

How the Government Created the Healthcare Industry Oligopoly Part II

Healthcare costs are controlled by the Insurance Companies

The Truth About The Healthcare Industry

"Let the people know the truth
and the country is safe."

Abraham Lincoln

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HEALTH
INSURANCE

District of Columbia, Feb 26, 2020 ([IssueWire.com](http://www.IssueWire.com)) - How the IRS Created the Healthcare Industry Oligopoly

The ongoing presidential debates on health care have highlighted the fact that the United States has the costliest system, estimated three times more expensive than the average of the other thirty-four industrial members of the Organization of Economic and Developing Countries (OECD). The other factor not spoken is that the U.S. has a ranking as the lowest in the quality of health care, with the highest infant birth mortality, Six hundred and fifty accidental medical deaths a year, and ninety million people without medical coverage. Although we spend more, we have the lowest life expectancy. In other words, high prices and poor quality of service, the two vital signs of the existence of an Oligopoly. An Oligopoly is like a trust, but instead of one company, it is the whole industry, usually controlled by several big companies. The big insurance companies control the Healthcare Industry Oligopoly.

The creation of this Oligopoly falls at the feet of the federal government. In its production of the Medicare/Medicaid Programs, it created a uniform billing system; then, by its effort to control medical costs by creating Health Maintenance Organizations (HMOs), that helped eliminate competition. The leading causes of the Oligopoly is the failure of the law enforcement agencies, the Department of Justice (DOJ) Antitrust group, failing to enforce the consumer protection laws; but Still greater, the failure of the Internal Revenue Service (IRS) due to its lack of knowledge of contract law and not enforcing Generally Accepted Accounting Principles (GAAP) for accrual taxpayers and the collection of taxes mandated by the tax code. Under the accrual method of accounting, revenues and deductions are recognized by financial instruments like bills and checks, not by cash flow.

In 1965 our Medicare/Medicaid programs were created; they created a pot of gold in the federal budget to pay for the allocated costs of medical services given to the beneficiaries. For the Medicare program, the reimbursements relied on the allocation of provider costs based on the proportionate amount of beneficiary bills compared to the total patient billings; therefore, there was a requirement for accurate billings for the same services of government beneficiaries and the private-pay patients. There was no provision for profits! The industry quickly began allocating or creating new medical costs or facilities associated with the beneficiaries' medical services, causing prices and costs to spiral upward.

The Medicaid program created a pool of federal money, divided into twelve regions, with each region getting a weighted amount, with each region annually proportion determined by the increase in charges for medical services. To increase a region's share of the pool of money, it motivated a competition for increasing charges or matching the increases in other regions. Through this writer's efforts, this competition was eliminated.

The government programs designed a breach of accepted accounting principles for the first time in our history from the accepted accrual accounting methodology, in that 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 new 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 with each other 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 the "secret discounts" trade secrets, removing medical billing transparency. The "secret discounts" went from zero percent in 1983 to eighty-five percent today.

In 1983, to control the spiraling beneficiary costs, Medicare went from the proportionate reimbursement of the expenses to the Prospective Payment System, the government grouped related procedures based on diagnostics and set a fixed reimbursement amount for each group (DRGs). The idea was that a provider could make a more significant profit by lowering its costs. The idea was that they would get higher returns by reducing their costs. It sounds like a great idea, but there was a flaw built in the reimbursement methodology. The new law required an annual increase in the reimbursement rates; the new amounts would be determined based on a bread basket full of indexes, with each index having different weights. The heaviest weighted indexes are under the control of the industry; they are the medical charges, the physicians' pay, and the Consumer Price Increase (CPI); the CPI included the fees listed on the patients' bills. 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 largest financial group of medical patients is the privately insured patients, at seventy percent. The insurance companies pass through the increasing charges by increasing their premiums to their customers, the nation's employers. But they were not willing to pay the higher fees for the medical providers to get more money from the government. Fraudulent accounting fixes the problem of increasing charges and maintaining the same costs. In 1983 the healthcare industry introduced the "secret discount," which is not a discount but a kickback paid to the insurance company in the form of a cancellation of debt. A legal discount is placed on the bill at the time of issuance and deducted from the gross amount given you a new net amount.

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 Department of Justice (DOJ) is responsible for the enforcement of 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 is that different amounts collected are what determines price discrimination, not the charges listed on the patient's bill. 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.

When it comes to billing the beneficiaries of the government programs, the bill does not create the legal obligation. Congress determines reimbursement amounts. The providers charge the government patients the same price as the private-pay patients but do not collect the full amount. The difference between the amount billed and the amount collected is a partial cancellation of debt. Canceled debt given to the government goes unreported to the Internal Revenue Service due to the fact the government does not pay itself taxes. In 1965, for financial reporting, to distinguish between the

canceled debt given to the private insurance companies and given to the government, the Financial Accounting Standards Board (FASB) created the contract adjustment account for government canceled debt deductions. In 1983 the industry began using the account for both government and private business canceled debts.

In the healthcare industry, a kickback paid to someone for referring a patient is illegal; it has criminal and financial penalties for the giver and receiver. The tax code states that no deduction from gross income is allowed for kickbacks. The tax code does not recognize contract adjustments as a legitimate deduction. The tax code only has two legal reductions from gross income, bad debts and canceled debts.

