

Transparency in health care

There's a prevailing misapprehension within the health care sector that insurance companies have the authority to negotiate lower service charges with health care providers on behalf of their insured members. It's essential to set the record straight: it is the end consumers of goods and services who possess the sole authority to negotiate price reductions.

The primary role of insurance companies within this context is not to meddle with pricing but to negotiate the reduction of debts they are obligated to fulfill. These debts originate from the total amounts billed to their insured members, who are legally bound to settle these charges.

In the intricate dynamics of the health care industry, insurance companies strategically select their in-network providers. The criterion for this selection primarily hinges on the health care providers' willingness to absolve a portion of these debts. The insurance companies then exercise their influence over their members' choice of providers. They manipulate the co-payment structures, reducing them for in-network services and elevating them for out-of-network services. This practice, which amounts to a form of economic coercion, effectively sways patients towards certain providers and away from others.

A common practice within the industry is to record this debt write-off, not as a cancelled debt as it should be, but as a contractual adjustment. This is not merely a semantic issue. The distinction is crucial because it has serious tax implications. A cancelled debt is a taxable entity, both for the insurance company and the health care provider.

Moreover, it's vital to add that this cancelled debt is essentially a kickback. A kickback is a return of money previously paid out, usually unbeknownst to the payer, creating a potential conflict of interest or undercutting fair competition. In this case, the health care providers give the insurance company a kickback in the form of the cancelled debt. And just like the insurance company, the provider is also legally obliged to pay taxes on this kickback.

From the perspectives of a tax lawyer, a prosecutor, an economist, and a Certified Public Accountant (CPA), this practice is concerning. Not only does it involve potential violations of fair trade and consumer rights, but it also has potential legal and tax implications. The misclassification of cancelled debts as contractual adjustments allows these entities to evade the tax liabilities they should rightly incur.

Given these issues, there is a pressing need for increased transparency within the health care industry. Consumers must be given the right to negotiate their prices, and strict adherence to tax laws should be enforced. By doing so, we can work towards an equitable health care system that respects both consumer rights and legal obligations.

Roy J. Meidinger, Fort Myers

Opinion:

"In Search of Fairness: Demystifying Medical Billing and the Call for Reform"

The world of medical billing, as we've discussed, is a maze of confusion and complexity. What often begins as a simple need for care can rapidly transform into a deluge of puzzling financial documents, leaving patients more worried about their wallet than their well-being. However, the bewilderment doesn't end with baffling bills and opaque insurance company explanations. The deeper one dives into this labyrinth, the murkier it becomes.

Now, let's turn our attention to antitrust laws and their role in this labyrinth. Under antitrust laws, competitors are barred from entering into agreements to fix prices, limit competition, or engage in deceitful practices. Yet, in healthcare, a glaring exception is glaringly visible: insurance companies and healthcare providers negotiate rates, effectively determining what patients will pay for services.

Similarly, the world of medical billing is fraught with potential for kickbacks - illegal payments made in return for favorable treatment. These can skew the free market, inflate healthcare costs, and put an undue burden on patients. With kickbacks often veiled in complex contractual agreements and payment structures, this is another area where healthcare's financial practices fall into a murky legal gray zone.

The argument that all private-pay patients should pay the same price for the same services further highlights these discrepancies. If transparency and fairness are our guiding principles, why is it that a patient without insurance may be charged much more for a service than an insurance company would pay for the exact same procedure? This inequality within the system indicates a breach of fundamental principles of justice and equity.

In fact, evidence indicates that agencies designed to uphold these principles, such as the IRS and state law enforcement, have failed to perform their due diligence. These agencies have the authority and the mandate to investigate and enforce the laws concerning customer income recognition, as stated in the SAC-606 standard and reinforced by the Generally Accepted Accounting Principles (GAAP). Yet, there appears to be a blind eye turned to these practices, perpetuating a system of opaque and questionable billing.

The need for clarity and fairness in medical billing has never been more apparent. Patients should not have to decipher a cryptic bill or bear the financial burden of a system that seems stacked against them. They should not have to navigate a complex web of laws and regulations that seem to serve the interests of healthcare providers and insurance companies more than the patients themselves. It's high time we unravel this tangled web and demand transparency, equity, and legality in our healthcare system.

We must advocate for thorough enforcement of existing laws by the IRS and state law enforcement agencies, push for stringent penalties for kickbacks and antitrust violations, and champion the rights of patients to fair and consistent pricing. Let us shine a light on the true cost of healthcare, and let that light guide us to a more just and equitable system for all.