Report on Trade Restraints, Transparency, Price Discrimination, Price Fixing, Boycotts and Tax Violations in the Healthcare Industry

(*it is noted that not all healthcare insurance companies and providers do not participate in the activities described in this report, but research shows the majority do. It must be noted that any provider and insurance company that entered into illegal agreements conspired to break our laws for their own benefit and must be punished.)

Signs that an Industry is acting like an Oligopoly are high costs and poor quality of service or goods.

The United States Healthcare System is the highest cost system, it is three times higher than the average of all the 35 industrial countries; the Whole Health Organization and the Organization of Industrial and Developing Countries rates its quality of service as the lowest; the United States has the lowest average life expectancies of the industrial countries.

In the United States there are two business sides in the healthcare industry: the private sector and the government sector. The private sector follows the same accounting principles and consumer protection and anti-trust laws, like every other business in the country. The providers and insurance companies are on the accrual method of accounting. The amount listed on the patient's bill is the price; it is the actual amount the provider is expected to receive. The government sector does not follow the same accounting principles or consumer protection laws as the private sector; the amount listed on the beneficiary's bills is not the legal obligation owed, but the government says how much it will pay.

The main parties of the Healthcare System are:

1. **The patient.** The patient is the customer of the healthcare provider; the customer is the party that receives the medical goods and services; the patient selects which provider to use; the patient has the responsibility for the payment of the bill; the patient either pays cash or transfers the debt to a third-party payor, an insurance company.
2. **The Healthcare Provider.** The provider performs the medical services; the provider sets the prices of the medical goods and services given to the patient; the provider charges the same price for each medical service or medical good; the provider issues the medical bill to its customer, the patient.
3. **The Insurance Company.** The insurance company spreads the risk of damages or high healthcare costs to many individuals; the insurance company passes the medical charges through its premiums; the insured members pay a lot less for the medical costs; the insured members that do not have any medical services still pay towards the total cost of the medical bills given to the group; for the payments of the premiums the insurance company assumes the patients' medical debts and pays the provider.

There are two main contracts that the provider enters, one is legal, and one is illegal.

1. **The contract with the patient.** The contract is straight forward; the provider provides the medical goods and services; the patient must pay for the services provided.
2. **The contract with the third-party payor, the insurance company.** The provider and the insurance company agree to substitute the obligation of the patient's debt to the insurance company; the provider agrees to pay the insurance company a brokering fee, a kickback, for steering the patient to the provider; the provider and the insurance company agree to financially

coerce the insured member to select an in-network provider; the provider and insurance company agree to hide the kickback by calling it something innocuous as a contractual adjustment; they also call it a negotiated price.

I. Restraint of Trade in the Healthcare Industry

1. Insurance companies exert a large influence over the healthcare facilities their insured members can use for medical services.
2. Price negotiations are exclusive to the healthcare provider and the patient; not the insurance company, which is a third party-payer.
3. For example, a credit card company is like a third-party payor, and it does not negotiate the prices of the goods or services provided and it does not buy anything. It only covers the customers' debts.
4. The providers are required to charge all private-pay patients the same price, no matter the method that they pay for the services.
5. The role of the insurance company is to spread the risk of high costs of medical services to as many people as possible; each participant paying a small share of the total medical costs of the group.
6. The insurance company, like any third-party payor, does not purchase any medical goods or services; there is no bill issued in the insurance company's name; therefore, the insurance company has no liability for the medical goods or services provided and is not sued for medical malpractice.
7. Third party payers do not determine prices of goods and services provided; third party payers only pay the legal obligation the customer owes the seller, the provider.
8. The insurance company engages in an illicit practice where it receives payment from a healthcare provider; in exchange, the insurance company directs its insured members to use this specific provider's services; the form of this payment, or 'kickback', isn't in cash, but instead, it's in the form of cancelled debt.
9. Insurance companies earn kickbacks from healthcare providers through cancelled debts, it is known as Forgiven Debt Income, which make up around 85% of the patient's billed debt.
10. The 85% cancelled debt is an operating expense of the provider; it is the provider's biggest expense; the provider deducts it from its gross income.
11. Insurance companies manipulate their insured members by imposing lower co-payments for in-network providers and higher co-payments for out-of-network providers, even though the providers charge the same price for the services.
12. The higher co-payment is economic coercion to make the insured member boycott the competition.
13. The insurance companies use the higher charges to increase their premium charges.

