

Healthcare Pricing Scandal Through Secret Contracts

Insurers and Providers Under Fire for Illegal Kickback Schemes, Price Discrimination, Restraint of Trade, and Tax Evasion Alleged in Collusive Agreements

Fort Myers, Florida Jul 16, 2025 ([Issuewire.com](https://www.issuewire.com)) - A growing number of legal experts and whistleblowers are sounding the alarm on what they say is a widespread, illegal collusion between healthcare providers and insurance companies. These agreements—commonly labeled as 'contractual adjustments' or 'negotiated rates'—are now at the center of multiple legal and regulatory investigations. Critics claim these arrangements restrict trade, violate federal and state price discrimination laws, encourage boycotts of off-network providers, distort accounting standards, and circumvent tax regulations. The result: higher healthcare costs for consumers and massive profits for both parties, even at not-for-profit hospitals.

How the Scheme Works

Consider two examples. In an open kickback scenario, a provider bills a patient \$100. The insurance company pays the full \$100, even though the actual contracted rate is only \$15. The provider then returns \$85 to the insurance company as a 'referral fee.' Ultimately, the provider retains just \$15, while the insurance company benefits by artificially inflating its reimbursement activity, thereby increasing its market value or justifying higher premiums. This transaction is straightforward, although it is blatantly illegal, and is easily obscured by documentation.

In a more common hidden version, the identical provider bills \$100. The patient's insurance company pays only \$15 based on a so-called 'negotiated rate.' The provider accepts this payment and writes off the remaining \$85 as a 'contractual adjustment.' On paper, the provider earned only \$15, thereby reducing taxable income, despite incurring a legal debt of \$100. The insurance company avoids paying \$85, secures exclusive referral arrangements, and benefits from steering patients to cheaper, in-network providers. Both parties benefit through the manipulation of accounting and billing practices. At the same time, the unpaid \$85 remains unreported to the IRS as a cancellation of debt, thereby bypassing the legal requirement to file a Form 1099-C.

Payment

In either case, the **payment of the \$100 billed amount is ultimately passed on to the patient's employer**, who pays the full premium cost as part of the employee's health benefits package. If the provider had honestly billed \$15—the actual payment received—then the employer's insurance premium obligation would have reflected this reduced cost. Instead, the employer unknowingly pays the full \$100, based on inflated billing practices that support the hidden kickback structure. That \$85 difference, which could have been retained by the employer or passed on to the employee as additional compensation or wellness benefits, is siphoned away. Thus, **both the employer and the employee are defrauded**—robbed of a legitimate financial benefit. This fraudulent arrangement enriches the insurance company and provider at the expense of those who fund the system, while leaving government oversight agencies in the dark.

Only the Patient Can Legally Negotiate Medical Prices

Under U.S. law and Generally Accepted Accounting Principles (GAAP), the *customer* is defined as the individual who **receives** the medical goods or services, not the insurance company that pays for them. Therefore, only the **patient or insured individual** has the legal right to negotiate prices with healthcare

providers.

The widespread acceptance of hidden kickback schemes in healthcare is rooted in the **false assumption** that insurance companies are the primary customers, as they pay the bills. In reality, they are merely **third-party payers**. This misunderstanding has enabled providers and insurers to negotiate behind closed doors, excluding the actual customer from the process, and leading to inflated pricing, discriminatory billing, and potential violations of tax and anti-kickback laws.

Why They Do It—And Why It's Illegal

Healthcare providers and insurers justify these practices by claiming they are routine industry standards or contractually allowed discounts. In reality, these arrangements enable insurers to pay less, direct patients to in-network providers, and extract financial benefits in return, essentially functioning as kickbacks. Providers gain patient volume and reduce their taxable income by underreporting revenue. However, under multiple federal laws, these practices are illegal.

Legal Framework and Precedents

Key violations include:

- Anti-Kickback Statute (42 U.S.C. §1320a-7b): Prohibits remuneration for referrals payable under federal healthcare programs.
- Internal Revenue Code §§61, 108, 6050P: Requires recognition and reporting of cancellation of debt income; disallows improper income reduction through adjustments.
- Robinson-Patman Act (15 U.S.C. §13): Outlaws price discrimination that harms competition.
- Sherman Act (15 U.S.C. §1): Prohibits restraint of trade through exclusive agreements and referral steering.
- Relevant Cases:

- Spring City Foundry Co. v. Commissioner, 292 U.S. 182 (1934): The Supreme Court held that for accrual-method taxpayers, income is recognized when the right to receive payment becomes fixed. This means the full billed amount, once issued, must be reported as income, regardless of what is ultimately collected.

- United States v. Greber, 760 F.2d 68 (3d Cir. 1985): The court ruled that even if a payment serves a legitimate purpose, it still violates the Anti-Kickback Statute if one purpose is to induce referrals.

- Hanlester Network v. Shalala, 51 F.3d 1390 (9th Cir. 1995): Reinforced that intent alone to induce referrals, not just the act, is sufficient to trigger liability under anti-kickback laws.

- Connecticut General Life Ins. Co. v. Humble Surgical Hospital, 878 F.3d 478 (5th Cir. 2017): Held that insurers must pay billed charges when ERISA plan requirements are not followed, reinforcing the binding nature of billed amounts.

- FTC v. Morton Salt Co., 334 U.S. 37 (1948): Established the legal precedent that price discrimination harming competition is unlawful under the Robinson-Patman Act.

Conclusion: A Call for Oversight and Reform

The widespread abuse of healthcare billing and contractual adjustment practices by providers and

insurance companies is not only unethical but also unlawful. These practices violate commercial, tax, and public health laws. Courts have repeatedly held that **billed amounts must be recognized and reported** in accordance with federal tax and accounting standards. Yet despite clear legal precedent, enforcement remains weak or nonexistent, allowing a hidden system of financial manipulation to flourish.

Unless Congress initiates formal investigations, these schemes will persist. Particular attention must be given to the **Internal Revenue Service**, which bears the statutory duty to interpret the tax code and regulate how gross income, write-offs, and debt forgiveness are reported. The IRS should be required to conduct **annual audits** of both for-profit and not-for-profit healthcare institutions, especially the latter, which supply the majority of medical goods and services in the United States. The billed amount is not merely a technical figure; it determines insurance premium pricing, Medicare and Medicaid reimbursement rates, and contributes directly to the Consumer Price Index, making it a vital benchmark of national economic health.

If the American public wants meaningful reform, **they must demand immediate action from Congress**. Silence perpetuates a rigged system—one designed to funnel money upward through deceptive billing and undisclosed kickbacks, while **employers, employees, and taxpayers bear the brunt of the cost**. Transparency and enforcement are long overdue. The IRS must treat these practices as tax evasion. The Department of Justice must prosecute them for criminal fraud. And **Congress must hold public hearings** to expose the depth of the deception and reclaim accountability.

Every Senator and Representative maintains a public website through which constituents can reach them. Use it. **Send a clear message: Stop the fraud. Enforce the law. Restore fairness to our healthcare system.**

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