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Sent: Wednesday, April 29, 2015 2:46 PM

To: FASB Comments

Subject: Fwd: Request for Agenda Review - Contract Adjustment v. Brokering Fees for PRIVATE SIDE OF BUSINESS

This request deals with the private side of the healthcare business; it does not deal with the healthcare programs sponsored by the federal government, such as Medicare and Medicaid. For your information I am attaching a write up title Misuse Of The Contract Adjustment Account In The Healthcare Industry. In the writing I have included references to the law which created the HMOs, you will see the insurance companies must pay the full amount of medical bills obligated by the insured member.

Request for formal review by agenda committee

Re: 954-605-25-4 Contractual Adjustments and 954-605-25-3 Posting of Patient Revenue

For the purpose of full disclosure and the identification of financial activities, the following items must be addressed:

Private-Pay Patients Contract and Bill with Healthcare Provider

- Forty-one States have Price discrimination laws stating all services provided to private-pay patients must be charged the same price, i.e. the same charge; These requirement falls under the consumer protection laws or antitrust laws;
- The private-pay patient is the customer; any discounts given must be listed on the patient's bill at the time of issuance;
- All private-pay patients whether they are non-insured or insured sign the same contract and are charged the same amount, for the same services;
- The contract provided to the private-pay patient is clear and stands by itself;
- The private-pay patient's contract calls for the guarantee of full payment;
- The bill issued by the healthcare provider is clear, stands by itself, and is enforceable in a court of law;
- The provider's consideration under the contract is the provision of medical services and medical goods;
- The patient's consideration under the contract is full payment;
- The patients contract and the patients bill cannot be changed or superseded by another contract because of the substantive law known as the **Parol Evidence Rule**;

Insurance Companies Contract with Healthcare Provider

- The insurance company is not the customer of the provider;
- The insurance company is a third party payer
- The insurance company never purchases any medical services or medical goods;

- The insurance company is not the agent for the insured member;
- The consideration paid by the provider is a forgiveness of debt; i.e. a forgiveness of the patient's debt;
- The consideration provided by the insurance company is to place the provider on its approved provider list; i.e. the provider is listed as an on-network provider;
- The insurance company refers the insured member to the healthcare provider; if the insured member chooses an off-network provider the insured members, co-payments are increased; this increase is also financial duress;
- The process of referring a patient to a provider and receiving a payment is known as **Brokering**;

Suggested Solution:

- In order to properly identify, the financial transaction, which reduces the total income, the healthcare provider should make a note listing the forgiven income paid to the insurance company as brokering fees paid, not as contract adjustments;
- In order to properly identify, the receipt of forgiveness of debt income, the insurance company should list it as brokering fees received and increase its total revenue.

Please Keep me informed.

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**Misuse of the Contract Adjustment Account
In the HealthCare Industry
OR
HEALTHCARE INDUSTRY TRADE SECRET**

by Roy J. Meidinger

May 21, 2013

In 2007, the Internal Revenue Service issued a memo, LMSB-04-0807-056, Tier II Industries Director's Directive on the Planning and Examination of Contract Adjustment Issues in the Healthcare Industry #2, to its auditors to clarify the proper use of the contract adjustment account for determining taxable income within the health care industry. The problem identified was the standard industry practice of billing an insured patient the standard rates, but allowing their health insurance company to pay a much lower amount. The LMSB memo contained several legal flaws. The memo failed to distinguish the difference between the patient's contract with the hospital for services; the creation of the indebtedness; the right to collect the billed charges; and the hospital's contract with the health insurance company. The memo also failed to take into consideration all of the applicable laws which help protect consumers in the health care industry.

This article, regarding misuse of the "contract adjustment account", concentrates on the largest users of this non-standard accounting procedure which are hospitals and the health insurance companies; and the tax consequences which have been created in the health care industry; but is applicable to all health care providers. The introduction of the LMSB memo includes a disclaimer: "This directive is not an official pronouncement of law or of the position of the Service (IRS) and cannot be used, or cited, or relied upon as such".

The main premise of the LMSB memo states that if a legally enforceable contract existed at the time the medical services were provided granting a discount to the insurance company, then the amount billed to an insured member would not be recognized as taxable revenue. The memo also states that the hospital and insurance company are allowed to use the contract adjustment account to write off the difference of the amount billed and the actual amount paid. According to the memo, this is an acceptable practice under Generally Acceptable Accounting Practices for corporations within the Accrual Method of Accounting.

