscious parallelism equilibrium.

In law practice, a contract can override the law to a certain extent, but it must still comply with applicable legal requirements. The general principle is that parties to a contract are free to make agreements that suit their needs, as long as the agreement is not illegal or against public policy. However, if the terms of the contract are illegal or against public policy, they will not be enforceable, regardless of the agreement of the parties. For example, a contract cannot be used to enforce an agreement to engage in illegal activity or to illegally get kickbacks from providers.

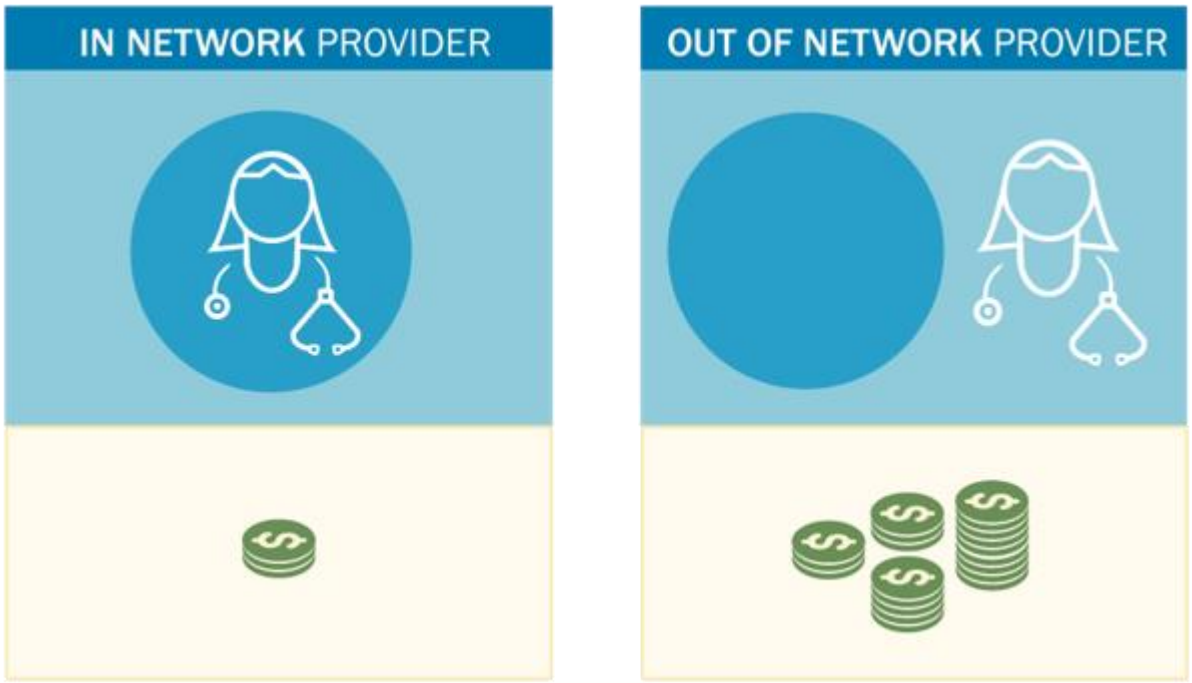
Exploring the Coercive Tactics Used by Insurance Companies in Approved Provider Networks

In recent years, insurance companies have implemented a list of approved providers known as the in-network providers. This list is meant to guide insured patients towards medical facilities and doctors that have agreements with the insurance company for discounted services. However, these insurance companies have taken it one step further by penalizing patients who choose to go to off-network providers.



The financial penalty imposed on insured patients is substantial, making it difficult for them to seek medical treatment outside of the approved network. In most cases, the co-payment for seeing an off-network provider is increased from 10% of the agreed contract amount to 20% of the billed amount, a 12-fold increase. This kind of financial coercion forces patients to avoid off-network providers, even if they offer better quality care or specialized services not available in the approved network.

For example, let's say the standard charge for both an in-network and an off-network provider is $100. The insurance company has an agreement with the in-network provider to only pay $15, so the co-payment is only $1.50. However, if the off-network provider bills $100, the new co-payment is $20, or 12 times the original co-payment amount.



These actions by insurance companies are considered a restraint of trade and illegal. They restrict patients' freedom to choose the best medical care for their needs, instead forcing them to conform to the approved network. It's time for insurance companies to reconsider their practices and allow

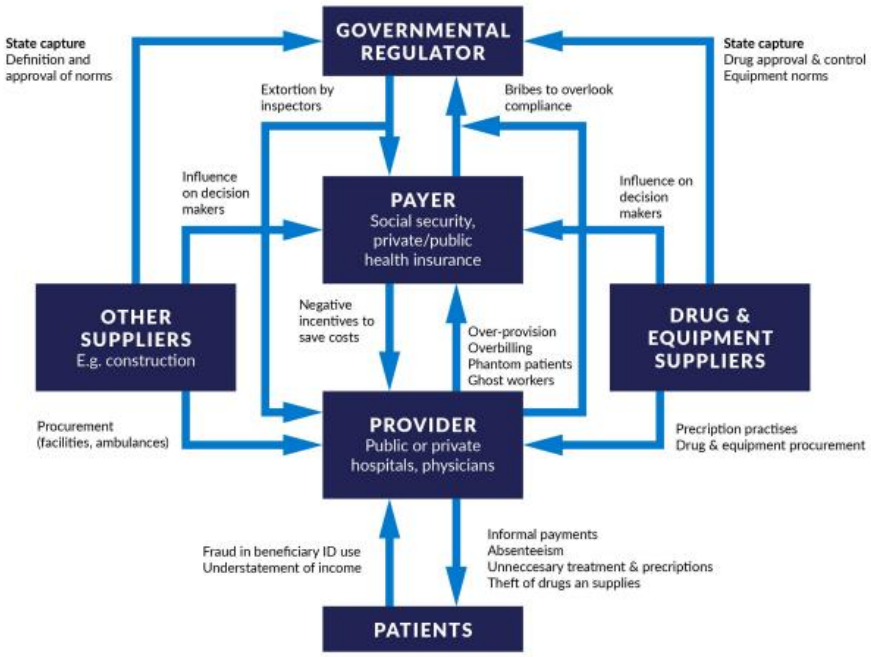
patients the freedom to seek medical treatment from the providers they choose, without fear of financial penalties.

Uncovering the Illegal Transactions in the Health Care Industry: The Role of Kickbacks and Accrual Accounting

Illegal transactions in the health sector can occur during the accounting phase of kickbacks that hospitals have to pay to insurance companies. The practice of kickbacks, or payments made to insurance companies in exchange for access to their insured members, is allowed by the IRS as long as the hospitals call the cancelled debt a contract adjustment to the patient's contract.

However, under the Revenue Recognition Principle and accrual accounting method, which is required by law, the recognized income is determined by the right to receive payment and not the actual receipt of payment. The IRS only recognizes cash payment as recognized income for privately insured patients.

Figure 1: Examples of corrupt practices among different health sector players

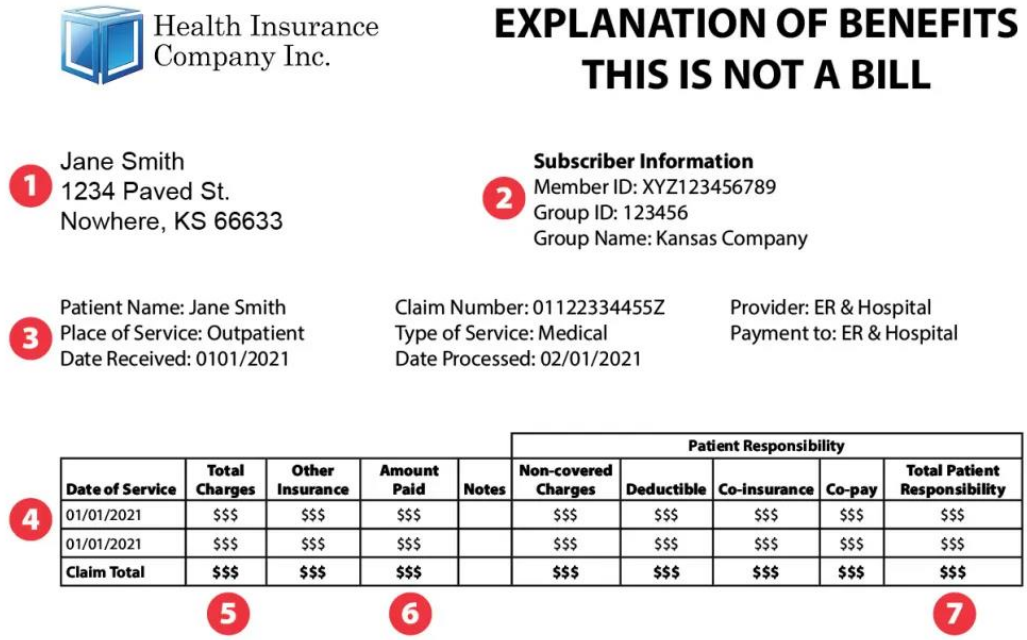


Source: Adapted from Savedoff and Hussmann (2006).

Kickbacks in the healthcare industry are illegal and not deductible as a business expense, according to 26 USC § 162 (C)(2) (c). The use of the write-off of contractual adjustment account as a means to pay kickbacks has been in practice since the start of the Medicare and Medicaid programs in 1965, but it is still illegal.

Hospitals do not give discounts and the only medical bills issued list the patient's name, not the insurance company's. Insurance companies act as independent third-party payers and send Explanation of Benefits Forms (EOB) to their insured members that show the patient's debt, how much the insurance company pays, and the co-payment and deductible owed by the insured member.

An example of a kickback transaction is as follows: a hospital bills a privately insured patient $100, but only collects $25 in cash. The difference of $75 is owed to the hospital by the insurance company, but is considered a cancelled debt and forgiveness of debt income for the insurance company. The hospital is treating the $75 write-off as a business expense, but it is actually a kickback for steering the insured member to the hospital.



Health Insurance Company Inc.

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

1 Jane Smith
1234 Paved St.
Nowhere, KS 66633

2 **Subscriber Information**
Member ID: XYZ123456789
Group ID: 123456
Group Name: Kansas Company

3 Patient Name: Jane Smith
Place of Service: Outpatient
Date Received: 0101/2021

Claim Number: 01122334455Z
Type of Service: Medical
Date Processed: 02/01/2021

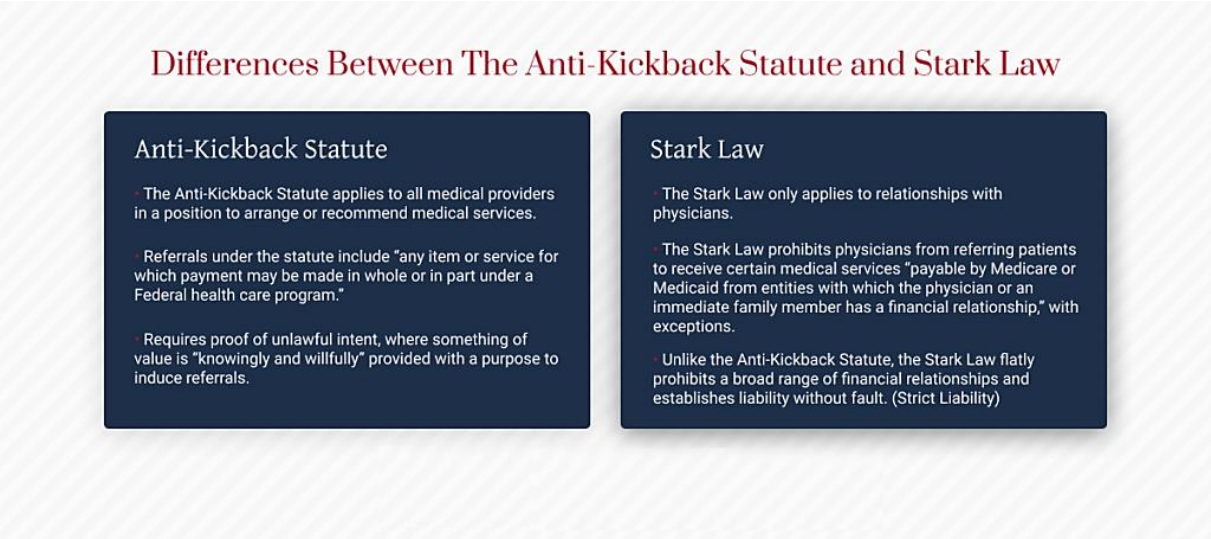
Provider: ER & Hospital
Payment to: ER & Hospital

						Patient Responsibility				
4 Date of Service	Total Charges	Other Insurance	Amount Paid	Notes	Non-covered Charges	Deductible	Co-insurance	Co-pay	Total Patient Responsibility
01/01/2021	$$$	$$$	$$$		$$$	$$$	$$$	$$$	$$$
01/01/2021	$$$	$$$	$$$		$$$	$$$	$$$	$$$	$$$
Claim Total	**$$$**	**$$$**	**$$$**		**$$$**	**$$$**	**$$$**	**$$$**	**$$$**
	5		6						7

1. Your name or the insured person's name and address.
2. Your insurance information, such as member ID, group ID and group name.
3. Details about who the patient was, when services were received, what type of services they were, claim information, and provider information.
4. Details about the services you received, including but not limited to: the date services were provided, the amount your insurance company paid the health care provider for those services, any discounts or reductions granted by the insurance company, your deductible and co-payments amounts, and any amounts not covered by insurance.
5. The total amount of benefits in the claim.
6. The total amount your insurance company is responsible for paying.
7. The total of how much you **MAY** owe, including your co-payments, deductibles, co-insurance, and any amounts not covered by insurance.

Laws and Regulations for the Prevention of Kickbacks

The main laws and regulations include the Anti-Kickback Statute (AKS) and the Physician Self-Referral Law (Stark Law), both of which are enforced by the Department of Health and Human Services (HHS) and the Office of Inspector General (OIG).



The Anti-Kickback Statute (AKS) and the Physician Self-Referral Law (Stark Law) are federal laws aimed at preventing illegal financial arrangements between healthcare providers and insurance companies. Despite these laws, some healthcare providers and insurance companies still engage in illegal kickback practices. This can be due to a variety of reasons, including lack of awareness of the laws, insufficient training on how to comply with them, and weak audition mechanisms.

For example, a healthcare provider may offer incentives to an insurance company in exchange for referring patients to their practice. This could be in the form of financial compensation, free or discounted services, or other benefits. This type of arrangement is illegal under the Anti-Kickback Statute, but it still occurs due to lack of education and weak enforcement.

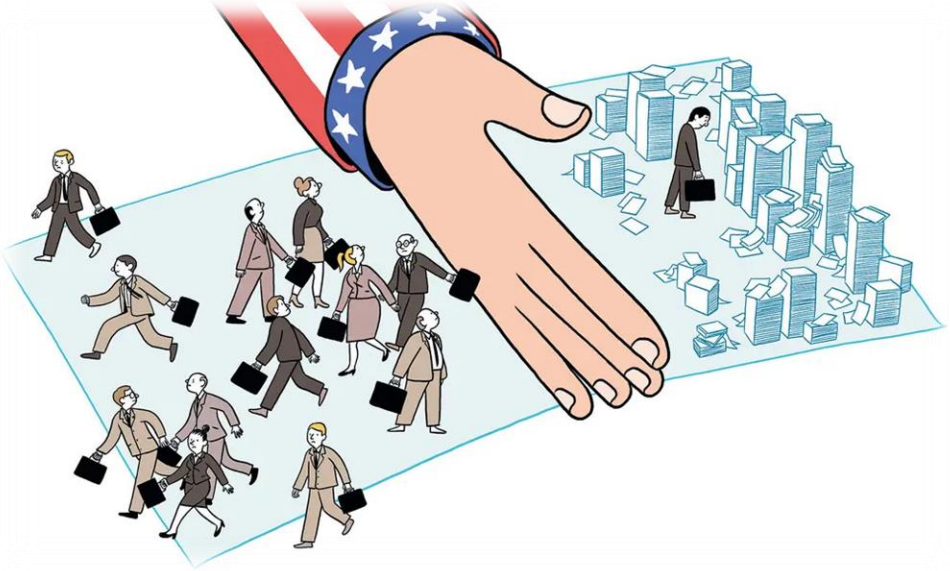
Another example is when a physician refers patients to a lab or imaging center in which they have a financial interest. This type of self-referral is illegal under the Stark Law, but it continues to happen because of insufficient training and weak enforcement.

