

IRS Whistleblower Files a Trillion-Dollar claim in U.S. Federal Claims Court

The IRS Whistleblower Office breached its contract to collect taxes on the secret kickbacks paid by health care providers to insurance companies for referring patients

District of Columbia, Sep 28, 2019 (Issuewire.com) - IRS Whistleblower Files a Trillion damages lawsuit in U.S. Federal Claims Court
September 25, 2019

IRS Whistleblower, Roy J. Meidinger, filed a One Trillion Dollar damage claim against the Internal Revenue Service for breaching its contractual obligations of collecting taxes on kickbacks paid in the Healthcare Industry. The kickback is the largest medical expense the providers include in their medical bills, paid to insurance companies. The kickback is the difference between what the provider bills the insured patients and what the insurance companies pay; for tax purposes, these differences are a cancellation of debt, which is cash equivalent payment to the insurance company for steering the insured member to the provider. The tax revenues lost is estimated to be at Nine Trillin Dollars, wherein the Whistleblower's reward is thirty percent of the tax revenues collected. The damages caused to the Whistleblower is due to the IRS's failure to collect the tax revenue promptly and allowing the statute of limitations to prevent collecting past taxes, making the loss irreversible.

The kickback scheme is flourishing due to fact the contracts between the providers and insurance companies are hidden from any scrutiny, and labeled as trade secrets. The IRS failed to realize that under the Uniform Commercial Code for contracts, the parole evidence rules state a newer agreement supersedes a preexisting contract and the old contract cannot change the final deal. All healthcare providers are on the accrual method of accounting; when issuing a bill, the amount listed is the legal obligation and must be collected. The charged amount is then part of the gross income. The IRS incorrectly assumes that since billing and accounting on the private side of its business are identical to the practices on the government side of its business, the deductions taken for cancellation of debt is legitimate. Medicare/Medicaid services payments are fixed by legislation, therefore falls outside standard billing methods; the same legislation makes it mandatory the same charges listed on the private-pay patients' bills are recorded on the beneficiary's bills. The IRS allows a write off the difference of what the government pays and what the provider bills the beneficiaries, although it is a cancellation of debt, is recorded differently than regular cancellation of debt because the government does not pay itself income taxes on cancellation of debt income. The IRS failed to properly apply Generally Accepted Accounting Practices (GAAP) for medical providers and insurance companies on the accrual method of accounting, and utilized for Income tax purposes.

The IRS holds the private-pay insured patients' contracts, and bills are worthless in determining gross realized taxable revenue or creating a legal obligation; it holds that the amount approved by the insurance company does determine gross realized taxable revenue.

At the time of issuing a patient's bill, the providers add the amount charged to their gross income; under the accrual method of accounting any deduction, other than regular business expenses, is either bad debt or cancellation of debt. These deductions are not bad debts where there is a mutual agreement in the secret contracts. The insurance companies agree to steer the patients to the provider, which has a value and the providers agree to cancel portions of the debt. Kickbacks in the Healthcare Industry are unlawful; they add costs and are anti-competitive; recording these cancellations of debt as a "contract adjustment" is a fraud. The provider never issues a new medical bill deducting 'contract adjustments.'

The "contract adjustment" account was established to record the differences of the government billing and adjustments and used in financial reporting. A "contract adjustment" deduction is not a legitimate tax deduction, it is not listed in GAAP, but is a recognized account for financial reporting. Financial recognition of revenue is entirely different from determining taxable income.

The providers and insurance companies hid the illegal kickbacks by claiming the write-offs were contract adjustments. The IRS failed to understand, under the Universal Commercial Code Parole Evidence Rule, the patient's contract supersedes the insurance companies' contract. The IRS allowed the providers to deduct from gross income, the difference between the billed amount and the amount the insurance companies paid, which is a violation of the tax code, which does not allow any deductions for kickbacks. The two transactions, one creating the debt and the other paying the kickback are two separate financial transactions and should have been recorded as such.

The providers and insurance companies hid these kickback transactions, instead of listing them as a cancellation of debts, listed them as contract adjustments, meaning somehow it is adjusting the patients' debts, without issuing a new patients' invoice. Any discount to be considered legal must be listed and deducted from the billed amount, at the time the bill is issued, creating a new net amount. The net amount determines gross income. All patients are charged the same. All private-pay patients have the same legal obligations for the same charges. There are no discounts. The function of a third-party payer is to pay in full the medical debt of the insured member.