The tax Courts rely on the Generally Accepted Accounting Principles (GAAP), "Compliance with GAAP will ordinarily "pass muster for tax purposes," though it does not create a presumption of validity." DAYTON HUDSON CORP. AND SUBSIDIARIES v. CIR, 153 F. 3d 660 (U.S. 8th Cir. 1998) citing *Thor Power Tool*, 439 U.S. at 540, 99 S.Ct. 773.; which also include other practices:

Basic Objectives Accounting

Financial reporting should provide information that is:

- useful to present to potential investors and creditors and other users in making rational investment, credit, and other financial decisions
- helpful to present to potential investors and creditors and other users in assessing the amounts, timing, and uncertainty of prospective cash receipts
- about economic resources, the claims to those resources, and the changes in them
- helpful for making financial decisions
- helpful in making long-term decisions
- helpful in improving the performance of the business
- useful in maintaining records

Basic concepts

To achieve basic objectives and implement fundamental qualities GAAP has four basic assumptions, four basic principles, and four basic constraints.

Assumptions

Accounting Entity: assumes that the business is separate from its owners or other businesses. Revenue and expense should be kept separate from personal expenses.

- **Going Concern:** assumes that the business will be in operation indefinitely. This validates the methods of asset capitalization, depreciation, and amortization. Only when liquidation is certain this assumption is not applicable. The business will continue to exist in the unforeseeable future.
- **Monetary Unit principle:** assumes a stable currency is going to be the unit of record. The FASB accepts the nominal value of the US Dollar as the monetary unit of record unadjusted for inflation.
- The **Time-period principle** implies that the economic activities of an enterprise can be divided into artificial time periods.

Principles

Historical cost principle requires companies to account and report based on acquisition costs rather than fair market value for most assets and liabilities. This principle provides information that is reliable (removing opportunity to provide subjective and potentially biased market values), but not very relevant. Thus there is a trend to use fair values. Most debts and securities are now reported at market values.

- **Revenue recognition principle** requires companies to record when revenue is (1) realized or realizable and (2) earned, not when cash is received. This way of accounting is called accrual basis accounting.
- **Matching principle.** Expenses have to be matched with revenues as long as it is reasonable to do so. Expenses are recognized not when the work is performed, or when a

product is produced, but when the work or the product actually makes its contribution to revenue. Only if no connection with revenue can be established, cost may be charged as expenses to the current period (e.g. office salaries and other administrative expenses). This principle allows greater evaluation of actual profitability and performance (shows how much was spent to earn revenue). Depreciation and Cost of Goods Sold are good examples of application of this principle.

- **Full Disclosure principle.** Amount and kinds of information disclosed should be decided based on trade-off analysis as a larger amount of information costs more to prepare and use. Information disclosed should be enough to make a judgment while keeping costs reasonable. Information is presented in the main body of financial statements, in the notes or as supplementary information

Constraints

Objectivity principle: the company financial statements provided by the accountants should be based on objective evidence.

- **Materiality principle:** the significance of an item should be considered when it is reported. An item is considered significant when it would affect the decision of a reasonable individual.
- **Consistency principle:** It means that the company uses the same accounting principles and methods from period to period.
- **Conservatism principle:** when choosing between two solutions, the one that will be least likely to overstate assets and income should be picked (see convention of conservatism).

Required departures from GAAP

Under the AICPA's Code of Professional Ethics under Rule 203 - Accounting Principles, a member must depart from GAAP if following it would lead to a material misstatement on the financial statements, or otherwise be misleading. In the departure the member must disclose, if practical, the reasons why compliance with the accounting principle would result in a misleading financial statement. Under Rule 203-1-Departures from Established Accounting Principles, the departures are rare, and usually take place when there is new legislation, the evolution of new forms of business transactions, an unusual degree of materiality, or the existence of conflicting industry practices. Under the Social Security law the use of the contract adjustment account is required because the amount listed on the Universal Bill, UB04, is not what the government is actually going to pay. The amount listed on the bill is the customary charge, based on the actual amounts paid by non-government patients or their insurance companies. If these amounts are listed higher than the actual amounts collected the government is required to raise the amounts paid for services provided to the Beneficiaries of the Medicare/Medicaid Programs. Since the Healthcare providers are reporting six times the amount actually collected the healthcare providers are collecting six times more from the government than they should.