In some cases, healthcare providers and insurance companies may engage in these practices knowingly and willingly, but in many cases, it is simply due to lack of source or auditions. To prevent illegal kickback practices and protect patients, it is important to have strong enforcement mechanisms and ongoing education for healthcare providers and insurance companies on the laws and regulations in place.

What responsibilities does the IRS have to assume under these laws to recognize kickbacks between insurers and providers?

The Internal Revenue Service (IRS) has responsibilities under the Anti-Kickback Statute (AKS) and the Physician Self-Referral Law (Stark Law) to recognize kickbacks between insurers and providers. The IRS is responsible for enforcing tax laws and regulations and ensuring that healthcare providers and insurance companies are in compliance with the AKS and Stark Law.

The IRS can assume these responsibilities by conducting audits of healthcare providers and insurance companies to detect illegal kickback arrangements. The IRS can also work with the Department of Health and Human Services (HHS) and the Office of Inspector General (OIG) to investigate suspected kickback arrangements and enforce penalties for non-compliance.



In addition, the IRS can also use its authority to disallow tax deductions for illegal kickbacks and impose fines and penalties for non-compliance with the AKS and Stark Law. The IRS can also collaborate with other agencies and organizations to educate healthcare providers and insurance companies about the consequences of engaging in illegal kickback arrangements and the importance of following these laws.

The IRS does not necessarily have a responsibility to recognize kickbacks between insurers and providers under these laws as its primary focus is on taxation. However, the IRS can recognize kickbacks if they are structured as taxable income and not reported properly.

Kickbacks can be recognized by the IRS through various forms, such as payments made to a third party, payments made to an individual or entity in exchange for services, and payments made to offset costs. The IRS can also recognize kickbacks through documentation, such as invoices, contracts, and bank records, that show the flow of money between the healthcare provider and insurance company.

Hospitals or insurance companies may evade taxation under the IRS by not communicating information regarding kickbacks as taxable income. This can include not reporting the amounts paid or received, mischaracterizing the payments as something other than income, or failing to report the payments on tax returns.

By evading the reporting of these kickbacks as taxable income, hospitals and insurance companies can reduce their tax liability and potentially avoid paying the appropriate amount of taxes owed. To prevent this, the IRS closely examines tax returns for evidence of unreported income and can pursue penalties and fines for non-compliance. Here are some examples to explain this further:

- Not reporting the amounts paid or received: Let's say a hospital pays an insurance company $10,000 as a kickback in exchange for sending more patients to the hospital. If the hospital doesn't report this $10,000 payment to the IRS as taxable income, they are evading taxes.
- Mischaracterizing the payments as something other than income: Instead of reporting the $10,000 payment as income, the hospital could try to label it as a business expense. This would reduce the hospital's taxable income, allowing them to pay less in taxes.
- Failing to report the payments on tax returns: If the hospital doesn't report the $10,000 payment on their tax return, the IRS won't be able to assess taxes on it.

Here are a few examples of how the IRS avoids unreported income from commission arrangements between insurance companies and healthcare providers:

Reviewing tax returns: The IRS closely examines tax returns for evidence of unreported income from kickback arrangements. This includes checking for discrepancies in reported income and expenses, as well as searching for patterns of behavior that may indicate illegal kickback arrangements.

Imposing penalties and fines: In the event that the IRS finds evidence of unreported income from kickback arrangements, it may impose penalties and fines to hold the companies accountable. This can include fines, interest charges, and potential criminal charges for tax evasion.

Working with whistleblowers: The IRS also encourages whistleblowers to come forward with information about kickback arrangements by offering financial rewards for information that leads to the detection and prosecution of these illegal practices.

However, the accrual method of accounting states that the private-pay patient's bill determines gross income. This means that the insurance company is not acting as an agent for their insured members, but is instead requesting a partial cancellation of debt from the patient's obligation transferred to the insurance company.

SAC 606 stands for "Substantial Amendment of ASU 2014-09, Revenue from Contracts with Customers." It is a new revenue recognition standard that was issued by the Financial Accounting Standards Board (FASB) in 2014 and became effective for public companies in 2018.

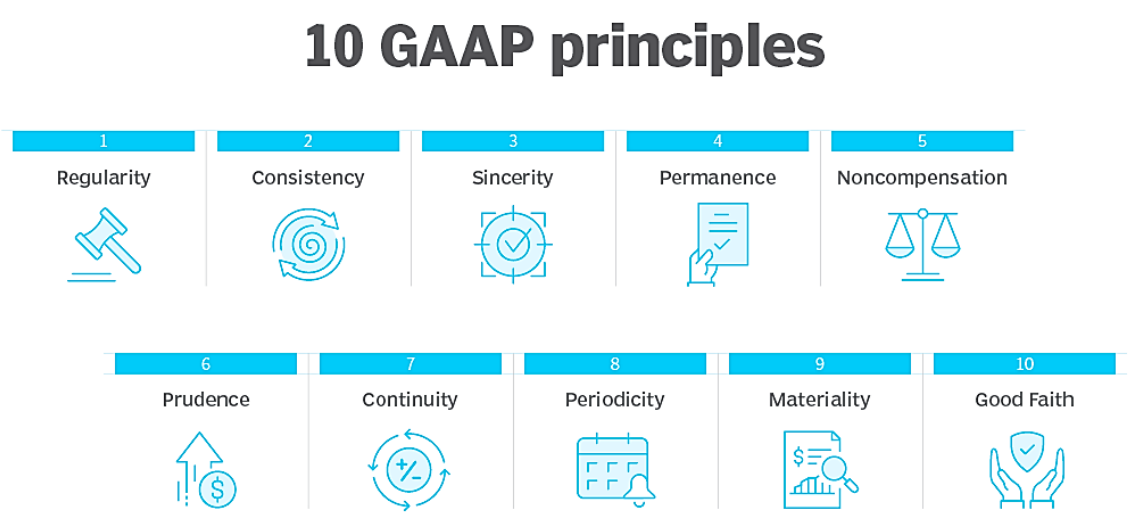
The customers affected by SAC 606 are primarily the companies that provide goods or services and have contracts with their customers. These companies need to comply with the new standard to properly recognize their revenue and ensure consistency in financial reporting. The customers of these companies may indirectly be affected if the implementation of SAC 606 impacts the pricing, delivery, or quality of goods and services they receive.

In general, a customer is someone who purchases goods or services from a company in exchange for payment. They can be individuals or other businesses, and their relationship with the company may vary depending on the nature of the products or services being provided.

In the context of SAC 606, customers are the counterparties to the contracts with companies that provide goods or services. The standard requires companies to identify the performance obligations in their contracts, allocate the transaction price to them, and recognize revenue when the obligations are fulfilled.

The IRS has also failed to understand the impact of the Universal Commercial Code for contracts. The parole evidence rules state that any prior agreements cannot change the amounts on a new bill or the new contract's terms. This means that the patient's medical bill supersedes any prior agreement between the provider and the insurance company.

The Internal Revenue Service (IRS) has a responsibility to monitor and collect taxes on kickbacks between providers and insurance companies in the healthcare industry. However, the IRS has not been effectively fulfilling this responsibility due to a lack of understanding of Generally Accepted Accounting Principles (GAAP) for the accrual method of accounting.



According to GAAP, private-pay patient bills determine gross income, not the insurance company's contracts. The IRS fails to recognize that the insurance company is not acting as an agent for their insured members but instead is requesting a partial cancellation of debt from the patient's obligation that was transferred to the insurance company. The IRS also fails to understand the Universal Commercial Code for contracts, which states that any prior agreements between the provider and insurance company cannot change the amounts on a new bill or new contract terms. As a result, the patient's medical bill supersedes any prior agreement.

In the healthcare industry, providers immediately add the amounts billed to their gross income and later deduct the difference not collected from insurance companies as a contract adjustment. The IRS does not allow contract adjustments as a deduction, as it is not listed in the tax code. Only operating expenses, bad debts, and cancelled debts can be deducted from gross income. The IRS director is unfamiliar with GAAP for accrual accounting.

The IRS believes that all insured private-pay patient bills are false, which is not the case. The amount listed on the patient's bill creates a legal debt and has been proven in state and federal claims courts where providers swear the amounts listed on patients' bills are accurate. These courts treat the invoices as prima facie evidence, with a sum certain, and 70% of the cases are against privately insured patients. The patient's contract states that they are liable for the full amount charged.

In cases where insured members go to out-of-network providers, the insurance company charges the patient a higher variable co-payment, a percentage based on the billed charges, instead of a low fixed amount required by the HMO law. This practice is considered economic duress and is in the contract between in-network providers and the insurance company to encourage insured members to boycott out-of-network providers. This practice is a restraint of trade.

What is an HMO?

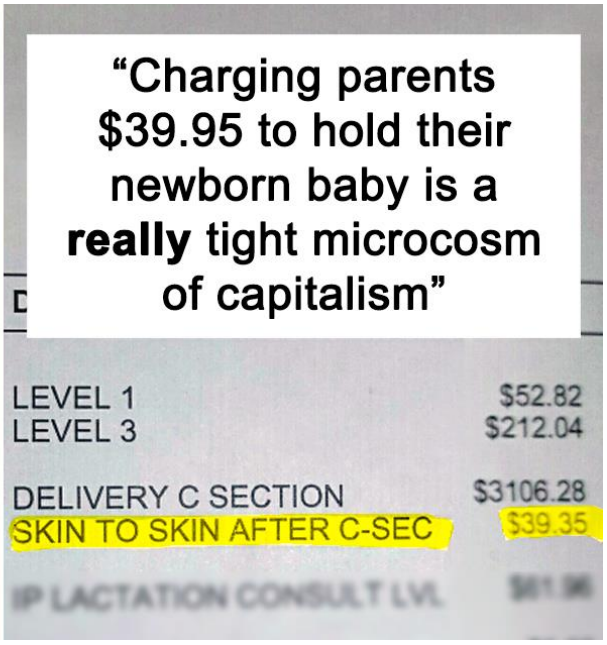
- Health Maintenance Organization (a type of managed care organization)
- An organization that provides comprehensive health care to a voluntarily enrolled population at a predetermined price.
- Contract directly with physicians, hospitals, and other health care providers
- Providers offer their services at a discounted rate, in exchange, HMOs offer referrals
- HMOs emphasize preventative care

The Importance of Understanding Healthcare Industry Accounting for IRS Auditors

The healthcare industry is complex and challenging, especially when it comes to accounting practices. As an auditor, it is crucial to be aware of the legal and financial implications involved in the billing and payment process. Some of the key points that auditors should be aware of when auditing healthcare providers and insurance companies:

1. Legal charges on patient bills

In all 50 states, it is illegal to submit a false claim to an insurance company. Therefore, the amount listed on the patient's bill must be a legal charge, known as the standard charge. Providers file medical claims in both federal and state courts and use the billed amount as prima facie evidence.



People' social media posts

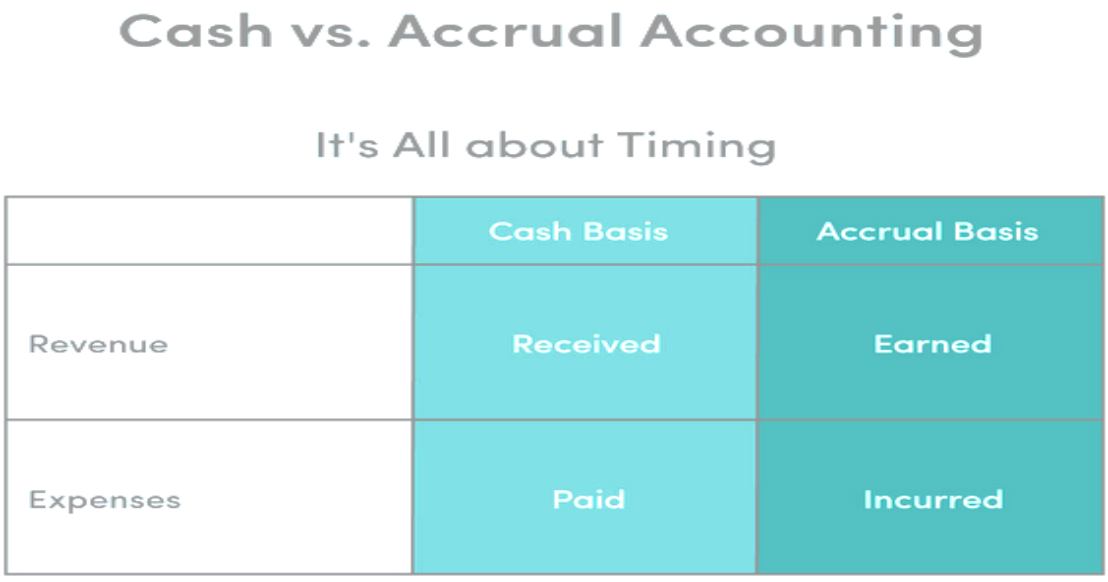
2. Price discrimination for services

Under federal and state statutes, price discrimination for services, which are recognized as a commodity, must be the same for all private-pay patients. This means that providers must collect the same amount from both insured and uninsured patients.

	With Insurance	Without Insurance
Hospital charges:	$6,500	$10,500

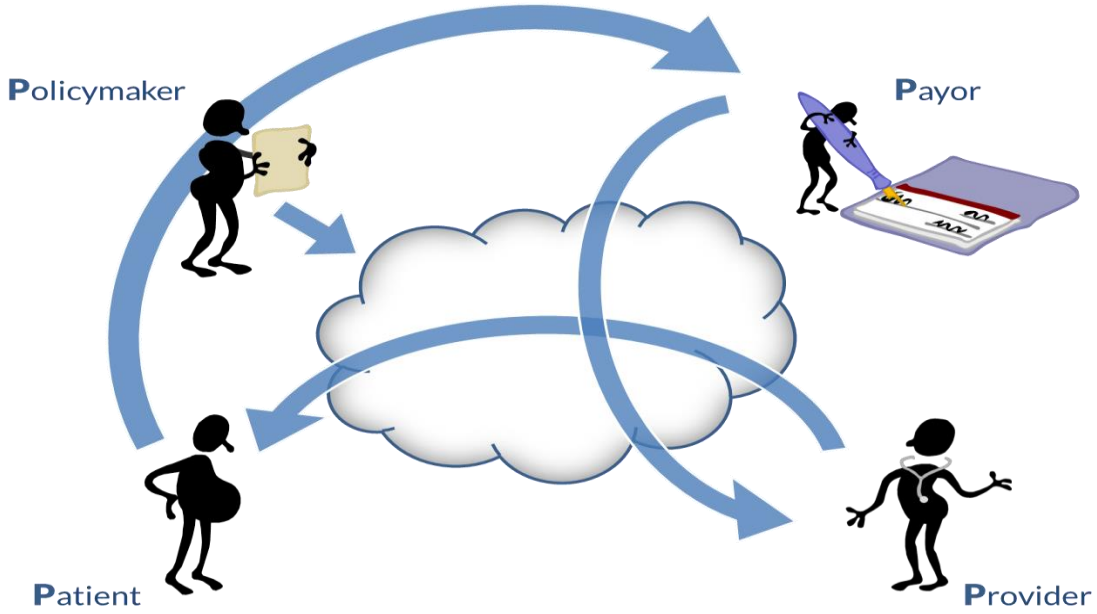
3. Accrual method of accounting

The tax problem's subject matter is how to handle the two separate financial transactions involved in the accrual method of accounting. The creation and recognition of the amount listed on the patient's bill as income for tax purposes, and the deduction or write-off of the kickback or cancelled debt not paid by a third-party payer, such as an insurance company. Under the accrual accounting method, the amount listed on a customer's bill is the amount recognized for income tax purposes.