The IRS is the only government agency that believes the billed amount charged to a patient has no meaning or for determining patient income. In the course of a year Forty-Five million patients, most of them privately insured, will be hounded in courts for payment of outstanding medical debts; The providers say the bills are accurate and reflect the legal obligation owed by the patient, all the courts involved in the disputes use charges listed on the patients' bills as primary evidence for determining the debts. Unpaid medical bills are the cause of one to one-and-half million personal bankruptcies each year.

Health and Human Services are responsible for managing Medicare/Medicaid Programs. The Centers for Medicare/Medicaid Services believes the patient's bills are accurate. These programs originally reimbursed beneficiaries allocated costs, primarily determined by the percentage of the beneficiaries' charges to the total charges of all patients. The billings were perfect; all patients were charged the same amount for the same services. In 1983 the Medicare Program changed its reimbursement methodology to the Prospective Payment System. A fixed amount was allowed for each service, known as the Diagnostic Related Group (DRG). The new procedure called for an annual re-determination of the reimbursement rates for each DRG. The program required the providers to list the average amount actually collected for the services provided to the private-pay patients for each DRG; the providers did not take into account the given to the insurance companies, instead put the standard charges on all patients' bills. Although the immediate bill does not determine the present reimbursement rates, the data submitted is fraudulent, it will affect future reimbursement rates; therefore, the charges through the years are grossly inflated, and is causing the Federal Government to overpay grossly.

The Antitrust Division of the Department of Justice believes all patients are billed the same therefore, there is no price discrimination for medical services. Price Discrimination is not determined by the charges for a specific good or service but is determined by the ratio of the actual amount collected amount compared to the cost of providing the good or service. The amount collected from the uninsured is about six times greater than the amount collected for the insured patients' services; therefore, this is a clear case of price discrimination. When a provider collects a lesser amount from an insurance company than from a non-insured patient there is a substantial difference in the ratios; under these billing

methodologies, the costs of medical services are shifted to the uninsured patients.

A substantially bigger problem is that the Antitrust Division failed to recognize the loss of competition in the Healthcare Industry and the creation of an Oligopoly. The only way a provider can stay in business is to get the insured patients' business, but the choice of providers is in the hands of the insurance companies. The insurance companies extort kickbacks from the providers in the form of canceled debt, and each year these kickbacks get larger and larger. To get the revenue for these kickbacks the insurance companies, like the government, use the charges to determine the premiums for the insurance policies. The latest average insurance cost for each employee just broke \$20,000. As the premiums continually increased. In order to cover the kickbacks, the providers are forced to raise their charges, causing revenues to be siphoned from other industries, in particular, the manufacturing industry. From the time the kickback scheme started in 1983, to the present, 11.2% revenues of the Gross Domestic Product were shifted from the Manufacturing Industry to the Healthcare Industry.

The Antitrust group failed to see the financial damages being done to the manufacturing industry caused by the growth of the kickbacks. The nation's economy should be kept in balance, with each sector given the most significant value for the costs it uses. With the loss of our nation's manufacturing segment, our trade deficits with other industrial countries have soared; no matter what trade agreements are made for the short time, in the long run, the United States will lose unless we fix the underlying cause damaging our manufacturing industries.

Other industrial countries control their manufacturing health care costs by two distinct methods, the first is they have a single-payer system that is 1/3 the cost of our free market system, and two a different way of paying for their health care system. In the United States, all health care costs eventually end up as part of our manufacturing costs; each provider of services or goods include in their prices the cost of covering their health care expenditures. For our manufacturers' these costs are incurred below what is known as the break-even point where all expenses must be covered before making a profit. In other industrial countries, no employer pays for health care services for their employees; therefore, the break-even point is much lower. The revenues for these services are included in an individual and firm's income taxes. Health care costs are taken from a business' profits, and these profits are above the break-even point. The same taxing methodology is used to cover all social programs, i.e., FICA taxes for Social Security, which means none of the costs of these programs are included in the costs below the break-even point.

For our country to regain our manufacturing economic power, we must fix the underlying problems. One way of immediately helping the lower and middle classes is to recognize that the \$20,000 allocated for each employee's health care premiums belongs to the employee and should be paid to them. The transfer of funds to the employees will be substantially more significant than any increase in taxes needed to pay for a single-payer health care system.

Roy J. Meidinger
14893 American Eagle Ct.
Fort Myers, Florida 33912
Tel # 954-790-9407
Email RoyJMeidinger@comcast.net

Media Contact

Saving the World

RoyJMeidinger@comcast.net

954-790-9407

14893 American Eagle Ct.

Source : Roy J. Meidinger

See on IssueWire : <https://www.issuewire.com/irs-whistleblower-files-a-trillion-dollar-claim-in-us-federal-claims-court-1645918863274850>