The use of the contract adjustment account can be traced to the beginning of the Medicare/Medicaid programs. The government created this new accounting methodology within the Accrual Method of Accounting when it started the Medicare/Medicaid Programs fifty years ago. This is the first time the amount listed on a bill was not accurate and therefore a reconciliation account for balancing accounts, known as the “Contract Adjustment Account”, had to be used. The Social Security Law required the “customary charge”, which is the medium amount actually collected from all the charge-paying patients, rather than the standard amount. The invoice was no longer a bill because the Government never intended to pay the amount listed but was to be used as a source of information to determine what was actually being paid in the private sector. During this time, the government only paid for the costs incurred by the beneficiaries and the charges listed on the invoice were used to apportion the costs. The “Contract Adjustment Account” was to be used only for government programs. The legal requirement for the customary charge is written in the Social Security Law and within the Hospital’s Medicare/Medicaid billing manual.

In the health care industry, all private-pay patients are to be treated the same and billed the same standard charge for the same services. These standard charges are listed in the hospital’s chargemaster. The same billing charge for all private-pay patients is guaranteed by both the state and federal antitrust laws; it is known as price discrimination if the amounts charged are different. United States antitrust law is a collection of federal and state government laws which regulate the conduct and organization of business corporations, generally to promote fair competition for the benefit of consumers. The main statutes are the Sherman Act 1890, the Clayton Act 1914 and the Federal Trade Commission Act 1914. These acts deal with price discrimination, price fixing, boycotts and restraint of trade. These laws originally dealt with only commodities, but in 1944 this changed when the Supreme Court declared insurance to be a commodity.

When a service is completed, a patient’s bill is issued listing all the standard charges listed in the hospital’s chargemaster. The billed amount is then posted to the patients’ accounts receivables and recognized as income to the hospital. A bill is then sent to the non-insured private-pay patients listing all services and medical items, along with the standard charges, which is the legal obligation of the patient. In the case of an insured private-pay patient the bill is first sent to the insurance company for payment. However, providers have contractual agreements with the vast majority of third-party payers regarding the amount that the payer will reimburse for specific goods and services (i.e., the contract provides for a discount for enumerated goods and services). The amount of discount typically differs in contracts between a provider and different payers and, in fact, often differs between different insurance plans offered by the same payer.

These billed amounts are certified correct when sent to third party payers, by the use of either the Uniform Billing Forms CMS 1500 or UB 04 which, if false, is subject to a fine, imprisonment or both. It is a felony crime to submit a false bill or invoice to a third party payer. In the legal system for Bills and Notes, the amount listed on a bill is a material fact

and is the legal obligation. If a legal discount is to be given, it must be listed on the bill at the time of issuance and the net amount listed on the bill. The net amount should also be listed on the patient's account receivable. This amount billed is the actual amount recognized for the computation of taxable income.

There is a different methodology for recognizing income for financial reports and tax returns. Also, there are different accounting methodologies used for government beneficiaries and private-pay patients. The private-pay patients, both insured and uninsured, also known as charge-paying private-pay patients, are billed the standard rates or usual charge. Government beneficiaries, because of the Social Security law, are billed the customary charge. The standard charge represents the legal obligation, which is also the creation of the indebtedness, and the actual amount to be collected.

Up until 30 years ago, the standard charge or the usual charge, and the customary charge were the same amount. Then, in 1983, the government introduced the Prospective Payment System for the Medicare and Medicaid Programs, whereby it utilized the Diagnostic Related Groups (DRG's) which had a fixed rate assigned to each DRG and these rates were determined by Congress. These rates were increased for the next year utilizing a basket full of economic items. One of the items used was the current customary charge listed on the beneficiaries' invoices, the universal bill submitted to the Medicare/Medicaid Programs. "42 CFR 405.503(a). Under 42 CFR 413.13 (e) (2) Customary Charges are reduced in proportion to the ratio of the amounts actually collected from charge-paying non-Medicare patients to the amount that would have been realized had customary charges been paid and the provider (i) Did not impose charges in the case of most patients liable for payment for its services on a charge basis; or (ii) Failed to make a reasonable effort to collect these charges." What this section means is the customary charge is determined by the average amount of all the monies actually collected from all the private-pay patients for the same service.

The indebtedness or legal obligation of the private-pay patient is created when the services are completed and the bill is issued, which is the standard for the Accrual Method of Accounting. A patient's contract is clear, precise and it stands alone. Parole evidence cannot be introduced to change the terms of the patient's contract with the hospital. The patient guarantees the payment of all medical items and medical services billed. A patient's contract is an enforceable contract and is not supplemented by the insurance companies' contracts. These are the contracts the hospital enforces in civil courts for payment of debts owed or sells them to collection agencies.