14. The higher charges issued by the providers force individuals to purchase insurance policies; the high prices keep out competitive insurance companies and stop employers from self-insuring; this is a restraint of trade.

15. The HMO law calls for a second co-payment for out-of-network providers; the second co-payment is supposed to be a low fixed amount to cover the additional administrative procedures covering for the payment to the provider; the insurance company breaks the law by charging a variable co-payment charge, a percentage of the billed amount instead of a low fixed amount. This is economic coercion and is illegal.

II. Lack of Transparency in the Healthcare Industry

1. The contracts between providers and insurance companies are hidden from public view; the insurance companies call their agreements trade secrets.

2. The insurance companies and providers do not want the public to know about the illegal kickbacks.

3. The insurance companies say they do not want other insurance companies to see the sweetheart deals the insurance companies get.

4. The insurance companies negotiate different rates for different services based on the make up of their insured members; there is no straight percentage applied; they shift the amounts paid; this is known as cost shifting and is illegal; it places the burden of covering the providers costs on another group.

5. The McCarran-Ferguson Act permits insurance companies to share pricing and cost information, which essentially amounts to a price fixing scheme.

III. Price Discrimination in the Healthcare Industry

1. All private-pay patients are charged the same prices; under the accrual method of accounting the amount listed on the customer's bill is the price, but the charges listed is not the main determinant for price discrimination; the determinant factors for price discrimination are the actual amount collected or paid and the cost of providing the service or good.

2. Price discrimination occurs when there is a discrepancy of the ratio between the actual amount paid or collected and the actual cost to provide the service.

3. Private-pay patients, insured or uninsured, are the customers, they are charged the same price; that means the provider must collect the same amount from each patient, for the same service; if the full amount that is charged is not collected then price discrimination takes place.

4. When discounts are issued to the customer, discounts must appear on the bill at the time of issuance; a new medical bill is not issued in the insurance companies' name; if a bill was issued in the insurance companies name the insurance company would be liable for the amount listed on the bill; the insurance company would then be liable for the quality of service provided.

5. The provider issues a second bill that is not for medical services; the second bill that it tries to collect covers the co-payments, deductibles, and secondary insurance, the insured member

owes the insurance company; these amounts are listed on the Explanation of Benefits (EOB) form sent by the insurance company notifying the insured member how much they owe.

6. Providers collect significantly more from uninsured patients, on average almost six times more, than insured patients due to debt cancellation; this is price discrimination; this is cost shifting; it is illegal.

IV. Tax Violations in the Healthcare Industry

1. The IRS applies similar rules to the private business side as it does to government business side.
2. The IRS does not treat the amount listed on the patients' bills as recognized income; this is a violation of our tax code; it is a violation of Generally Accepted Accounting Principles (GAAP).
3. In 2014, the Financial Accounting Standards Board (FASB) and the International Financial Accounting Standards Board (IFASB) stated in their Standard Accounting Coding Principles, SAC-606, the revenue on the customers bill is the recognized income revenue. There is no standard accounting coding for contractual adjustments for financial reporting.
4. The IRS believes the contract between the insurance company and provider that calls for a partial cancellation of debt determines the recognized income; the secret contract is illegal and would not be enforceable; the problem is the IRS has no training in contract law; The IRS cannot see the provider and insurance companies' contracts because of state laws that say they are trade secrets.
5. The IRS believes that since the provider never intended to collect the amount billed it allows the recognition of the amount paid by the insurance company as the recognized income and the kickbacks, the cancelled debts, to be written off; under the tax code that covers allowable canceled debts, contractual allowances in the healthcare industry are not listed, therefore the IRS, the providers, and the insurance companies should have known they are not an allowable deduction from gross income.
6. All other industries in the United States, that are on the Accrual Methodology of Accounting, treat the customers billed amount as recognized income.
7. These billed charges are used by other industries for income tax purposes.
8. The contract adjustment is defined as the difference between the amount billed and the amount collected.
9. The contract adjustment account was meant to be used only for government differences; although the difference not paid by the government is a cancellation of debt that should have been reported for tax purposes as forgiven debt income, the government does not pay itself taxes, therefore there is no need to report the forgiven debt revenue.
10. The contract adjustment account has been misused in the private sector.
11. The IRS allows providers to write off the cancelled debt of the insurance company as a contractual adjustment.