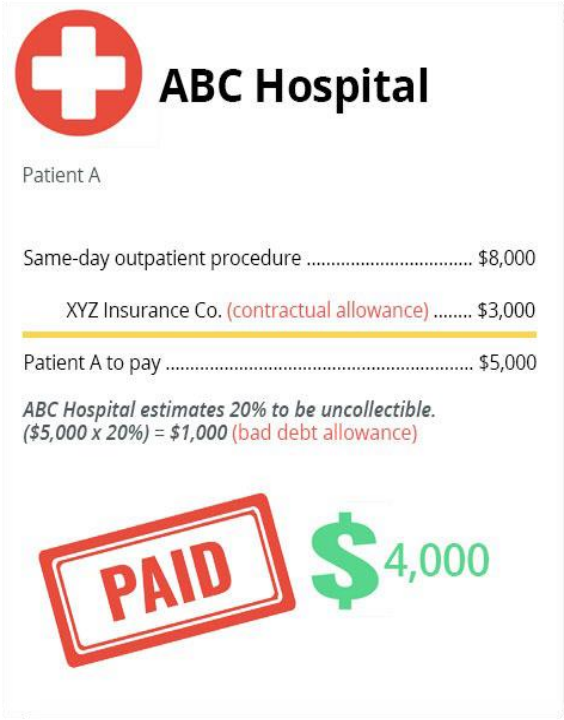
4. Private-pay patient contracts

All private-pay patients' contracts call for the full payment of billed amounts for medical goods and services. Under contract law, only the parties to the contract can make effective changes to the contract and billed amount. However, the insurance company is not a party to the contract between the patient and the provider.



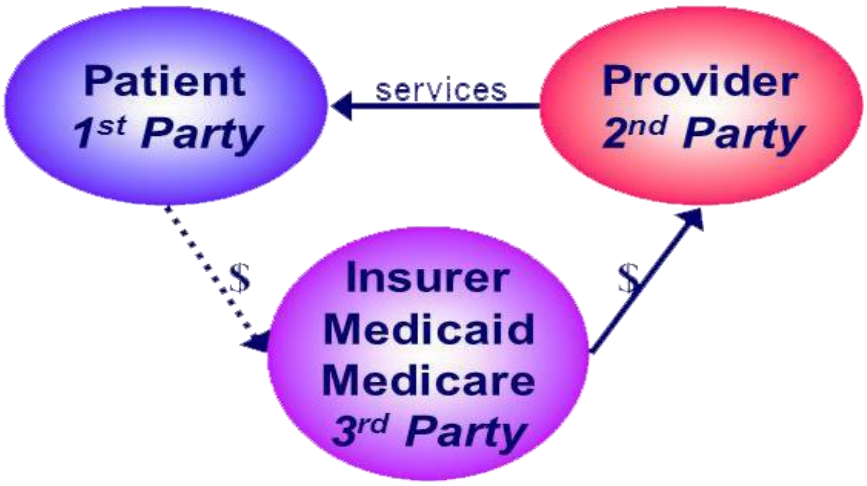
5. Contra account "contract adjustment"

The contra account "contract adjustment" can never be used to write off the difference between the billed amount and the actual amount paid by the insurance company. This contra account is used only for financial reporting and is not recognized in the tax code. It is illegal to use it for tax purposes to write off the difference between the billed amount and the amount the insurance company agrees to pay.



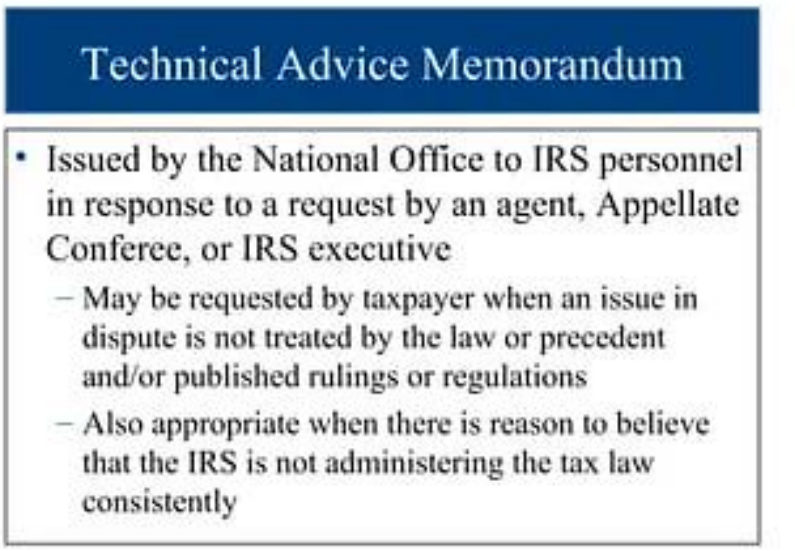
6. Third-party payers

The insurance company is a third-party payer, whose function is to spread the risks of medical expenses among many, not to solicit kickbacks from providers in exchange for access to its insured members. The third-party payer's function is to pay off in full the medical bills of the insured member.



7. Technical advice memorandum (TAM)

Technical advice memorandum, or TAM, is guidance furnished by the Office of Chief Counsel upon request by an IRS director or an area director, appeals, in response to technical or procedural questions that arise during a proceeding. TAMs are not law and are issued for one taxpayer and cannot be used as legal precedence.



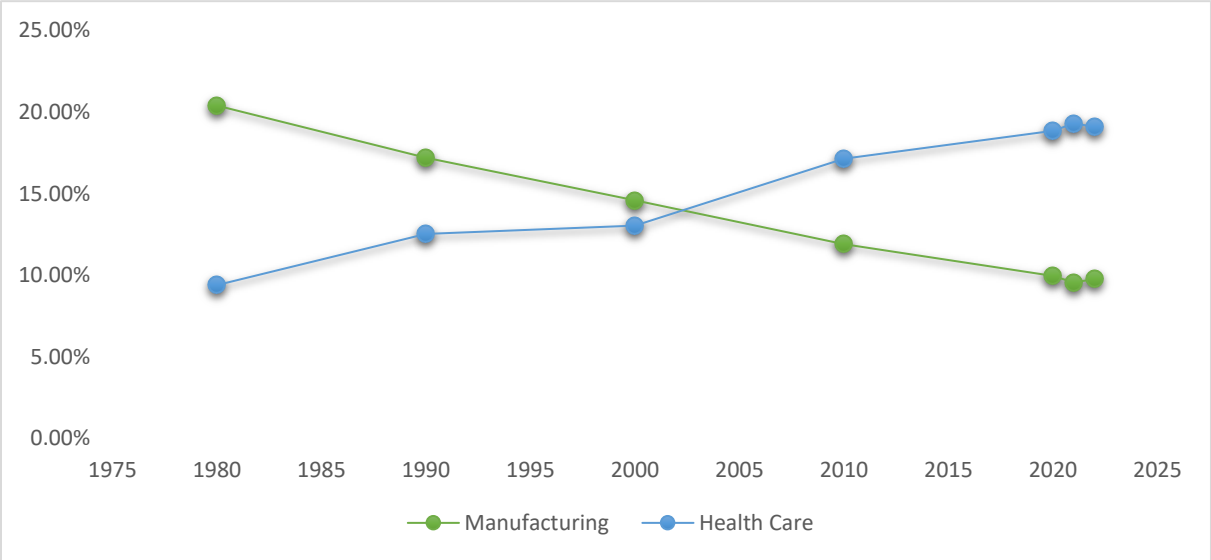
8. Industry Director's Directive

The Industry Director's Directive made it mandatory for all auditors of the Healthcare Industry to review all contracts involved with a "contract adjustment" write-off.

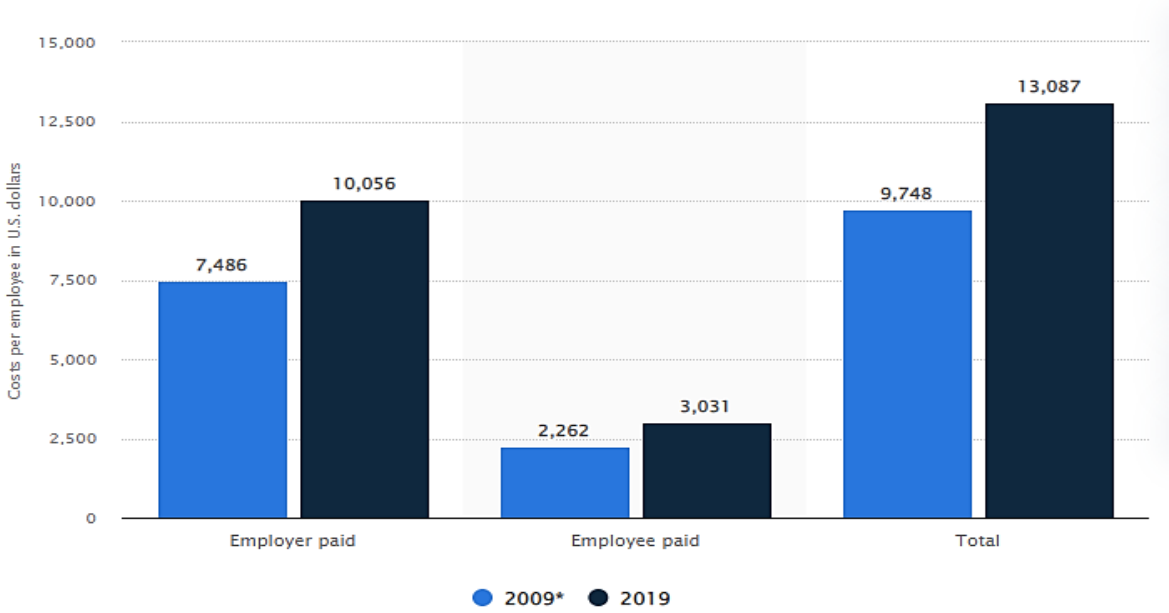
The Increase in Healthcare Costs and Its Impact on the Manufacturing Industry

The increasing cost of healthcare is a major concern for many industries, including the manufacturing industry. The manufacturing industry is particularly susceptible to the impact of rising healthcare

costs as it is a large employer, with many workers relying on employer-sponsored health insurance. Over the last several decades, the cost of healthcare has risen significantly, and this has had a significant impact on the manufacturing industry.



the insurance coverage they need.



Total employer/employee health care costs in the U.S. in 2009 and 2019

In addition to increased labor costs, the increase in healthcare fees can also impact the profitability of manufacturing companies. For example, if a manufacturing company is required to pay more for its employees' health insurance, this will reduce its profit margins. This can lead to a decline in the company's stock price and can make it more difficult for the company to invest in new equipment and technology.

Another impact of the increase in healthcare fees on the manufacturing industry is a decline in employee morale. When employees are required to pay more for their healthcare, they may feel that

their employer is not fully committed to their well-being. This can lead to lower job satisfaction, increased absenteeism, and a decline in overall productivity.

One example of the impact of the increase in healthcare fees on the manufacturing industry is seen in the automobile industry. In recent years, the cost of healthcare has risen significantly, and this has made it more difficult for automobile manufacturers to compete with companies in countries where healthcare is less expensive. In order to remain competitive, many automobile manufacturers have had to shift production overseas, which has resulted in job losses in the United States.

Another example is seen in the steel industry, where the increase in healthcare costs has made it more difficult for steel manufacturers to compete with companies in countries where healthcare is less expensive. This has led to a decline in the number of steel manufacturing jobs in the United States, and has made it more difficult for steel workers to obtain affordable health insurance.

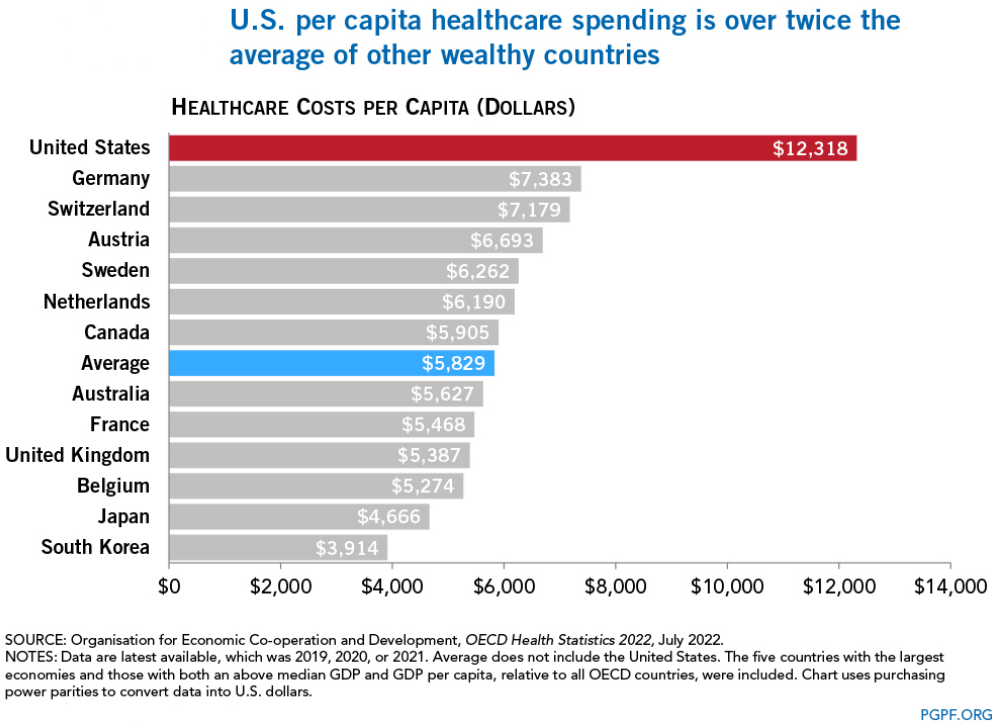
The US Government Can Take Steps to Revive the Manufacturing Industry and Reduce Rising Healthcare Costs

The increasing cost of healthcare and the downturn in the manufacturing industry are two major challenges facing the US economy today. To address these issues, the US government can take a number of steps to prevent personal bankruptcies and create a more equitable and care healthcare system.

Implement Universal Healthcare Coverage: One of the most effective ways to reduce the rising cost of healthcare is to implement a universal healthcare coverage system. This would ensure that all Americans have access to quality healthcare services, regardless of their income or employment status. By pooling resources, the government could negotiate lower prices for medical services and prescription drugs, which would help to reduce the overall cost of healthcare for individuals and businesses.

Promote Capitalism in the Healthcare Industry:

Another approach to lowering healthcare costs is to promote capitalism within the industry. This could be accomplished by fostering competition between private insurance companies and government-run programs, such as Medicare and Medicaid. The increased competition would drive healthcare providers to lower their prices in order to remain competitive and attract consumers, ultimately leading to a reduction in healthcare costs for individuals.