The IRS has a two-prong test it uses for determining taxable revenue. First, it relies on documentation that the services were performed, such as the patients' bills; the universal bill UB-04; the hospital's chargemaster, which lists all of the standard charges; and the patients' accounts receivables. Second, and most importantly, the IRS relies on the contract between the patient and the health care provider.

Like any promissory note, if a legal discount is provided to the patient, it must be listed on the bill at the time of issuance with the net amount listed on the bill and recorded on the

patient's account receivable. The transaction between the hospital and the third party payer, the health insurance company is not a re-pricing of the bill. For Internal Revenue Service and contract law, the legal obligation is determined by the face amount on the patient's bill.

Health insurance companies base their premiums on what their members are billed by health care providers. These premiums must cover the full amounts billed, which are the legal obligations of its members. The insurance companies do not base their premiums on what they pay for the medical services provided to their members. Therefore, when a patient sees an Explanation of Benefits (EOB) statement from the insurance company, it shows both figures: the amount the member was billed, which is the patient's legal obligation; and the amount the insurance company paid, which includes the co-payments. The difference is the kickback the health care provider paid the insurance company for coercing the member to use the services of the health care provider.

The insured private-pay patient is never billed on the original bill for co-payments, stop-loss limits and deductibles by the health care providers, these items are not listed in the hospital's chargemaster. These billable amounts are legal obligations the members owe to the insurance companies. The insurance company must track how much is owed on the deductible; the co-payment; determine any amount which might exceed the members limit; and determine whether or not the insurance company is going to pay for the procedures. If the insurance company approves payment, it requests that the hospital collect the amount owed to it by its members and to apply it against the payment. The insurance company requests the health care provider to collect these amounts, rather than billing its member for it. If, during the billing process, the member cannot pay these amounts it is not a bad debt for the health care provider. Instead, this situation necessitates that the health care provider collects these amounts from the health insurance company; this is the same method used with the Medicare Program, where the government is liable for any unpaid co-payments. A note receivable turns into a bad debt when there is no longer a chance of collecting the amount owed. However, the IRS does require that a reasonable attempt to collect the debt is made to prove it is worthless.

The hospital gives no discounts to the health insurance companies. The hospitals are the customers of the health insurance companies. There are no account receivables in the health insurance companies name for services rendered. The insurance companies are not the hospitals' customers. There is no re-pricing of services. If any discounts are to be given, the insurance companies should give them to the hospitals. But the insurance companies never issue bills to the hospitals. Assumption of indebtedness exists when a person binds himself to pay debt incurred by another. *Pawnee County Excise Board v. Kurn*, 187 Okl. 110, 101 P.2d 614, 618.

Price adjustments that are illegal are generally treated as reductions of the sales proceeds when they are made between the buyer and seller directly, as opposed to reflecting them as nondeductible expenses. However, in cases where the price adjustments are made between the parties other than the buyer and the seller, the sales reported are increased to the original

invoice amount and a corresponding nondeductible expense item is reported for the illegal payment.

The insurance company purchases no medical services or medical supplies from the hospital, therefore incurs no liability on its own. The only liability the insurance company obtains is the legal liability of its insured member. The insurance company is not an agent of its insured member and has no right to negotiate any discounts for its insured members. The lower amounts actually paid are for its own benefit for services rendered.

The contract between the health care provider and the health insurance company make the health care provider the customer, the purchaser of services from the health insurance company. The consideration paid by the provider is the forgiveness of debt owed by the insurance company's member. The consideration provided by the insurance company, the seller, is the financial coercion of its members to use the medical services of the provider and boycott other health care providers. The coercion is an agreement by both parties, which calls for the insurance companies' members' co-payment to be increased if the member uses an off-network provider. The contract between the health care provider and the health insurance company is for illegal purposes. It calls for a restraint of trade and a boycott of other health care providers. It calls for the price fixing of a third party, the member of the insurance company.

There is a myth that the health insurance companies bring their members to the hospital and should receive a bulk discount because of lowered cost. This is partially true and partially false. It is true that the more patients a hospital has, the lower its average cost of handling services for all patients becomes, also known as economy of scale. But the important point is that all patients' costs go down because it is an average cost, also known as overhead absorption. The health care laws and the state and federal price discrimination laws are very specific. In order to not shift costs to one group of patients, all patients must be charged the same and maintain the same price-to-cost ratios. Therefore, all patients must be charged the same price for the same services and have the same legal obligation.