The Internal Revenue Service (IRS) is responsible for auditing the accounts of 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 following is what the IRS is doing; it is taken from a letter sent to me in 1999 through my Senator, by the Director of Exempt Organizations and Large businesses:

"Mr. Meidinger raised a question regarding the proper tax treatment by hospitals and insurance companies of the difference between the amount billed to patients and the amount paid by insurance companies pursuant to contractual arrangements with the hospitals to satisfy those bills. Mr. Meidinger expressed concern that the current practice caused costs to shift to patients and government programs, such as Medicare and Medicaid.

Health care providers, such as hospitals, establish fees and charge patients accordingly. However, patients frequently are not responsible for payment of these charges due to arrangements with third-party payers, such as insurance companies and Medicaid. The providers enter into contractual arrangements with the payers regarding the amounts necessary to satisfy obligations on behalf of the patients. The difference between the amount originally charged, and the amount paid to satisfy the obligation is known as a contractual allowance. Whether or not the arrangement present federal tax questions depends on the facts of the particular case. We can assure you that we share your constituent's concerns with possible improper reporting.

Thank you for bringing your concerns to our attention."

Needless to say, nothing was done. The IRS believes the price of the services is determined by the insurance company's contract, not the patient's contract or the patient's bill. The IRS lost sight of the fact that under the accrual method of accounting, the private-pay patient's bill determines gross income. They lose sight of the fact 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 debt transferred to the insurance company.

In the healthcare industry, the providers instantly add the amounts billed to their gross income then later, after receiving the Explanation of Benefits form 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 two deductions from gross income, bad debts or canceled debts, contract adjustment is not an allowable deduction. 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 had the experience of going to the state and federal claims courts where the providers swear the amounts listed on the patients' bills are accurate. The courts treat the invoices as prima facie evidence or the fact that seventy percent of the cases are against privately insured patients. The IRS lacks knowledge of the Uniform Commercial Code for contracts that the Parole Evidence Rule states that a prior agreement cannot alter

the new contract with the patient or the billed amount. A patient's contract that states they are liable for the full amount charged.

It is easy to argue that even though the insurance companies overcharge for their services and the costs for the medical services are lowered by the canceled debt; their profits would increase and be taxed. For the kickbacks given to the insurance companies, the insurance companies reciprocate by steering their insured members to the providers. 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 lower fixed amount required by the HMO law, for additional administrative purposes. This practice is economic duress, and 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 kickback process has been going on since 1983, with devastating results to our country; the kickbacks started at 1%, but today stands at 85%. To cover the payments given to the insurance companies, the providers have continuously raised their charges. The Industry has continually grown, increasing its portion of the Gross Domestic Product in two and a half decades by 11.2%. When one industry grows, another shrinks, in this case, the manufacturing industry that has shrunk by 11.2%, eliminating over hundred-thousand manufacturing companies and millions of manufacturing jobs. With the loss of manufactured goods made in the United States, we created a humungous trade deficit; the trade deficit is sending the wealth of our nation overseas. Manufacturers are moving to Canada and Mexico, where all these countries have lower health care costs, and the employers do not pay for employee health care benefits. It is now estimated that within twenty years, we will no longer be able to maintain our military, and we will lose our standing as the world's most powerful nation.

As a nation, the adoption of a single-payer healthcare system will see a reduction of health care costs, an increase in personal income, and an increase in tax revenues. The first costs to go are the kickbacks paid to the insurance companies. Other cost reductions are the elimination of the financial burden of collecting payments from patients, which include bill collectors, court costs for collections of unpaid medical bills, and personal bankruptcies, and the cost of medical malpractice insurance. The next cost reduction is the elimination of 250,000 highly paid insurance salesmen; their need will no longer exist. The good news is the employers are now paying for employees' health care benefits, will transfer these revenues to the employees' pay, these revenues now become taxable income, with the more significant portion becoming disposable income for the employees. A single-payer health care system would allow each to choose the provider of their choice. Universal health care coverage would create new freedom for employees, allowing them to change jobs without fear of losing their health care coverage.

The physicians and hospital managers would see a reduction of their income, being that these incomes were created through illegal business practices. Their income would be more in line with their counterparts in other industrial countries; it is estimated they make four times more than their counterparts. The biggest gain for them would only be greater self-respect, something our country has lost sight of.

The heads of the DOJ Antitrust group and the Commissioner of Internal Revenue, along with their bosses, should be fired. The Antitrust group failed to see the damage done to the un-insured private pay patients. It failed to recognize the change in the balance between industries and losses in the Manufacturing Industry. The head of the DOJ was unable to understand the illegal kickback scheme in the healthcare Industry or prosecute the offenders, the penalty being three years in prison and a twenty-five thousand dollar fine for each kickback. The IRS failed to recognize and tax the kickback payments, which allowed the creation of the Oligopoly.

To destroy the Healthcare Industry Oligopoly, without throwing all participants in jail, the government must collect the proper taxes on the kickbacks and barter income. If you have an Explanation of Benefits form from your insurance company that shows the amount billed by the provider and a lower amount paid by the insurance company, please file an IRS whistleblower claim. The claim form and filing instructions are on the IRS Whistleblower website. Just say this provider and insurance company is not paying taxes on the kickbacks. You may be entitled to a share of the collected taxes as an award. The un-insured patients, who have overpaid their medical bills, contact an attorney that specializes in state class-action lawsuits and sue the provider for your overpayments.

President Kennedy said, "Ask not what your country can do for you, ask what you can do for your country." If you want to save our country from financial ruin, bring back manufacturing to this country, eliminate trade deficits, we must fix the problem that causes it; we must put an end to the Healthcare Industry Oligopoly.

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