What the Europeans do is that they help the citizens to regulate the healthcare prices while also helping them out in the healthcare payment. However, the United States sees this type of system as a socialist type of system.

Provide Tax Incentives for Employers to Offer Health Insurance:

To help reduce the cost of healthcare for employees and employers, the government could provide tax incentives for employers who offer health insurance to their employees. This could include tax credits for small businesses, tax-free health savings accounts, and other incentives. By reducing the cost of providing health insurance, employers would be more likely to offer coverage to their employees, which would help to reduce the cost of healthcare for workers.

Support the Manufacturing Industry:

To help revive the manufacturing industry, the government could provide financial and technical assistance to small and medium-sized manufacturers. This could include grants for research and development, low-interest loans for capital expenditures, and tax incentives for companies that create new jobs in the manufacturing sector. By supporting the manufacturing industry, the government could help to create new jobs, boost economic growth, and reduce the number of personal bankruptcies.

The Implementation of Universal Healthcare Coverage: Potential Benefits for the American People and Economy

One of the most promising solutions for reducing the rising cost of healthcare in the United States is the implementation of a universal healthcare coverage system. This system would ensure that all Americans have access to quality healthcare services, regardless of their income or employment status. The benefits of such a system are numerous and far-reaching, and would help to improve the overall health and well-being of the American people while also boosting the economy.

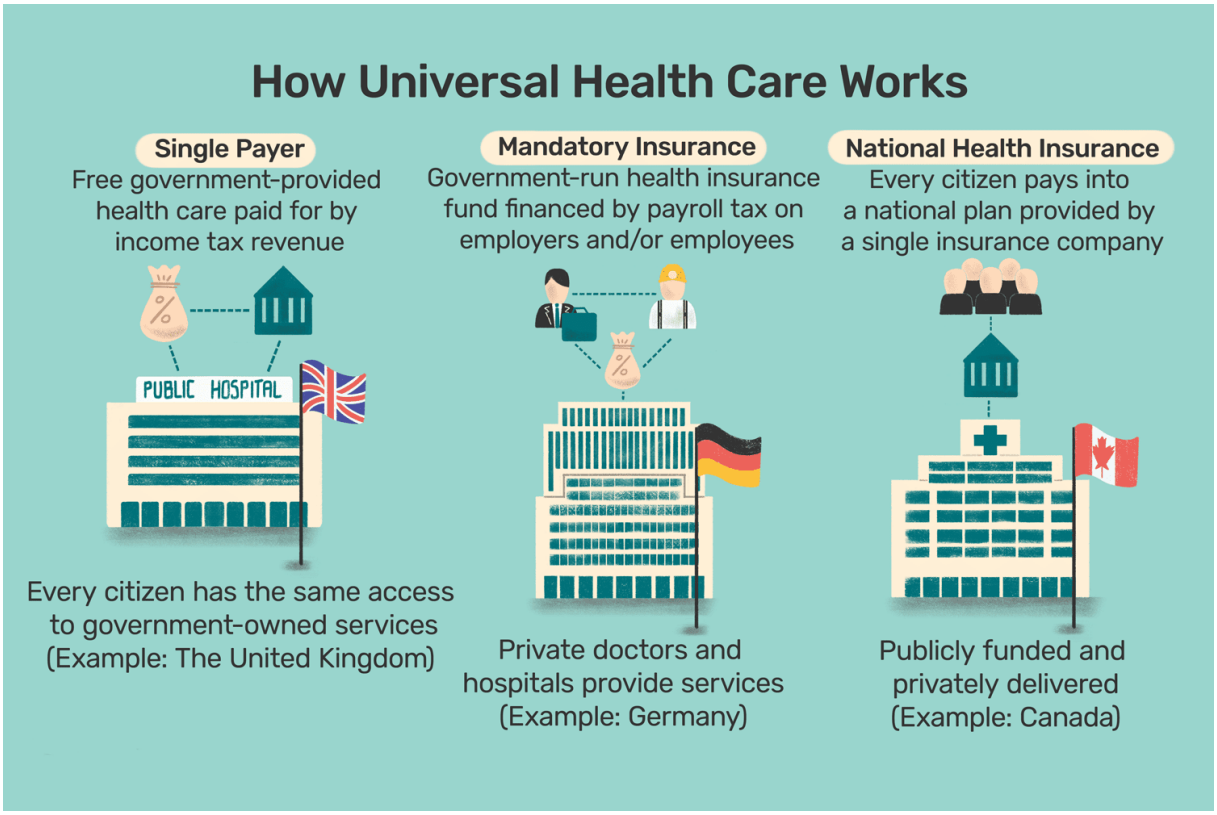
Reduced Healthcare Costs for Individuals and Businesses

One of the most significant benefits of universal healthcare coverage is that it would reduce the overall cost of healthcare for individuals and businesses. By pooling resources, the government would be able to negotiate lower prices for medical services and prescription drugs. This would help to reduce the financial burden that many Americans face when it comes to paying for healthcare, and would make it easier for businesses to provide healthcare coverage to their employees.

Improved Health Outcomes

Universal healthcare coverage would also help to improve health outcomes for Americans. By providing access to quality healthcare services, individuals would be able to receive the care they need to stay healthy and prevent and treat illnesses. This would not only improve their quality of life,

but would also help to reduce the overall burden of healthcare costs, as preventative care is often more cost-effective than treating advanced illnesses.



Reduced Bankruptcy Rates

The high cost of healthcare is one of the leading causes of personal bankruptcy in the United States. By implementing a universal healthcare coverage system, the government would help to reduce the number of individuals who are forced into bankruptcy due to medical debt. This would provide peace of mind for millions of Americans, and would help to reduce the overall financial burden on the individual and the economy.

Boosted Economy

Finally, universal healthcare coverage would have a positive impact on the economy as a whole. By reducing the financial burden that healthcare costs place on individuals and businesses, the government would help to stimulate economic growth. This would create jobs and help to boost the overall health of the economy.

In conclusion, the implementation of universal healthcare coverage would have numerous positive benefits for the American people and economy. By providing access to quality healthcare services, reducing healthcare costs, improving health outcomes, reducing bankruptcy rates, and boosting the economy, universal healthcare coverage would help to create a healthier, more prosperous future for all Americans.

Solution Proposal

The transition to a single payer health system has the potential to greatly improve capitalism and the production industry in America. While the concept of a single payer health system has been met with controversy and criticism from some, it has the potential to increase economic efficiency and ultimately boost income for Americans.

The current American healthcare system is heavily reliant on private insurance companies, which can lead to higher costs for consumers and businesses. With a single payer system, healthcare would be funded through a universal tax system, leading to lower costs for businesses and consumers alike. This lower cost of healthcare would increase the competitiveness of American businesses, as they would no longer have to factor in the high cost of healthcare when determining their operating expenses.

The production industry would also benefit from the transition to a single payer health system. With lower healthcare costs, businesses would have more money to invest in their operations, including increasing the production capacity. This increased production capacity would then lead to increased economic growth, as businesses would be able to produce more goods and services.

The income of Americans would also increase with the transition to a single payer health system. The lower cost of healthcare would free up money for businesses and consumers, allowing them to invest in other areas of their lives, such as education and home improvement. This increased spending would drive economic growth, leading to more job opportunities and higher wages.

In conclusion, the transition to a single payer health system has the potential to greatly improve capitalism and the production industry in America. Lower healthcare costs would increase the competitiveness of American businesses, increase production capacity, and ultimately boost the income of Americans. While the transition may not be easy, the long-term benefits for the economy and for individuals are undeniable.

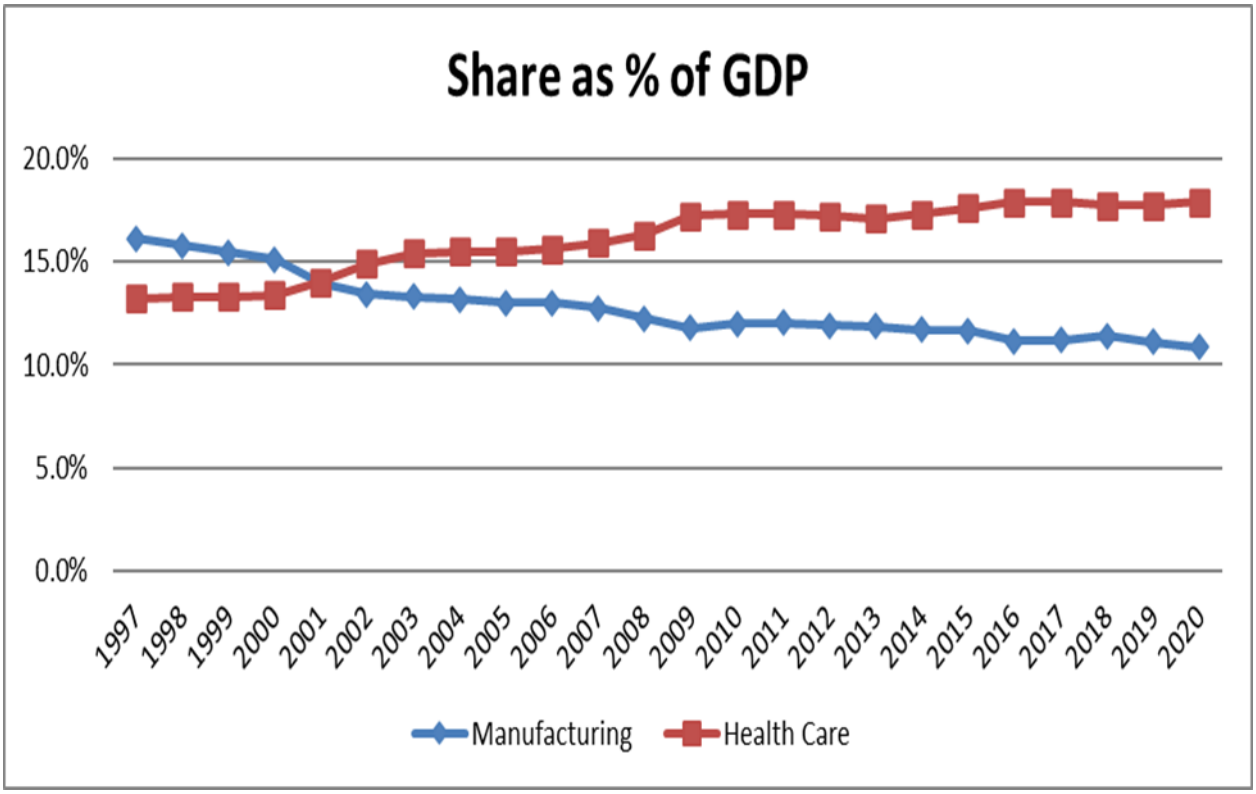
Why U.S. Manufacturing Industry has shrunk to its lowest percentage revenue level

The U.S. manufacturing industry is at its lowest level in modern history, now at 11% of GDP down from 24.3% in 1970. The U.S. tax expenditures are higher than the average of OECD members. This is two and a half times the average of OECD.

On a closer look, it is imperative that the cause is healthcare industry and its rising overhead to the manufacturers. A simple comparison of the percentage change in GDP of the healthcare industry versus the manufacturing industry shows a direct correlation between the growth of one and the shrinkage of the other, percentage point for a percentage point. No other industry besides manufacturing has seen such a decline during this time period.

The cause is the growth of the healthcare Industry and how the US pays for it. US is the only industrial country where the employer directly pays a substantial share of employees' health care benefits. In other nations, citizens themselves and businesses foot the bill, through income taxes.

The decline of the manufacturing sector in the U.S. economy is even more evident looking back further in time. In 1998, there were 18.1 million manufacturing jobs, 11% of total jobs and 5.6 million more than in 2018. In addition, while total GDP increased 47% from 1998 to 2018, the manufacturing sector increased just 5%.



Cycle of Manufacturing Organization

A manufactured good is made through several steps to get to finished product, with each step adding the subsequent employee healthcare benefits cost to the finished product. These costs are referred to as the indirect healthcare costs. For instance,

Step one, in the manufacture of a car, the miners of the ore have direct healthcare costs, which are marked up and passed along in the cost of the ore.

Step two, the ore is purified and shaped in the steel mills, which adds one more indirect healthcare cost and one direct healthcare cost, that are passed on.

Step three, all the various components are assembled by the auto mobile manufacturers, adding two more indirect healthcare cost and one direct healthcare cost, then passed on.

Step four, the retail auto sale force sells the cars, adds one direct healthcare cost and three indirect healthcare costs, to the selling price.

Each individual group must sell its products above its break-even point of costs to stay in business and then add amounts to cover its profits and taxes. By eliminating the direct and indirect employer's healthcare costs the final finished good's break-even point is much lower and can be competitively priced. All internationally manufacturing competitors have eliminated employer paid health care costs. For the United States to compete we must eliminate employer-paid health care insurance costs.

All health care costs and Social Security Benefits are pushed forward, continually raising prices of goods and services.

Inside Healthcare Industry

USA health-care sector is in many ways the most consequential part of the United States economy. It is a fundamental part of people's lives, supporting their health and well-being. Moreover, it matters because of its economic size and budgetary implications. The health-care sector now employs 11 percent of American workers (*Bureau of Labour Statistics [BLS] 1980–2019b and authors' calculations*) and accounts for 24 percent of government spending (*Centres for Medicare & Medicaid Services [CMS] 1987–2018; Bureau of Economic Analysis 1987–2018; authors' calculations*). Health insurance is the largest component (**26 percent**) of nonwage compensation (*BLS 2019b*) and health care is one of the largest categories of consumer spending (*8.1 percent of consumer expenditures; BLS 2019a*). The United States has a health-care system that largely consists of private providers and private insurance, but as health care has become a larger part of the economy; a higher share of health-care funding has been provided by government. As of 2018, 34 percent of Americans received their health care via government insurance or direct public provision

The Healthcare Industry providers are paying huge kickbacks to insurance companies in the revenue form of cancelled debts. These kickbacks are included in the premiums charged to employers. The providers and insurance companies violated the tax laws, antitrust laws, federal and state kickback laws and destroyed the nations' manufacturing industry. Price discrimination concept also prevails in it in terms of Different amount collected from private-pay patients, insured v. uninsured, Different

amount collected from different insurance companies, the kickback amounts are separately negotiated, Different amount collected, within same insurance contract, for different services, this is what is known as cost shifting, many times the charges reflect the demographics of the insured members not the average cost to price ratios of each service, this is especially true when increasing the charges for the elderly where the government picks up the charges.
The amounts collected from different insurance companies are different due to the amounts of the kickbacks paid, this is done to get the insurance companies insured members and have the insured members boycott the competitive providers, this is why the kickbacks are called trade secrets and hidden from competitors, the competitors many times are lower in price but with the kickbacks paid by the providers the insurance company gets a better financial deal. The charges do not reflect the actual price, except for the uninsured, but the charges are used to reflect the premiums charged by the insurance companies to their customers the employers.