When Congress legalized HMO's in 1976, it included several protections for the insured HMO members. The law calls for the complete payment of the members' legal obligation for medical services and for a small fixed amount to be billed in the case where the member uses an off-network provider. It does not call for a variable amount, or a percentage of the total amount billed to be charged. This would mean almost every member would be billed a different amount for doing the same thing when using an off-network provider.

The law that created the HMOs and PPOs, Title 42, Chapter 6A, Subchapter XI, § 300e: Requirements of Health Maintenance Organizations: (7), is quite specific in its contractual requirements. It states that health insurance companies must fully pay the legal obligation of its members when they use the services of a hospital which the insurance company has a contract with. The insured member of the HMO or PPO is charged the same amount as a non-insured private-pay patient and has the same legal obligation; the methodology of payment does not change the legal obligation.

- i. 42 USC § 300e - Requirements of health maintenance organizations:
 1. Manner of supplying basic and supplemental health services to
 2. members;
 3. A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:
- ii. Each member is to be provided basic health services for a basic
 1. health services payment which;
 2. (b.) (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician.
 3. c. (c) Organizational requirements;
 - a. Each health maintenance organization shall;
 - b. (7) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization;
 - c. (A)a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

Included within the insurance company's contract is a clause which states that the insurance company assumes all medical liabilities and the insured member is not to be billed for any medical services provided. "Assumption of Indebtedness Exists when person binds himself to pay the debt incurred by another." Pawnee County Excise Board v. Kurn, 187 Okl. 110, 101 P.2d 614, 618.

The initial entry of the hospital would be to record the invoice in the amount of services rendered and other costs billed. The total amount invoiced would be recorded as a receivable from the patient and an equal amount is reported as taxable income by the hospital. Income is recorded by the hospital at the time when all the events have occurred which determine the

hospital's right to receive it, and the amount can be determined with reasonable accuracy, irrespective of the fact that the taxpayer hospital later forgives the obligation to make payment (Regs. 1.451-1(a)). This would be at the time services are invoiced to the patient. "Although this case involves the accrual of income under § 451, the all-events test for determining the accrual of deductions under § 461 also requires that the amount of the liability must be determined with reasonable accuracy. See § 1.461-1(a)(2)(i). The Service has acknowledged that the last event necessary to establish the fact of liability under the all-events test of § 1.461-1(a)(2)(i) is the same event that fixes the right to receive income under the all-events test of § 1.451-1(a). Rev. Rul. 98-39, 1998-2 C.B. 198. Accordingly, interpretations of the reasonable accuracy prong of the all-events test of § 1.461-1(a)(2)(i) are applicable in analyzing the reasonable accuracy prong of the all-events test of § 1.451-1(a)." Pawnee County Excise Board v. Kurn, 187 Okl. 110, 101 P.2d 614, 618.

The forgiveness of debt given by the health care provider is a non-deductible tax item since it is being paid for having the health insurance company refer members and/or coerce members to use the health care provider. The tax laws clearly cover this un-allowed deduction. Both Federal and State laws make this practice a felony crime. Generally, deductions are not allowed for payments that constitute a bribe, kickback or other payment that is illegal under any law of the United States or under any generally enforced law of a state subjecting the payer to a criminal penalty or the loss of license or privilege to engage in a trade or business (IRC §162(c)(2) & (3))

26 USC § 162 - Trade or business expenses:

- b. Illegal bribes, kickbacks, and other payments:
- c. (2)Other illegal payments:
- d. 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 payer 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. The burden of proof in respect of the issue, for purposes of this paragraph, as to whether a payment constitutes an illegal bribe, illegal kickback, or other illegal payment shall be upon the Secretary to the same extent as he bears the burden of proof under section 7454 (concerning the burden of proof when the issue relates to fraud).
- e. (3)Kickbacks, rebates, and bribes under Medicare and Medicaid:
- f. No deduction shall be allowed under subsection (a) for any kickback, rebate, or bribe made by any provider of services, supplier, physician, or other person who furnishes items or services for which payment is or may be made under the Social Security Act, or in whole or in part out of Federal funds under a State plan approved under such Act, if such kickback, rebate, or bribe is made in connection with the furnishing of such items or services or the making or receipt of such

payments. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, patient, or customer.