12. Under Generally Accepted Accounting Practices (GAAP), the contractual adjustment account does not exist. GAAP does not allow an entity to go back and change a customer's bill, it is an illegal practice. Under GAAP something not paid would be written off as a bad debt, if the party was not capable of paying the obligation.

13. The IRS does not understand the legal principles of the Universal Commercial Code (UCC) dealing with contractual agreements; the parole evidence rule says an old written agreement cannot supersede and new contractual agreement or a new price; therefore the contract between the provider and the insurance company that determined the negotiated price is replaced by the contract between the patient and the provider; the amount on the patients bill cannot be changed by a previous agreement.

14. The patient's billed amount is the one that the court's uphold when there is a case for non-payment of a medical claim.

15. Under the U.S. tax code, the contractual adjustment account does not exist; the tax code does not recognize it as a legitimate deduction.

16. The providers do not issue information tax returns, 1099C Cancellation for debt, which is a tax law violation.

17. The insurance companies do not report the forgiven debt income and pay taxes on these amounts.

18. The steering of the patients by the insurance company is a very valuable service; this service must be recognized as income to the provider; the service is barter income to the provider.

19. Tax laws require that every dollar paid, or cash equivalents must be recognized for tax purposes.

20. The not-for-profit hospitals must report these income tax items as other non-business income; therefore, they must report the kickbacks paid, which are non-deductible expenses as income and the barter income, as taxable income.

V. Impact on Government Medicare Program

1. The cost of services provided to Medicare recipients and reimbursement amounts is reviewed annually and annually adjusted.

2. The Centers for Medicare/Medicaid Services use several indexes to determine the payment for each service; the heaviest weighted item of these indexes is the private-pay billed amount for medical services and goods.

3. A good example is the Consumer Price Index, the medical bills are sampled, the charges reflect the price of the services, these prices are false because they do not show the actual amount paid; the index did not reflect the amount of the cancelled debts, the kickbacks.

4. If the standard charges are inflated, then the amount Medicare pays is also inflated.

5. The standard charges used are false, resulting in fraudulent billing practices.

6. Under the False Claims Act every incorrect Medicare bill filed by a provider should result in a $10,000 fine.
7. The providers and insurance companies conspired to get more revenue from the government.

VI. Accountability of Law Enforcement Agencies

1. The McCarran-Ferguson Act of 1945 shifted the responsibility of enforcing anti-trust laws for insurance companies, from the federal government to the states, but these anti-trust and consumer protection laws are not enforced.
2. Anti-kickback laws have serious penalties, but these are not enforced; the laws are not enforced because the states do not audit the providers; the only agency that is supposed to perform audits is the internal Revenue Service.
3. The IRS does not enforce the taxes on kickbacks paid by the providers to the insurance companies.
4. In many cases the IRS believes the not-for-profit healthcare providers are state agencies, so they do not audit them; in many cases the not-for-profit corporations do not file income tax returns.

VII. Actions to be taken.

1. The findings and solutions listed on the website SavingTheWorld.us, need to be shared widely, to be effective they must be examined closely and then implemented.
2. The IRS should audit Not-For-Profit hospitals and other entities in the healthcare sector; the IRS must audit all entities in the healthcare system.
3. Congress should audit the Internal Revenue Service.
4. Congress should have access to the secret contracts between providers and insurance companies.
5. The IRS should perform audits to ascertain the unreported forgiven debt income and report their findings to Congress.
6. Repealing the McCarran-Ferguson Act and the HMO law is crucial; there should be no insurance company networks.

VIII. Materials Provided

1. A website, SavingTheWorld.us, has been created providing extensive information and expert opinions on the issues at hand.
2. Copies of write-ups have been provided.
3. Copies of contracts between providers and insurance companies have not been provided as they should be accessed by Congress.
4. Cost worksheets from the Florida Financial Healthcare Administration have been provided, which reflect data from 7,000 hospitals reporting to CMS annually.

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