All Healthcare Costs and FICA Taxes are Passed Forward

Moving to New Financial System Eliminates All These Costs

	Raw Materials Procurement	Component Manufacturing	Assembly	Distribution	Retail
					Price
				Price	
			Price		
		Price			
	Price				
					New Cost
				New Cost	Previous+
			New Cost	Previous+	Previous+
		New Cost	Previous+	Previous+	Previous+
	New Cost	Previous+	Previous+	Previous+	Previous+

New Cost – Direct healthcare cost Previous+ - indirect healthcare cost plus mark-up for profit

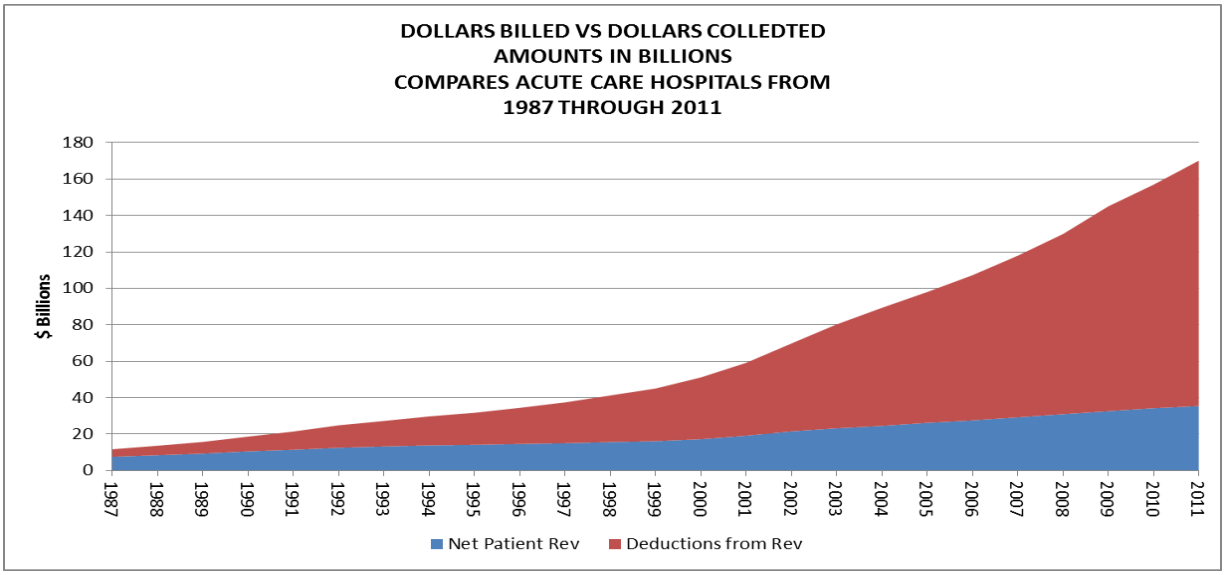
The healthcare industry quickly realized that by increasing the amount listed on the beneficiaries' bills the government would increase the Medicare reimbursements. The healthcare insurance companies and the healthcare providers worked together to increase the billed amounts thereby shifting the payment of healthcare costs to the government. The insurance companies would not pay the increased amounts, so the providers partially cancel the debt created on the insured patient's bill. Instead of recording it as canceled debt, **which is a violation of the price discrimination statutes**, it is recorded as a contract adjustment. To justify these accounting practices, the insurance companies and providers entered into contracts with an agreement to pay less than the standard charge.

The insurance companies went even further, requiring any provider who wished to access its insured members must give them a kickback in the form of a partial cancelation of debt. The practice of referring patients, for cash or cash equivalents is barred by the anti-kickback statutes and Stark laws. The contract also requires all patients to be billed the standard charge, which include Medicare and non-insured patients. Presently non-insured patients are paying seven times more than the amount collected from insurance companies. Since the customer of the healthcare provider is the patient, the difference in the amounts collected is price discrimination.

The insurance companies created a list of approved providers, which is known as the in-network providers and gave substantially financial penalties to the insured patient if he or she took their business to an off-network provider. The insured patients are financially coerced to boycott any Provider not listed as an in-network provider. The coercion is simple. Instead of paying a 10% co-payment of the amount agreed to in the contract, the insured member must pay at least a co-payment of 20% of the billed amount. This increase is a 12-fold increase of the co-payment. Let us say both the in-network provider and the off-network provider standard charge is $100. The insurance company has an agreement to pay only $15 to the in-network provider, so the co-payment is $1.50. The off-network provider bills $100 and the new co-payment is $20 divided by 1.5 is 12. These actions are all a restraint of trade and illegal.

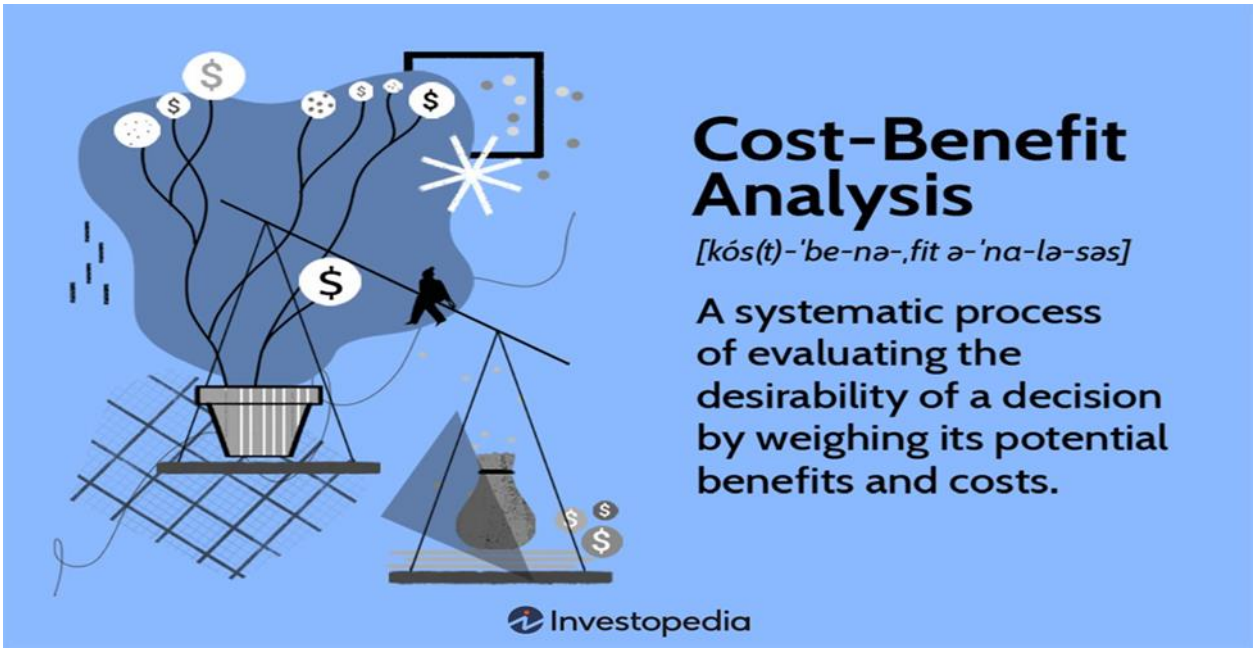
Over time, healthcare providers started charging insured patients more to compensate for the kickbacks paid to insurance companies and to cover the billed amount listed on public beneficiaries' bills. Initially, the difference in billed amounts and collected amounts was just a few percentage points, but it increased every year. Currently, the difference is greater than 85%. As healthcare prices rose, so did industry revenues, resulting in an increased contribution to GDP. The Florida Healthcare Finance Administration created a chart to demonstrate the growth of hospital revenues and billings, which is shown below.

1987 – 2011	**Percentage Changes**
Hospital Gross Billing	1354%
Hospital Revenue	372%
Consumer Price Index	95%



Ways to fix Manufacturing Industry in terms of % revenue

There are many causes of U.S. Manufacturing Industry has shrunk to its lowest percentage revenue level, but the main cause is the growth of the healthcare Industry and how the US pays for it, and the manufacturers cannot cover the spiralling healthcare benefit costs.



For manufacturing industries to remain in business and make a profit, they need to sell their products above their break-even point, which includes the costs of production, profits, and taxes. By removing the burden of direct and indirect employer healthcare costs, the break-even point for the finished goods can be lowered, making it more competitively priced. Other industrialized countries have already eliminated these costs, which means that the US needs to reconsider its healthcare and social security payment policies. Currently, confusion exists regarding whether to pay taxes before or after the provision of goods and services. To improve competitiveness, it is necessary to move these costs above the break-even point, and payments should be made from profits collected after the product is sold to avoid increasing the selling price. Contributions to healthcare and social security programs should come out of income taxes, rather than FICA taxes, which ultimately ends up in the government's general revenue fund. By changing how these benefits are paid, the manufacturing sector can become more competitive with other countries.

Firstly, to solve the problem at hand, we need to review our taxation policy and consider implementing a new tax. By doing so, we can assess its impact on an individual in terms of competitive pricing and FICA taxes. It's worth noting that FICA taxes are a cost imposed prior to the sale of products or services, which inevitably increases their selling price. On the other hand, eliminating the FICA tax leads to more competitive pricing, making our manufactured goods more affordable and attractive for sales both in the United States and abroad.

When these recommendations for a single payer system and revised tax system are implemented there will be many changes taking place, some good and some bad.

On the good side, everyone will be covered for health care, people with pre-existing conditions will be covered and people will have their choice of healthcare provider. Employees with existing illnesses or disabling skills will be able to get jobs and hold on to them with their skills to produce. The money allocated to the employees for health care will be paid to them in the form of higher wages, about $10 thousand per employee, plus FICA taxes. The salary increase will be the biggest recorded in our nation's history while creating a huge consumer group flush with money. The 1.7 million bankruptcies personal bankruptcies due to health care costs will be eliminated. The 25 percent of administrative health care expenditures for billing and collecting will be eliminated. The national health care expenditure will be cut in half or lower. The trade deficit will be eliminated. The National Debt will be lowered. With universal healthcare all employees will have a greater freedom of choice of where they work and not have to worry about changing jobs with a loss of medical coverage. The state's Medicaid expenditures will be eliminated and should immediately be moved to offset the cost of free higher education, like every other industrial country.

On the downside, the bad news is based on a comparison with the insurance companies' employees per capita of Canada, 250,000 administrative and sales jobs will be lost, there is no need for sales people; these sales jobs should easily be moved to the manufacturing industry. Taxes paid for The Federal Insurance Contributions Act (FICA) will be substituted by a flat tax added to the corporate and personal income rates. The total FICA tax is 15.3%. That percentage is given to the employee's gross pay.

The New tax system adds $15,000 to cover the addition of the average health care employee expense and the FICA taxes. The $15,000 in now taxable income, therefore the tax revenues going to the United States have increased. The lower- and middle-income classes see an increase in their take home wages. The New tax rates are the 2017 Tax rates **plus 4% for each tax group**. Although this seems a tax increase, it is lower for the lower- and middle-income groups because it has eliminated the 7.5% FICA taxes, therefore it is lowering their taxes by 3.5%. The upper income groups will have a 3% increase. The amount of tax revenues will be substantially increase due to the fact all individuals will be paying taxes on healthcare costs and FICA taxes; all lower- and middle-income groups will be taking home larger pay checks but pay larger taxes.

In this case, the employer and employee each pay 7.65%. Here is the breakdown of these taxes. Within that 7.65%, the OASDI (Old Age, Survivors, and Disability program, AKA, Social Security) portion is 6.2%, up to the annual maximum wages subject to Social Security.The Medicare portion is 1.45% for each employee, on all employee earnings.

The new amount of the flat tax will have to be determined by the General Accounting Office and should be added on all earned income tax levels, which will insure all people pay their fair amount of taxes. The medical portion should only rise 3% to 4% raising each contribution to 10.65% to 11.65%. Included will be the government's obligation to our military veterans. The rise in the amount collected for the new taxes will be far lower than each person's increase of income.

Our progressive personal income tax system is fair. We realize certain individuals will always make more than others, allowed to keep most of it which is a strong motivator for success. We also realize that when more is given to an individual under our capitalistic system, a strong financial system is required for maintaining our freedom, therefore in the short run more has to be given to the government for the maintenance of the country, maintenance of our capitalistic system and the benefit of its citizens who make it possible. In the future we will pass legislation for the maintenance

of a balanced budget. When the transition is finished, we must allow market forces to stabilize all industries and keep government interference to a minimum.

The country must make the changes advocated or we will be facing financial ruin. Manufacturing creates wealth. Without a strong manufacturing industry, we will become a third world country, with our main industry becoming agriculture. The cost of our produce will keep rising because other rich nations will be buying our produce and will inflate our costs.

A massive stimulus program will take place to give more money to employees directly and the first steps to rebuild the United States manufacturing industry. At a future date, the employers are to cancel all health insurance contracts for employees; take this cost savings and average it out, and give each employee the same salary increase, of the amount allotted for health care benefits. Medicare is going to cover all medical expenses, at the rates already determined. Every patient will give the health care provider their Social Security Number or their guardians. All assets of health insurance companies will be frozen by Internal Revenue Service while audits are in process.

The highest rated government sponsored health care system is the United Kingdom's; it is least expensive and provides good service. This system controls the salaries of its' doctors, which will have to be reduced in this country. Moving to this health care system means the US national health care costs will be $1.5 trillion. This will cover medical services, medicines, hearing aids and glasses.

In a nutshell. In order to improve the quality of our lives, substantially lower the nation's healthcare costs, cover all individuals including those with existing conditions, improve employees' salaries, make our manufacturing industry competitive with other countries, we must eliminate employer-paid health care benefits and have a single-payer healthcare system, with universal coverage and change the tax system to pay for healthcare and Social Security benefits.

Legal and taxation laws

I am sure that everyone is wondering about the possibility of the above mentioned points and there are lot of questions from legal and taxation standpoint.

The first question that comes to the mind is **Can a secret contract between two parties is above the Law?** The simple answer to that is No. However, it depends upon which law enforcement agency you are referring to. The Department of Justice would not legally allow you to contract a killer to murder someone or allow you to hire an arsenous to burn down your business to collect the insurance money. On the other hand, the IRS does allow health care providers to pay kickbacks to insurance companies to have access to their insured members, as long as the providers call the cancelled debt a contract adjustment to the patient's contract. The tax code not enforced is 26 USC 162(c)(2).

Secondly, when is income recognized, when the bill is issued, or when the cash payment is made? Typically, the organizations use accrual method for such transactions. A method of keeping accounts that shows expenses incurred and income earned for a given period, although such expenses and income may not have been actually paid or received. Right to receive and not the actual receipt determines inclusion of the amount in gross income.

Revenue Recognition Principle is a fundamental of accrual accounting. They both determine the accounting period in which revenues and expenses are recognized. According to the principle,

revenues are recognized when they are realized or realizable, and are earned (usually when goods are transferred or services rendered), no matter when cash is received.

The IRS does not recognize the accrual accounting method for a privately insured patient. The IRS believes the cash payment of the insurance company determines the recognized income. The IRS does not support:

Thirdly, Legal Discounts are given to customers and shown on the bill when issued. Whose bill did the discounts show up on, the patient's bill or the insurance company's bill?

Health care providers do not give anyone a discount. The only medical bills issued list the patients' names, there are no bills listed in the insurance companies' names. The insurance companies are independent third-party payers, which spread the medical costs of their insured members, the insurance companies are paid to cover the medical bills of the insured members.

Fourthly, The difference between billed amount and amount paid, is it a business expense, or bad debt, or cancellation of debt?

The private insurance companies send Explanation of Benefits Forms (EOB) to the insured members that clearly states it is not a bill but show how much the patient was billed (Patient's Debt), how much the insurance company pays, and the co-payment and deductible the insured member owes the insurance company.

An example of what we are talking about: A provider bills a privately insured patient $100, the actual amount recognized, for income purposes but only collects $25 in cash; the difference is $75 of debt owed to the provider. Is the $75 a business expense, or bad debt, or cancelled debt?

The first determination is who owes the $100 to the provider. Through contract determinations between the insured patient, insurance company, and provider, the insurance company accepts the medical debt's legal obligation of $100. In legal parlance, it is a novation, where one debtor, through contractual agreements, is substituted for another.