The entry made by the insurance company would be to record the cash payment of the hospital invoice. If the payment amount is less than the amount invoiced by the hospital (including invoice adjustments) and the hospital accepts the reduced payment amount as full payment for the invoice, the insurance company must treat the amount discharged by the hospital as debt forgiveness income (Regs. 1.61-12(a)). In general, the debt forgiveness income would be recognized at the time that the creditor discharges the unpaid amount of the invoice.

The entry made would be to record the debt to the hospital equal to the amount invoiced by the hospital. The invoice from the hospital would be a deductible trade or business expense of the insurance company (Code Section 162(a)). The time at which the invoice would be deductible by the insurance company would be the taxable year in which (a) all the events have occurred which fix the fact of the liability; (b) the amount can be determined with reasonable accuracy; and (c) economic performance has occurred. Since all the above factors would be met upon receipt of the invoice by the insurance company, the expense would be deductible at the same time that the hospital invoice is recorded (Code Section 461(h)).

As to the amount on the bill: A prior or contemporaneous extrinsic agreement as to the amount to be paid is ineffective to vary the express terms of the instrument. In the case of *Payne v. Nicholson*, supra, the Supreme Court of Florida, in discussing whether oral testimony in support of a claimed set-off constituted an attempt to alter or vary the terms of the note, stated: "As regards a promissory note, an extrinsic agreement as to the mode of payment, or the amount of payment, must be ineffective, since the parties have expressly dealt with those matters in the instrument; but an agreement to concede a credit or counterclaim, as offsetting the obligation of the instrument, would be a separate transaction, not dealt with in the instrument, and valid." *Wigmore on Evidence*, § 2444; *Bennett v. Tillmon*, 18 Mont. 28, 44 P. 80; *Buckeye Cotton Oil Co. v. Malone*, 33 Ga.App. 519, 126 S.E. 913; *John Lucas & Co. v. Bradley*, 4 Cir., 246 F. 693; *Roe v. Bank of Versailles*, 167 Mo. 406, 67 S.W. 303; *Branch v. Wilson*, 12 Fla. 543.

"Evidence of a parole agreement, made at the time of the execution of notes, that the maker should have the right to offset an account then existing in his favor, is not a variance from the contract embodied in the notes. 'Bennett v. Tillmon, supra'".

Internal Revenue Code (IRC) section 451 provides rules for determining the taxable year of inclusion for items of gross income. Section 1.451-1(a) of the Income Tax Regulations provides that under an accrual method of accounting, income is includible in gross income in the taxable year in which the "all events" test is met. The two-prong all events test is met when (1) all the events have occurred that fix the right to receive the income, and (2) the amount thereof can be determined with reasonable accuracy. Under the first prong of the all events test, a fixed right to receive income occurs when (1) the required performance occurs, (2) payment is due, or (3) payment is made, whichever happens first. See Rev. Rul. 74-607,

1974-2 C.B. 149. When an amount of income is properly accrued on the basis of a reasonable estimate and the exact amount is subsequently determined, the difference, if any, shall be taken into account for the taxable year in which such determination is made.

The Patient Protection and Affordable Care Act (Public Law 111-148) was signed into law on March 23, 2010 and was followed by the Health Care and Education Reconciliation Act of 2010 on March 30. This will ensure that all Americans have access to good quality, affordable health care while containing costs of treatment. The Affordable Care Act contains over a thousand pages of reforms to the insurance industry and the health care industry in order to cut healthcare costs and to provide affordable health insurance to all Americans. In order to provide affordable health care, the Internal Revenue Service has hired an additional 50,000 health care auditors.

During the first twenty years of the Medicare/Medicaid Programs, national health care costs grew from 6.5% of the Gross Domestic Product (GDP) to 8% of GDP. During this period, the standard charge and the customary charge were the same amounts and the health care providers gave no discounts. The hospitals were reimbursed for only the costs of treating beneficiaries of the Medicare/Medicaid Programs. The methodology identified all costs for all patients, and then the costs were apportioned between all the private-pay patients and the government beneficiaries, using the standard charge and the customary charges. Then, due to the rising costs of national health care, Congress changed to the Prospective Payment System, whereby the hospitals were paid a fixed fee for each Diagnostic Related Group (DRG). The fees for each DRG were increased annually through the measurements of a basket of financial indicators, which included the changes in the “customary charges” listed on the beneficiaries’ bills.