The $75 is not a bad debt because it is mutually agreed between the insurance company and the provider that the actual amount paid in cash is $25. The $75 is debt owed by the insurance company to the provider and not collected, thereby making it a cancelled debt of the provider and forgiven debt income for the insurance company. But if it is a cancelled debt, the law requires the provider to send in an information tax return, 1099C, to the IRS to identify the insurance company's forgiveness of debt income. The $75 is forgiveness of debt income to the insurance company.

The contract between the insurance company and the provider states their legal relationship is that of a subcontractor and employer. The provider is treating the $75 write-off as a business expense. Their contract shows that the $75 paid is because it steered the insured member to the provider. The $75 is a kickback. Kickbacks in the Healthcare Industry are illegal. Kickbacks are not deductible as a business expense.

26 USC § 162 (C)(2) (c)Illegal bribes, kickbacks, and other payments "No deduction shall be allowed under subsection (a) for any payment (other than a payment described in paragraph (1)) made, directly or indirectly, to any person, if the payment constitutes an illegal bribe, illegal kickback, or

other illegal payment under any law of the United States, or under any law of a State (but only if such State law is generally enforced), which subjects the payor to a criminal penalty or the loss of license or privilege to engage in a trade or business. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, patient, or customer.

Fifthly, why the contract adjustment account can be used for the government business side but cannot be used for the private business side?

The use of the write-off of contractual adjustment account has been around since 1965 when the Medicare and Medicaid programs were started. No place in the Tax Code or Code of Federal Regulations allows for a contractual adjustment write-off. What happened was that the Financial Accounting Board created the contractual adjustment account designation to identify the difference of the amount listed on financial reports of the billed to the beneficiaries of the government programs of Medicare and Medicaid and what Congress approved for payment. In business, for the accrual accounting method, the difference not collected is a cancellation of debt. The party receiving the forgiveness of debt income must pay taxes on it, but the federal government does not pay itself taxes.

The billing and contractual procedures for the private business side look very similar to the government business side but have different tax considerations. On the private business side, the billed amount listed on the customer's bill creates realized income, a legal debt, and gross income. The bill does not create realized income or a legal debt on the government business side, but the amount is in the provider's gross income. The provider's realized income from the government, the income account is reconciled with what the government pays.

The provider's deviation from Generally Accepted Accounting Principles for the government business side is allowed because the Social Security laws for Medicare and Medicaid require it. The government business side accounting is a cash accounting method of accounting, not an accrual accounting method. The providers utilize two accounting methods. The Social Security law requires the providers to be on the accrual accounting method for the private business side. The tax problem is that the providers and the Internal Revenue Service (IRS) do not recognize the distinction between a provider's two business sides.

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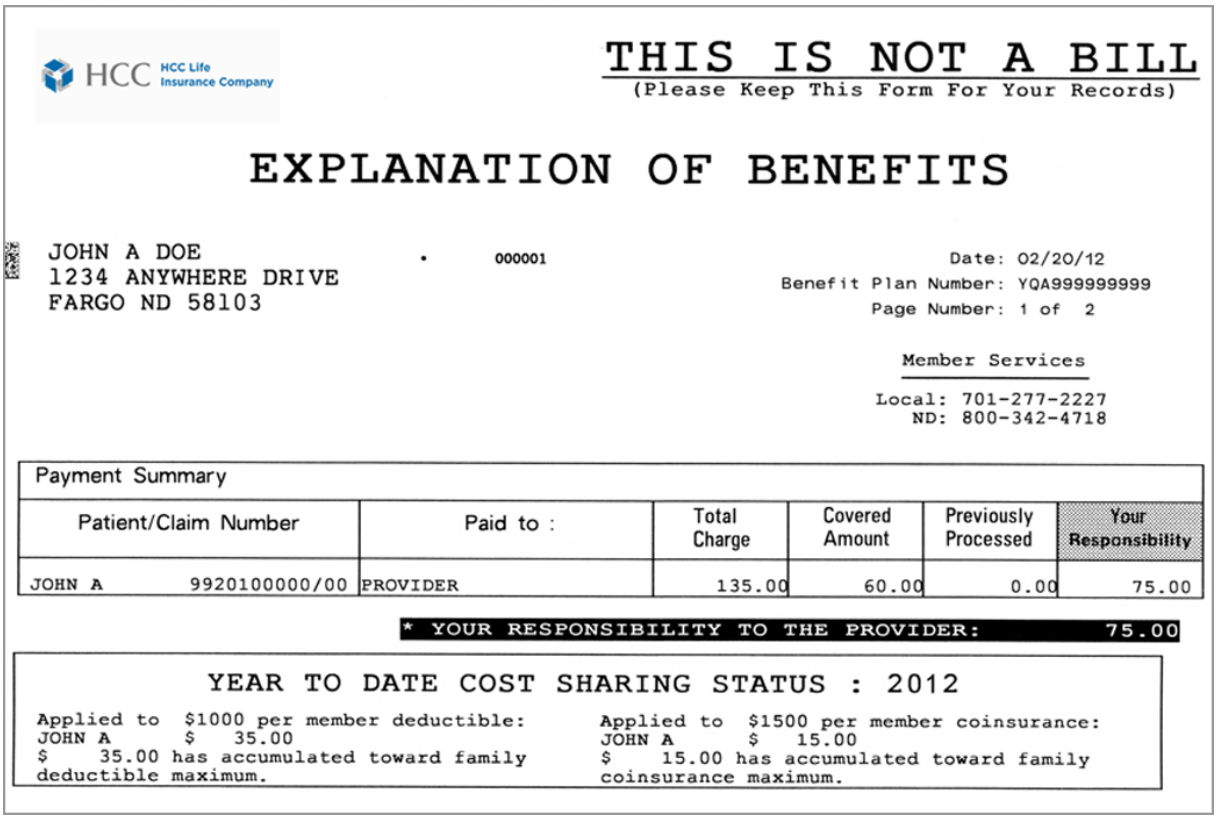
Unlawful Activities & favouring laws in Healthcare Industry

In the United States, **seventy percent of all patients are private-pay insured patients**; they are covered by private health care insurance, mostly paid by employers. The delivery of health care and payment consists of two parts; the providers perform medical services, and the insurance companies are legally obligated to pay for the services.

The main business of providers is to provide medical services and goods to their customers, the patients. Usually, upon completing medical services, the provider issues a bill, listing the standard charges for both insured and non-insured patients. All patients are the same, which is a requirement of state and federal price discrimination laws. The providers are on the accrual accounting method; when the bill is issued, income is recognized and included in gross income. The recognition of income has nothing to do with when the provider receives payment for the services provided or who pays.

The insurance company's primary business is spreading the risk of an individual's sizeable medical bill among many individuals. The majority of the payments to cover these medical bills come from employers, and the employers call them medical benefits. When an insurance company receives a bill for an insured member, it recognizes the debt as an expense. The insurance company is liable for the full debt. In most cases, the insured member is partially responsible to the insurance company for co-payments and deductibles, and these expenses are not medical expenses. Through business agreements, the insurance companies have managed to make the providers collect these co-payments and deductibles from the insured patients.

The tax problem happens when the co-payments, deductibles, and the amount the insurance company pays is less than the amount billed, the insured patient's legal debt. Since it is mutually agreed between the provider and the insurance company, the uncollected amount cannot be written off as bad debt to be deducted from gross income. The only accepted method recognized by the tax code is a cancellation of debt for the provider and forgiveness of debt income for the insurance company.



HCC Life Insurance Company

THIS IS NOT A BILL
(Please Keep This Form For Your Records)

EXPLANATION OF BENEFITS

JOHN A DOE
1234 ANYWHERE DRIVE
FARGO ND 58103

000001

Date: 02/20/12
Benefit Plan Number: YQA999999999
Page Number: 1 of 2

Member Services
Local: 701-277-2227
ND: 800-342-4718

Payment Summary

Patient/Claim Number	Paid to :	Total Charge	Covered Amount	Previously Processed	Your Responsibility
JOHN A 9920100000/00	PROVIDER	135.00	60.00	0.00	75.00

* YOUR RESPONSIBILITY TO THE PROVIDER: 75.00

YEAR TO DATE COST SHARING STATUS : 2012

Applied to $1000 per member deductible:
JOHN A $ 35.00
$ 35.00 has accumulated toward family deductible maximum.

Applied to $1500 per member coinsurance:
JOHN A $ 15.00
$ 15.00 has accumulated toward family coinsurance maximum.

EXPLANATION OF BENEFITS (EOB)

Not a Bill—Save Your EOB

Around the time you receive your patient billing statement, you will also receive an explanation of benefits (EOB) from your insurance provider. An explanation of benefits is a document that explains how your insurance processed the claim for the services you received.

It breaks down the information like this:

- The services we provided
- What the doctor or hospital charged (all charges)
- What your insurance covered and did not cover
- What your insurance agreed to pay
- The amount you must pay (amount you are responsible for)

While **this document is not a bill**, it is an important tool that shows you how your bill is broken down between the medical service provider(s), your insurance, and you. From it you can determine the difference between the billed amount and the actual amount paid, which is the kickback amount.

A close examination of the contract's consideration shows **the provider is paying the insurance company to steer its' insured members to the provider**, which is legally defined as a kickback payment. Usually, the provider would be allowed to deduct cancelled debt as a business expense from its' gross income. In the Healthcare Industry, kickbacks are illegal and are not legally deducted,

even for not-for-profit corporations. The insurance company is performing an unlawful service on behalf of the providers on its network, but it has value. The provider must recognize the value as barter income and pay taxes on it. The purpose of making kickbacks illegal in the Healthcare Industry is to keep costs as low as possible. Not collecting taxes on the kickbacks defeats the purpose of the law.

The root of the tax evasion issue stems from the IRS's belief that a private contract between a healthcare provider and an insurance company, acting as a third-party payer, could supersede Congress's tax laws. The IRS mistakenly assumed that the amount agreed upon in the contract represented the actual income earned by the provider. However, the legal obligation of the third-party payer is based on the amount listed on the bill given to the privately insured patient; in legal parlance the amount listed is the sum certain.

The IRS's confusion also arose from their misinterpretation of the accrual accounting method, particularly for privately insured patients. The agency recognized income based on the cash payment made by the insurance company, a method similar to the one Congress uses to pay for government services. The IRS failed to realize that the insurance company has no connection to the medical services provided and the provider does not issue bills in their name. Therefore, the bill given to the patient is the recognized income for tax purposes, with the amount listed as the debt owed.

As a result, any unpaid amount by the insurance company is considered a cancellation of debt for the provider and forgiven debt income for the insurance company, which the latter must pay taxes on.

What is a TAM?
Private Letter Rulings ("PLRs"), Technical Advice Memoranda ("TAMs") and Field Service Advice Memoranda ("FSAs") are taxpayer-specific rulings furnished by the IRS National Office in response to requests made by taxpayers and/or Internal Revenue Service officials. A TAM cannot be used for legal purposes, but the IRS tax auditors use them anyway.

Several TAMs, written about using contract adjustments for writing off the partial cancelled debt or forgiven debt, have two premises. The contract between the insurance company and the provider must be legally enforceable and must be in effect prior to the bill being issued to the insured patient. The later requirement is false! The Universal Commercial Code Parole Evidence Rule states a prior agreement cannot be used to change a new contract, the patient's contract, or the amount listed on the patient's bill. The patient's contract and the patient's billed amount supersede any prior contract with the insurance company. The insurance company and the provider are two separate entities that have no legal relationship. The insurance company cannot modify the contract between the provider and patient or readjust the standard billed amount. The second part is false. An insurance company cannot receive a discount, it is not a customer, it purchases nothing, and the provider cannot give a discount because of our price discrimination laws. A legal discount must be listed on the patient's bill at the time of issuance. The providers do not record any discounts on the patients' accounts.

Not-For-Profit Hospitals' normal income would not be taxed, but the law is clear that the illegal payment of kickbacks cannot be deducted from gross income; therefore, these corporations must pay taxes on these kickbacks. These corporations participate in unlawful activity; therefore, their tax-exempt status is revoked, and all profits become taxable income.

The Tax Code recognizes the provider's income under the accrual accounting method when the provider performs the medical services on the patient, has a right to be paid, and issues a bill to the

patient, where the amount can be easily identified. The patient's bill is paid in several manners, either by cash, credit card, check, or through a third-party insurance company. The cash payment of the bill does not have any effect on the recognition of income for the provider, under the accrual method of accounting.

When an insurance company is utilized, **the bill's full amount, the sum certain, or the patient's debt or legal obligation is transferred to the insurance company**. The insurance company has an authoritative role in steering patients to providers by classifying the providers as in-network or out-of-network and using financial duress of charging different amounts of co-payments for the various providers. For the provider to gain access to the privately insured members, the provider must pay a kickback to the insurance company of partial cancellation of debt, which is a cash equivalent. In the healthcare industry, paying kickbacks by the provider is illegal. The Tax Code does not allow any deduction from income for the payment of kickbacks. To hide the unlawful practice of paying kickbacks, the providers record them as "contract adjustments." The Tax Code does not recognize contract adjustments as a legitimate deduction to gross income. The cancelled debt given by the provider becomes the forgiven debt income of the insurance company. To hide the forgiven debt income, the insurance company lists the amount as a contract adjustment and does not recognize the revenue.

The Providers and Insurance companies cannot use the excuse that they were simply following the guidance of the Internal Revenue Service as a means to avoid paying taxes. This is because of the principle of estoppel, which prevents them from claiming ignorance of tax laws. On the other hand, the IRS cannot refuse to collect taxes by claiming estoppel. This is because the principle of equitable estoppel cannot be used to deprive the public of statutory protections, even if public officials have made mistakes. Furthermore, even if a government official or agency made a promise to waive a public right, this cannot be used as a defense against the government in a court of law. This was established in the Supreme Court case of United States v. Stewart in 1940.

In 1965 the Medicare/Medicaid programs were created; the government made a pot of gold in the federal budget to pay for the allocated costs of medical services given to the beneficiaries. For Medicare, the reimbursements relied on the allocation of provider costs based on the proportionate amount of beneficiary bills compared to the total patient billings. This method created for the **first time a difference between the billed amount and the actual amount paid to or collect by the provider**, this deviation was only done for government programs. There was no provision for profits! No one in business works only for costs, everyone wants a little profit! The industry felt the federal government is a blind victim, with deep pockets. The industry quickly began allocating or creating new medical costs or facilities associated with the benefices' medical services, causing prices and costs to spiral upward. The Medicaid program started a federal money pool, divided into twelve regions, with each area getting a weighted amount determined by average charges. A region's share of the money motivated a competition for growing charges or matching the other areas increases. Through this writer's efforts, this competition has been stopped.

The government programs **designed a breach of accepted accrual accounting principles** for the first time in our history. The amount listed on the beneficiary's bill was not the actual debt owed to the provider; this is unlike the amounts listed on the private-pay patients' bills. The government programs created two accrual accounting systems. The government's invoice was and still is a fake invoice that only contains medical and billing information but does not create a debt or legal liability owed to the provider.

In 1973 Congress passed the HMO law, **allowing insurance companies to create provider networks**, to select and direct their insured members to the lower charging providers in a geographic area. The idea was that the providers would compete by lowering their charges to get access to the insurance companies' members. The law was and is a restraint of trade. HMOs did not take off until the late 1980s, but for a different reason; the insurance companies began choosing higher charging providers rather than lower charging providers but demanding that the provider accept a smaller payment

amount than the standard charges listed. The difference not paid was nick-named a "secret discount"; the insurance companies and providers called these "secret discounts" trade secrets, removing medical billing transparency.

The HBO law includes a provision related to billing for medical services received from out-of-network providers. This provision permits a second co-payment charge, which was intended to be a low-fixed fee to cover administrative costs for processing the claim. For instance, if an out-of-network provider charged $250 for a medical service, the insurance company would charge an additional $25 fixed fee; if the provider charged $250,000 the same co-payment charge of $25 would be added on. However, instead of a low-fixed fee, some insurance companies have implemented a variable charge, typically a percentage of the out-of-network charge, such as 10%. This means that for a $250 charge, the additional co-payment would be $25, but for a $250,000 charge, the additional co-payment would be $25,000. This practice is referred to as financial coercion, as it can be a burden on patients and may discourage them from seeking care from out-of-network providers and to boycott them.

A provider may have a contract from one to a hundred insurance companies, but an insurance company may be contracted to one million providers. **“Conscious parallelism”** is a term used in competition law to describe pricing strategies among competitors in an oligopoly without an actual agreement between the players. Instead, one competitor will take the lead in raising or lowering prices. The others will then follow suit, raising or lowering their prices by the same amount, understanding that greater profits result. The providers appear to establish their prices in a "consciously parallel" fashion; also known as the "interdependence theory" of oligopoly pricing. Once the healthcare industry realized the IRS was not properly enforcing the tax code, they took advantage of it to enrich themselves.

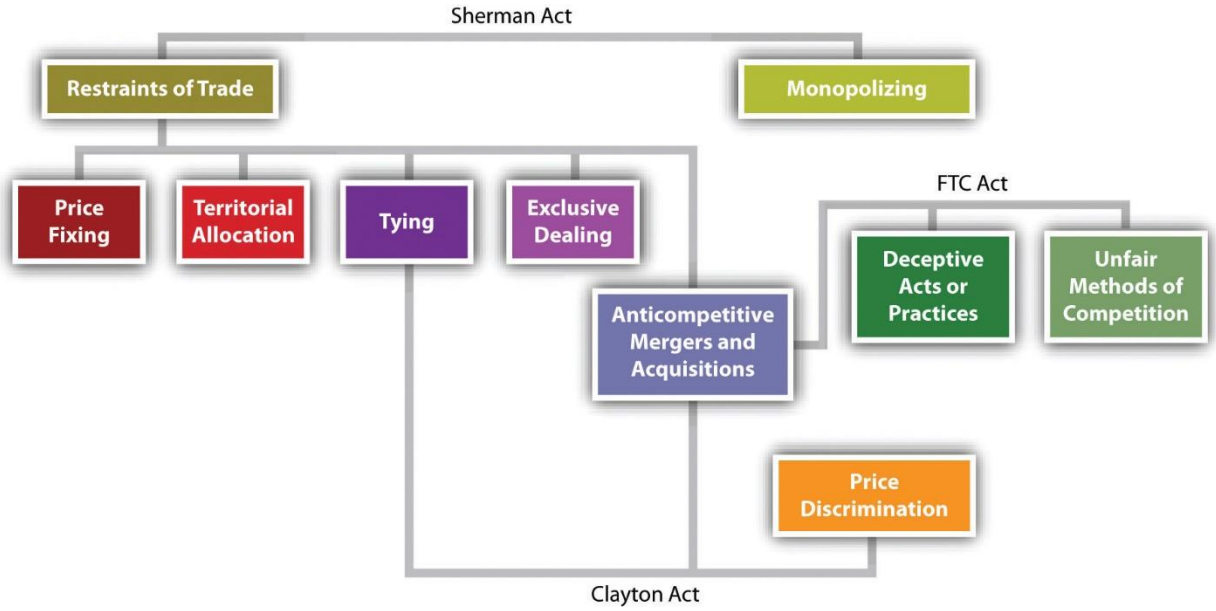
In 1983, to control the spiralling beneficiary costs, Medicare went from the **proportionate reimbursement of medical costs to the Prospective Payment System**. The government grouped related procedures (DRG) based on diagnostics and set a fixed reimbursement amount for each group. The idea was that a provider could make a more significant profit by lowering its costs. It sounds like a great idea, but there was a flaw built in the reimbursement methodology. The Social Security Law, 42 CFR 1395, Prohibition against any Federal Interference, mandated the federal government not interfere in the administrated practices of the providers. The government paid the providers trillions of dollars but could not audit the providers to ensure they followed proper administrative procedures or accounting practices.

The Social Security Law **mandates all the providers be on the accrual method of accounting**. The Health Care Financial Administration (HCFA), now known as the Centres for Medicare/Medicaid Services (CMS), relies on the Internal Revenue Service to do its audits and ensure the billing practices followed GAAP, for the private side of the providers business. The new law required an annual increase in the reimbursement rates; the new amounts would be determined based on a breadbasket full of indexes, with each index having different weights. The heaviest weighted indexes are under the industry's control; they are the medical charges, the physicians' pay, and the Consumer Price Increase (CPI); the CPI included the fees listed on the patients' bills, not the actual amount collected. Since 1983 medical charges index has always been higher than the CPI, bringing the CPI higher. So, by increasing medical charges and physicians' pay, the government pays out more money, and each year the pot of gold in the federal budget gets more significant, and so does our taxes.

From this point in time, health care revenues begin to climb; the major contributing factor is an increase in medical charges.

The designers of the Prospective Payment System relied upon the enforcement of other laws. Under the Consumer Protection Law, also known as the Antitrust Law, the prices are the same for all private-pay patients. The legal definition for the price is the actual amount paid or collected. The Department of Justice (DOJ) is responsible for enforcing these laws, especially price discrimination and price-fixing. It is easy to look at the providers' bills and decide all patients have the same amounts listed, especially since there are no discounts listed on any patient's bill. The DOJ failed to recognize that different actual amounts collected determine price discrimination, not the charges listed. The different ratios of the actual amount collected compared to the cost of the service or medical good create price discrimination. When the provider collects more from the un-insured patient than from the insured patient, the provider is violating the price discrimination laws, which makes them subject to criminal and civil lawsuits.

Antitrust laws are crucial in promoting fair competition and preventing monopolistic practices across all industries, including healthcare. In the healthcare industry, one of the key issues is kickbacks, where healthcare providers offer payment to insurance companies in exchange for patient referrals. Such arrangements are prohibited under antitrust laws to prevent healthcare providers from gaining an unfair competitive advantage and to safeguard patients from undue financial influence. Discriminatory pricing practices, such as higher co-payments for out-of-network providers, can also limit patient choice and increase healthcare costs. Antitrust laws address this by prohibiting insurance companies from engaging in such practices. Healthcare providers and insurance companies must ensure their arrangements are transparent, equitable, and do not impede patient choice or increase healthcare costs.
It's important to note that certain antitrust violations, such as price-fixing, price discrimination, restraint of trade, and boycotts, fall under the purview of the McCarren-Ferguson Act, which transfers law enforcement to the state. Violations of antitrust laws can result in significant penalties, including fines and lawsuits, and may harm the reputation of those involved.



The contract between that the Provider and Insurance company agreed to the kickback scheme is considered a trade secrete and not open to public scrutiny.

The IRS is **responsible for auditing providers and insurance companies**; it is their job to collect taxes on kickbacks. It is their responsibility to know GAAP for an accrual method of accounting

The IRS believes the insured patient's bill and the contract are false; the insurance company's contract determines the taxable revenue. The providers swear the amounts are legitimate debts when they go to court to force payments of the medical bills. The IRS lost sight that under the accrual method of accounting, the private-pay patient's bill determines gross income. They lose sight that the insurance company is not acting as an agent for their insured members but are requesting a partial cancellation of debt from the patient's obligation transferred to the insurance company. The IRS failed to understand that under the Universal Commercial Code for contracts, the parole evidence rules state any prior agreements cannot change the amounts on a new bill or the new contract's terms. Therefore, the patient's medical bill supersedes any prior agreement between the provider and the insurance company.

In the healthcare industry, **the providers instantly add the amounts billed to their gross income**. After receiving the Explanation of Benefits form (EOB) from the insurance company, deduct the difference not collected from the insurance companies as a contract adjustment. The IRS does not know the tax code, which only allows three deductions from gross income, operating expenses, bad debts, or cancelled debts. Contract adjustment is not an allowable deduction, it is not in the tax code. The IRS director is unfamiliar with GAAP for accrual accounting. The **IRS is the only agency that thinks that all insured private-pay patients' bills are all false**. Somehow, they forgot that the amount listed on the patient's bill creates a legal debt and has never experienced going to the state and federal claims courts where the providers swear the amounts listed on the patients' bills are accurate. These courts treat the invoices as prima facie evidence, listing the sum certain and that seventy percent of the cases are against privately insured patients. A patient's contract states they are liable for the full amount charged.

When an insured member goes to an out-of-network provider, the insurance company charges the patient a higher variable co-payment, a percentage based on the billed charges rather than a low fixed amount required by the HMO law. This practice is the economic duress. Its requirement is in the contract between the in-network providers and the insurance company; its sole purpose is for the insured members to boycott the out of network providers. This practice is a restraint of trade.

The auditors should be aware of the following:

- In all fifty states, it is illegal to submit a claim to an insurance company that is false, therefore the amount listed on the patient's bill, the standard charge must be a legal charge,
- The providers file medical claims in both federal and state courts and use the billed amount as prima face evidence,
- In both federal and state statutes, price discrimination for services, services being recognized as a commodity, must be the same for all private-pay patients; therefore, the provider must collect the same amount from both insured and uninsured patients,

- The tax problem's subject matter is how the two separate financial transactions, under the accrual method of accounting, should be handled. The creation and recognition of the amount listed on the patient's bill as income tax purposes and the deduction or write off of the kickback or canceled debt not paid by a third-party payer, and as insurance company income. Under the accrual accounting method, the amount listed on a customer's bill is the amount recognized for income tax purposes.
- All private-pay patients' contracts call for the full payment billed for medical goods and services.
- Under contract law, only the principles to the contract can make an effective change to the contract and billed amount, but there are no changes made to the billed amount. The insurance company is not a party to the contract of the patient and provider. The contra account "contract adjustment" can never be used to write off the difference of the amount billed and the actual amount the insurance company pays, the canceled debt the insurance companies' contracts call for,
- The contra account "contract adjustment" is used only for financial reporting. This write-off account is not recognized in the tax code; therefore, it is illegal to use it for tax purposes to write off the difference between the billed amount and the amount the insurance company agrees to pay,
- The insurance company is a third-party payer, whose function is to spread the risks of medical expenses among many, not to solicit kickbacks from providers to allow them to access its insured members,
- The third-party payer's function is to pay off, in full, the medical bills of the insured member.
- The technical advice memorandum, or TAM, is guidance furnished by the Office of Chief Counsel upon the request of an IRS director or an area director, appeals, in response to technical or procedural questions that develop during a proceeding. TAMs are not law and are issued for one taxpayer and cannot be used as legal precedence.
- The Industry Director's Directive made it mandatory all auditors of the Healthcare Industry must review all contracts involved with a "contract adjustment" write-off.

TAX CRIMES HANDBOOK

I suspect that all tax attorneys and Tax CPAs are familiar with the Tax Crimes Handbook put out by the IRS. I only wish that the IRS auditors were just as familiar.

Future trends in USA Manufacturing Industry

2020 has been a year like no other in recent history, and the US manufacturing industry has felt the impact. Along with declines in production, forced shutdowns in the early days of the pandemic caused a significant dip in manufacturing employment levels. In our 2021 outlook, we look at the future of manufacturing and outline four trends for the year ahead.

Looking ahead to 2024, the recovery may take longer to reach pre-pandemic levels, as Deloitte projections based on the Oxford Economic Model (OEM) anticipate a decline in annual manufacturing GDP growth levels for 2020-2021, with a forecast of -6.3% for 2020 and 3.5% for 2021.

Reeling from the effects of a global pandemic-driven shutdown, US industrial production (-16.5% year over year) and US total factory orders (-22.7% year over year) saw a steep decline in April, followed by suppressed improvement. The current US Industrial Production Index stands at 105.7 in December (the most recent month available), a substantial dip from its pre-pandemic level of 110. Production and order levels are still below 2019 levels, but the trajectory of the decline has slowed. Total industrial capacity utilization improved to 74.5% in December, up from 64.1% in April; however, it's still below pre-pandemic levels of 77%.

In 2021, there are four manufacturing industry trends which are: navigating disruption in the manufacturing industry, digital investment, supply chain resilience, adapting to the new workplace plays a vital role in the success of the USA manufacturing industry. How these trends help the USA manufacturing industry explain below:

The year ahead (2021) will vary for manufacturers depending on where they have felt the greatest impact from the pandemic. For some, it will focus on rebuilding lost revenue streams; for others it could require recalibrating supply networks to serve different market demands. But for all manufacturers, it should include a commitment to increasing agility in operations. By continuing to invest in digital initiatives across their production process and supply network, manufacturers can respond to the disruptions caused by the pandemic and build resilience that can enable them to thrive.

Conclusion

Conclusion

I. Introduction

The US healthcare system faces a range of challenges, including price discrimination, kickback arrangements, restrictions on patient choice, and inadequate enforcement of laws and regulations. These issues have led to high healthcare costs and have had a negative impact on the manufacturing industry and the US trade deficit. To address these challenges, it is essential to understand the laws and regulations that govern the healthcare industry and the impact they have on patients, providers, and manufacturers.

II. Price Discrimination and Kickback Arrangements

Federal laws and regulations prohibit price discrimination based on factors such as race, color, national origin, sex, age, or disability. Medical providers who engage in price discrimination may face penalties, including fines, lawsuits, and damage to their reputation. The Anti-Discrimination Provision in several federal laws and regulations, including the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Affordable Care Act, requires medical providers to charge all patients the same price for their services and products, irrespective of the patient's ability to pay.

Antitrust laws play a crucial role in preventing monopolistic practices and promoting fair competition in the healthcare industry. Kickback arrangements, where healthcare providers pay insurance companies for patient referrals, and discriminatory pricing practices, such as higher co-payments for patients seeking care outside their network, can limit patient choice and drive-up healthcare costs. To comply with antitrust laws, healthcare providers and insurance companies must ensure that their arrangements are transparent, equitable, and do not restrict patient choice or increase healthcare costs. Violations of antitrust laws can result in penalties such as fines, lawsuits, and damage to their reputation.

III. The Kickback Process and its Impact

The kickback process is a significant issue in the US healthcare system and has resulted in healthcare costs that are three times higher than other industrialized countries. Healthcare providers pay kickbacks to insurance companies to steer their insured members to the provider. This kickback payment takes the form of a partial cancellation of debt, which is the difference between the patient's debt and the amount that the insurance company pays. The provider records the kickback payment as a contractual adjustment, which is like the methods used for the government business side but does not follow Generally Accepted Accounting Principles (GAAP) or the United States Tax Code.

This kickback process has had a negative impact on the manufacturing industry and the US trade deficit. Healthcare providers have continuously increased their charges to compensate for these payments, leading to healthcare costs that are three times higher than the average of all other industrialized countries. The loss of manufacturing jobs has also contributed to the significant trade deficit that the US currently faces, as manufacturers move to countries like Canada and Mexico where healthcare costs are lower and employers do not have to pay for employee healthcare benefits.

Paying for Social Security and Healthcare benefits from profits collected after the product is sold, would make the manufacturing segment more competitive in the global market. As manufacturing jobs decline, the trade deficit in the US increases.

IV. Challenges Facing the US Healthcare Industry

The US healthcare industry faces several challenges, including the use of conscious parallelism pricing strategies, inadequate enforcement of laws and regulations, prohibition of price discrimination, and restrictions on patient choice.

Conscious parallelism pricing strategies refer to situations where healthcare providers set their prices at the same level as their competitors without explicitly colluding. This practice is difficult to prove and can be challenging to prosecute, leading to inadequate enforcement of laws and regulations.

Prohibition of price discrimination is a critical issue in the US healthcare industry, and providers violate antitrust laws by charging more from uninsured patients than from insured patients. This practice can lead to higher healthcare costs and limit access to care for uninsured patients.