During the last thirty years, under the Prospective Payment System, national health care costs grew from 8% of GDP to 18% of GDP. During this period, the hospitals gave what came to be known in the industry as “secret discounts” to the health insurance companies. However, the hospitals called these discounts “trade secrets”, so that the discounts would not be disclosed to the public. The health care hospitals and insurance companies then began to use the non-standard accounting procedure on the private side of the business, utilizing the “Contract Adjustment Account” to hide their indiscretions. Moreover, the insurance companies pushed on the American public the insurance policies creating HMOs and PPOs, which contained many restraints of trade, eliminating their members’ right to choose their health care provider, with promises these insurance products would lower our medical costs. The hospitals are now writing off 85% of the private-pay and insured patients’ billed revenue. This 85% write off is actually taxable billed revenue.

There exists a clear intention on the part of the hospitals and the insurance companies to defraud the government by their INTENTIONAL OMISSION to include in their returns that huge amounts of kickbacks (income) were condoned and purposely not included in said returns. This intentional omission shall void the tax exemption granted by the government to the aforementioned entities. Consequently, all of the condoned amounts or kickbacks must be subjected to tax.

The IRS cannot say they are unable to collect taxes because of the principle of estoppel. The principle of equitable estoppels cannot be applied to deprive the public of the protection of a statute because of the mistaken action or lack of action on the part of public officials ^[1]. Estoppel will not operate against the Government even by an affirmative undertaking on the part of an officer or agency of the United States to whom no administrative authority has been delegated to waive or surrender a public right. (United States v. Stewart (1940) 311 US 60, 85 L ed. 40, 61 S Ct 102.) It is also worthy to note that bills and receivables partake of the nature of promissory notes. (State v. Robinson, 57 Md. 486, 501; Miami Coal Co. v. Fox, 176 NE. 11, 16, 203 Ind. 99.) Assumption of Indebtedness exists when person binds himself to pay a debt incurred by another. (Pawnee County Excise Board v. Kurn, 187 Okl. 110, 101 P.2d 614, 618.)

The contract between the hospital and the patient creates the indebtedness. The contract between the hospital and the health insurance company make the hospital the customer, the purchaser of services from the health insurance company. The consideration paid by the provider is the forgiveness of debt owed by the insurance company's member. The consideration provided by the insurance company, the seller, is the financial coercion of its members to use the medical services of the provider and boycott other health care providers. The contract between the health care provider and the health insurance company is for illegal purposes. It calls for a restraint of trade and a boycott of other health care providers. It calls for the price fixing of a third party, the co-payment of the insured member of the HMO. The forgiveness of debt revenue is taxable revenue for the hospital and the insurance company. Both must pay taxes, whether or not these corporations are for-profit, not-for-profit or tax exempt.

The hospitals, for their private-pay insured patients and the patients on the Medicare Plus plans, have been writing off six dollars for every dollar realized. Therefore, these write offs are subject to taxation, and both the hospitals and the insurance companies owe trillions of dollars to the American people. Our Tax Code mandates the Internal Revenue Service to collect these taxes or come to some fair settlement with each non-compliant taxpayer, whether the taxpayer is a private or public corporation, for-profit, not-for-profit, taxable or Tax exempt, and state entities.

Specifically, IRC 501, the ruling provision with regard to tax exemptions, appears to be self-enforcing. IRC 503 refers to IRC 501 in every case where an exemption is granted or denied -- thus, IRC 501 is the basis for all organizational tax-exempt status. IRC 501(a) provides that "An organization described in subsection (c) or (d) or section 401(a) shall be exempt from taxation under this subtitle **unless such exemption is denied under section 502 or 503.**"

Moreover, Treas. Reg. 601.201(n)(6) provides authority to revoke 501(c) tax-exempt status, under the general administrative powers conferred on the IRS Commissioner by the Secretary of the Treasury, pursuant to IRC 7805(a). Treas. Reg. 601.201(n)(6) (which is extremely long), begins, "(i) An exemption ruling or determination letter may be revoked or modified

by a ruling or determination letter addressed to the organization, or by a revenue ruling or other statement published in the Internal Revenue Bulletin. The revocation or modification may be **retroactive if the organization omitted or misstated a material fact**, operated in a manner materially different from that originally represented, or **engaged in a prohibited transaction** of the type described in subdivision (vii) of this subparagraph. In any event, revocation or modification will ordinarily take effect no later than the time at which the organization received written notice that its exemption ruling or determination letter might be revoked or modified."

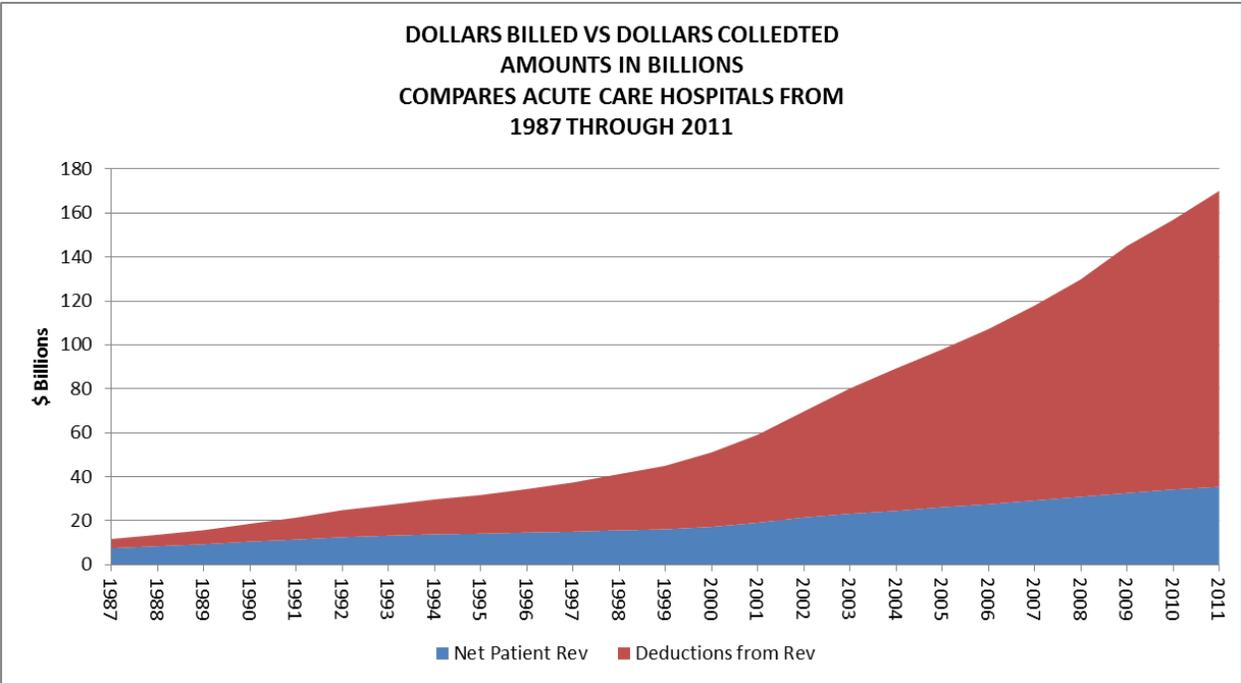
In the near future both the hospitals and the insurance companies will have to lower their charges by 85%. The hospital will have to determine the lowest priced, money actually received, to the lowest cost ratio of a DRG and then apply this ratio to all the DRG's to determine their charges. This methodology is required under the Social Security Law and makes sure there is no cost shifting among patients. The insurance companies will have to determine their premiums based on the actual revenues spent on health care, plus a reasonable administrative cost, close to the Medicare/Medicaid Programs administrative cost of three percent (3%). Both the hospitals and insurance companies will have to eliminate any restraint of trade agreements and return to open competition in the health care industry. If the industry does not change its methods of doing business, it will be taxed out of existence and the Federal Government will take over the Health Care Industry.

A word of caution, to anyone required to certify financial reports and tax returns. Wrongful endorsement and certification is seen as a malpractice and can cost you your license. You may also face legal action with fines and, at times, even imprisonment. To avoid this, ensure that you know the contracts used by these health care institutions and their legality. Study the returns thoroughly for such misuse of the "Contract Adjustment Account" and any other such misappropriations before certifying a return or financial report. Please be mindful of the fact, no contract, no matter how well written or what good the intentions are can change the law.

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<u>Percentage Changes 1987 – 2011</u>	
Hospital Gross Billing	1354%
Hospital Revenue	372%
Consumer Price Index	95%



The above chart was provided by the Agency for Florida Health Care Finance Administration from the financial annual cost reports submitted by all the hospitals in Florida.