Misunderstandings by the IRS regarding gross income determination and contract law are also a challenge in the healthcare industry. The IRS believes that the partial payment made by the insurance companies determine the gross income, but the tax code says differently.

IV. Challenges Facing the US Healthcare Industry

1. Conscious Parallelism Pricing Strategies and the Inadequate Enforcement of Laws and Regulations

Conscious parallelism pricing strategies in the healthcare industry refer to the common practice where most healthcare providers, hospitals, and insurance companies pay or receive kickbacks, even without any formal agreement or collusion. Some argue that this practice may still constitute collusion, due to the use of secret contracts between the parties. The providers, hospitals, and insurance companies justify their similar pricing of writing off the difference between billed amount and the actual amount paid, by claiming that such practices are allowed on the government side of the healthcare business.

2. Prohibition of Price Discrimination and Charging Uninsured Patients More than Insured Patients

Price discrimination is the practice of charging different prices, (the actual amount collected), for the same product or service, with no reasonable justification for the price difference. It is prohibited under antitrust laws in the healthcare industry. However, some healthcare providers still engage in this practice by charging uninsured patients more than insured patients. This practice limits access to care and drives up healthcare costs, as uninsured patients often delay seeking care until their conditions become severe.

3. Misunderstandings by the IRS Regarding Gross Income Determination and Contract Law

The IRS seems to misunderstand the concept of gross income determination and contract law in the healthcare industry. Under the accrual method of accounting, the private-pay patient's bill determines gross income. The amount listed on the patient's bill creates a legal debt, and healthcare providers instantly add the amounts billed to their gross income. However, the IRS believes that the insured patient's bill and the contract are false and that the insurance company's contract determines the taxable revenue. This misunderstanding can lead to inappropriate tax collection on kickbacks.

4. Restrictions on Patient Choice and their Impact on Healthcare Costs

Insurance companies often restrict patient choice by limiting the network of providers that insured patients can use. This can lead to higher healthcare costs for patients, as they are often required to use providers within the network to receive coverage. Patients seeking care outside the network are often required to pay higher out-of-pocket expenses, which can be prohibitively expensive.

V. Solutions to Address the Challenges

1. The Need for Government and Regulatory Bodies to Enforce Laws and Regulations

To address the challenges facing the US healthcare industry, government and regulatory bodies need to enforce laws and regulations strictly. The enforcement of antitrust laws will ensure that there is fair competition in the industry and limit monopolistic practices that drive up healthcare costs. The enforcement of tax laws and regulations will also ensure that tax evasion schemes are identified and prosecuted, and the appropriate taxes are collected.

2. The Removal of FICA Taxes that Fund Healthcare Benefits and Paying for Them Through Income Taxes Instead

The current system of funding healthcare benefits through FICA taxes can make American manufacturing less competitive in the global market, as the cost of these benefits is often passed on to consumers through higher prices. To make American manufacturing more competitive, the FICA taxes that fund healthcare benefits should be removed, and healthcare benefits should be funded through income taxes instead.

3. The Potential Benefits of Making American Manufacturing More Competitive and Reducing the Trade Deficit

Making American manufacturing more competitive by reducing healthcare costs will create more jobs and reduce the trade deficit. By paying for healthcare benefits through income taxes, the cost is spread across all taxpayers, making it a more equitable and efficient way to fund healthcare.

VI. Conclusion

The US healthcare system faces several challenges, including price discrimination, kickback arrangements, and inadequate enforcement of laws and regulations. These

Furthermore, restrictions on patient choice, such as the use of higher variable co-payments for out-of-network providers, also limit access to care and drive-up healthcare costs. This practice is considered a restraint of trade that creates economic duress for insured members to boycott out-of-network providers. The enforcement of antitrust laws is crucial in promoting fair competition and protecting patients' access to quality healthcare services.

However, there are challenges that the US healthcare industry faces. One such challenge is the inadequate enforcement of laws and regulations regarding conscious parallelism pricing strategies. These strategies allow healthcare providers to coordinate their pricing without explicitly agreeing to do so, leading to artificially inflated healthcare costs. Another challenge is the prohibition of price discrimination, as providers violate antitrust laws by charging uninsured patients more than insured patients. Additionally, misunderstandings by the IRS regarding gross income determination of an accrual methodology taxpayer and the Universal Commercial Code for contract law, have led to inappropriate tax collection on kickbacks. Restrictions on patient choice and access to care also contribute to the challenges facing the industry.

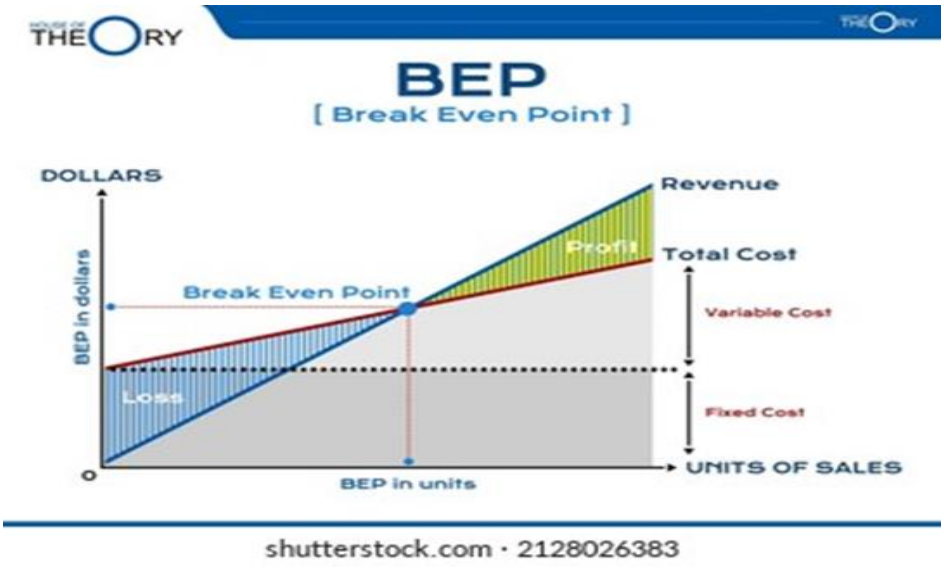
To address these challenges, there is a need for government and regulatory bodies to enforce laws and regulations that promote fair competition in the industry and increase patient choice and access to care. One potential solution is to remove FICA taxes that fund healthcare benefits and pay for them through income taxes instead, making American manufacturing more competitive and reducing the trade deficit. Another solution is to ensure that the IRS understands gross income determination and contract law principles in the healthcare industry to prevent inappropriate tax collection on kickbacks.

In conclusion, the US healthcare industry faces significant challenges, including price discrimination, kickback arrangements that promote restraint of trade, and tax evasion. The enforcement of antitrust laws, tax laws and other regulations is crucial in promoting fair competition and protecting patients' access to quality healthcare services. By removing FICA taxes and paying for healthcare benefits through income taxes and creating a Single-Payment Medicare-for-All System, the US can make American manufacturing more competitive and reduce the trade deficit, leading to a more self-sufficient economy.

Take Action

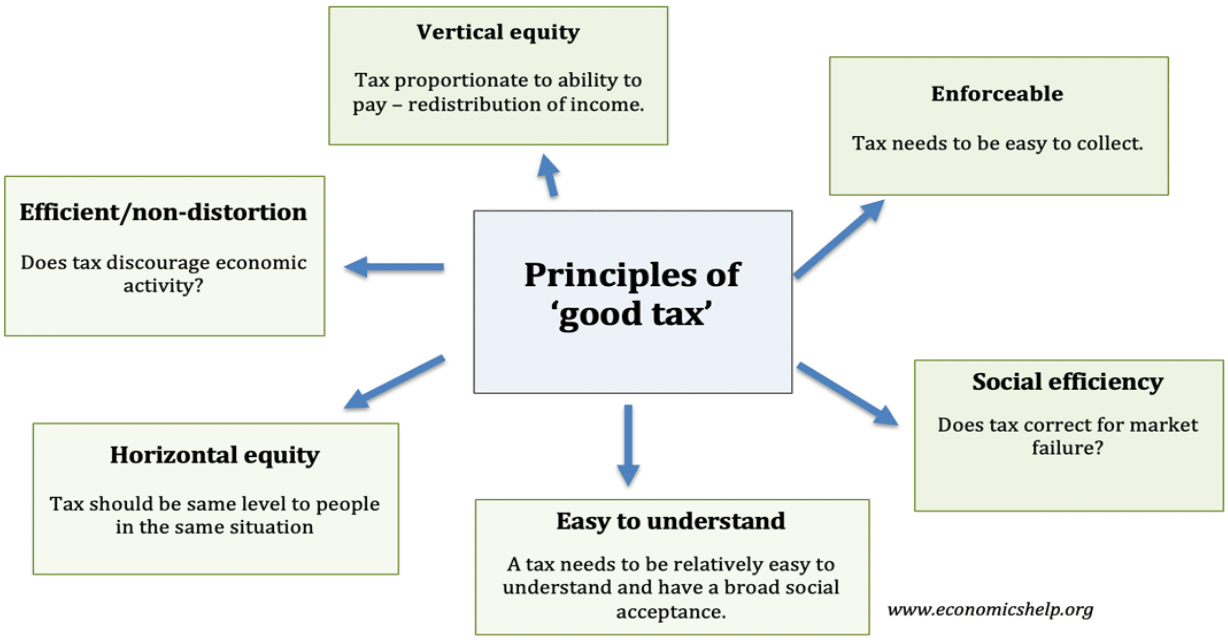
The president financial environment in the United States does not support the Manufacturing Industry; it must be changed.

In order to create prices for services and goods that are free of FICA taxes and healthcare benefit costs, such expenses must be removed from the formula used for price calculation, including those borne by all employers.



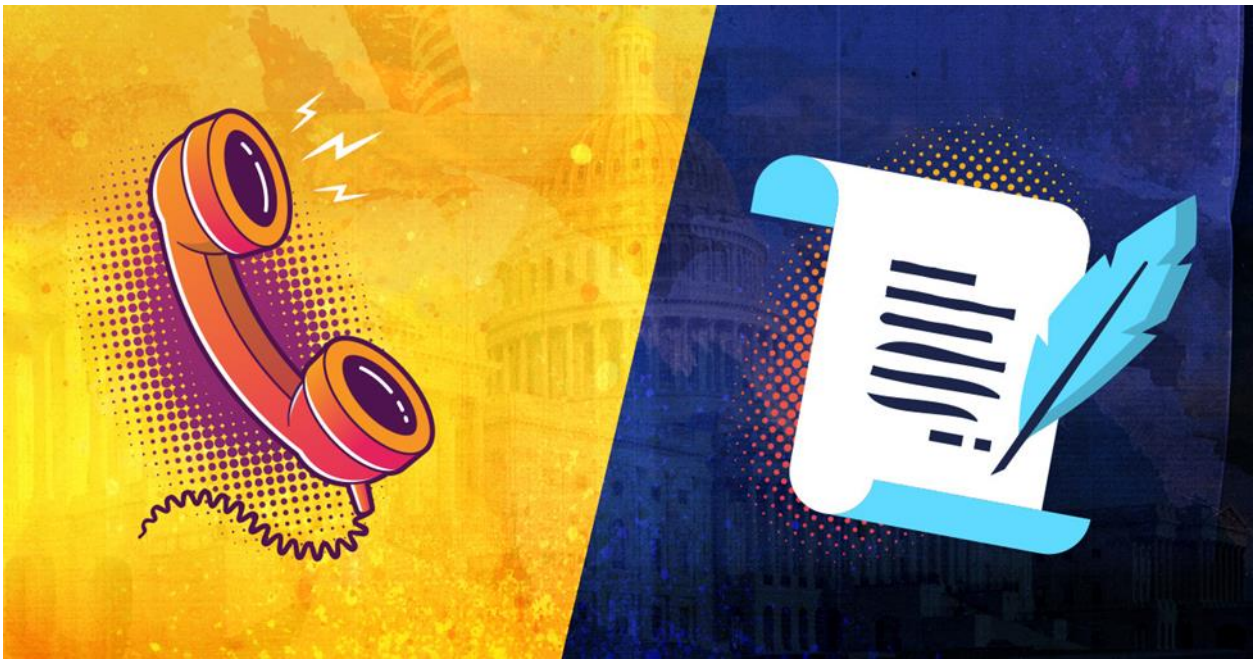
the United States to compete with other industrialized countries, it must adopt a single-payer healthcare system funded by income taxes.

The United States needs to establish a sound tax system that covers the entitlements we are owed and secures a strong financial future. This is because there is a proven correlation between financial stability and democracy. When economies are robust and financial systems stable, democratic institutions can function effectively by having the resources they need. In turn, democratic systems can foster economic growth by creating greater political stability, promoting transparency, and incentivizing investment and entrepreneurship.

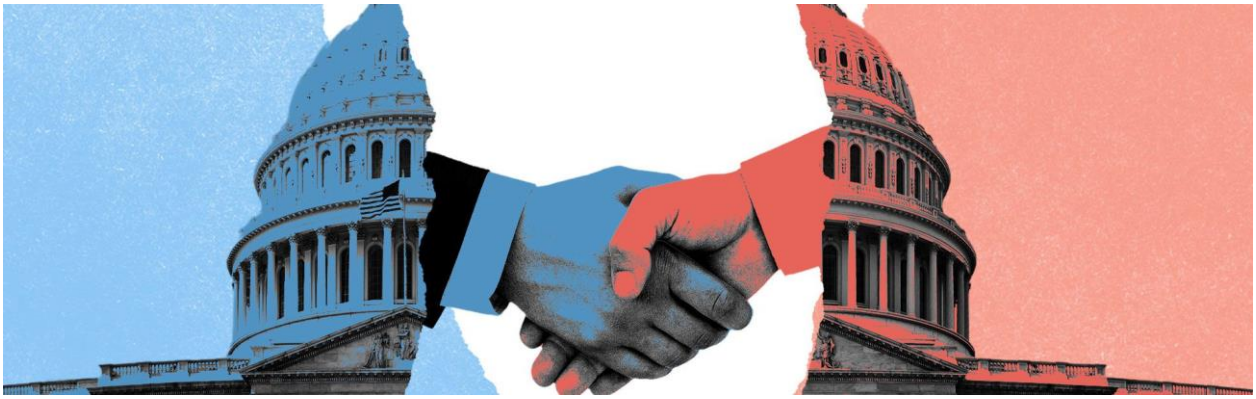


Congress, who took an oath to protect the country, creates the laws that the people have control over.

To effect change, it is necessary to inform Congress of our wishes, and thus we should both call and write to our respective Congressional representatives.



For changes to be made, it is essential that all Americans prioritize the welfare of our nation above their fears and actively support the implementation of recommended changes.



Implementing these changes will create a better financial environment for business to grow.

If you're interested in learning more about the topic discussed in this write-up, or simply want to explore further on related subjects, I invite you to visit our website https://savingtheworld.us/. There, you'll find a wealth of information and resources that can help you deepen your understanding and stay up-to-date with the latest trends and developments. From informative articles and engaging information to interactive tools and community forums, our website offers something for everyone. So why not take a moment to check it out and see for yourself what we have to offer? We look forward to seeing you there!

List of blogs on website :-

- Fixing USA Economy and Healthcare
- Economist Report – The Healthcare System and Manufacturing in America: An Economic Analysis
- Tax Attorney's Analyst of Tax Evasion Scheme
- CPA's Analyst of Tax Evasion Scheme
- Four Hospitals' Annual Cost Reports; Patient Billings and Deductions
- International Profiles of Healthcare Systems – A study by the Commonwealth Fund