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Technical Line

FASB — final guidance

The new revenue recognition standard — health care

A key implementation issue for health care entities is how to record patient service revenue from uninsured or underinsured patients.

What you need to know

- The new revenue recognition standard is more principles-based than current guidance and will require health care entities to exercise more judgment.
- Health care entities will have to change their presentation for and disclosure of amounts they charge uninsured or underinsured patients.
- While the amounts entities report as revenue from government programs may not change under the new revenue standard, health care entities will have to review their processes to make sure they properly address the new guidance on estimating variable consideration and appropriately document their conclusions.
- The new standard is effective for public entities, including conduit bond obligors, for fiscal years beginning after 15 December 2016, including interim periods within those years, and for nonpublic entities in years beginning after 15 December 2017.

Overview

Health care entities may need to change certain revenue recognition practices as a result of the new revenue recognition standard[1] jointly issued by the Financial Accounting Standards Board (FASB) and the International Accounting Standards Board (IASB) (collectively, the Boards). The new revenue recognition standard will supersede virtually all revenue recognition guidance in US GAAP and IFRS, including industry-specific guidance that health care entities use today.

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The new standard provides accounting guidance for all revenue arising from contracts with customers and affects all entities that enter into contracts to provide goods or services to their customers (unless the contracts are in the scope of other US GAAP requirements, such as the leasing literature). The guidance also provides a model for the measurement and recognition of gains and losses on the sale of certain nonfinancial assets, such as property and equipment, including real estate.

Our Technical Line, *A closer look at the new revenue recognition standard* (SCORE No. BB2771), provides an in-depth discussion of the new revenue standard. This publication summarizes the key implications for health care entities.

Health care entities also may want to monitor the discussions of the Boards' Joint Transition Resource Group for Revenue Recognition (TRG) and the task force established by the American Institute of Certified Public Accountants (AICPA) to focus on health care issues. The Boards created the TRG to help them determine whether more implementation guidance or education is needed. The TRG won't make formal recommendations to the Boards or issue guidance. The AICPA's health care industry task force is one of 16 groups the AICPA has formed to help develop a new Accounting Guide on Revenue Recognition and to aid industry stakeholders in implementing the standard. Any views discussed by the TRG or guidance produced by the AICPA is non-authoritative.

The views we express in this publication are preliminary. We may identify additional issues as we analyze the standard and entities begin to interpret it, and our views may evolve during that process. As our understanding of the standard evolves, we will update our guidance.

Key considerations

To apply the new standard, entities will need to change the way they evaluate transactions with self-pay patients and governmental payors, even if the amounts they report do not change significantly.

Self-pay patient contracts

The key issue for health care entities is how and when to record amounts they charge uninsured or underinsured patients (i.e., self-pay patients). Under the standard, entities will have to determine whether a contract is enforceable and whether the amounts they charge meet a collectibility threshold. Entities also will have to estimate variable consideration. All of this will be challenging for health care entities that often provide care to self-pay patients without assessing the patients' ability to pay and eventually collect pennies on the dollar for those services.

Under the new standard, one of the criteria for determining that a contract is enforceable is that the parties have approved the contract and are committed to performing their respective obligations. However, a hospital that provides required medical services to a patient admitted through the emergency department may not be able to conclude that the patient is committed to performing his or her obligations (i.e., paying for the medical services) until a later date.

Entities also must conclude that it is probable that they will collect the consideration to which they expect to be entitled. In making this assessment for self-pay patients, health care entities must consider the patient's credit risk. However, hospitals may not be able to assess an uninsured patient's ability and intention to pay before providing any services.

It is important to note that the collectibility assessment relates to the amount of consideration to which an entity expects to be entitled (i.e., the estimated transaction price), not the stated contract price. For example, a hospital that treats a patient with an emergency condition and

does not assess the patient's ability to pay at the time of service may bill the patient and vigorously pursue through collections charges of $10,000, but it may actually expect to collect $1,000, based on its experience with similar self-pay patients. The hospital will need to determine whether the $9,000 it doesn't expect to collect is an implied price concession (and therefore a reduction of the transaction price) or bad debt (presented in operating expenses). Today, entities report the full charge (after any standard price adjustments) in revenue and then deduct the uncollectible amount as bad debt.

Health care entities may struggle with applying the standard's collectibility criterion. If a health care entity believes it will receive partial payment for performance, it may be able to determine that the arrangement meets the definition of a contract (and that the expected shortfall of consideration is more akin to an implied price concession). However, significant judgment will be required to determine the amount to which an entity is entitled and whether a partial payment indicates that an arrangement lacks sufficient substance to be considered a contract within the scope of the guidance.

If an arrangement does not meet the definition of a contract under the new standard, a health care entity will need to meet either of the following criteria to recognize any consideration received as revenue:

- The entity has no remaining obligations to the customer and all or substantially all of the consideration promised by the customer has been received by the entity and is nonrefundable.
- The contract has been terminated and the consideration received from the customer is nonrefundable.

Health care entities may struggle with the standard's collectibility criterion.

This guidance also raises questions about when it is appropriate to recognize cash received from self-pay patients as revenue. A health care entity might conclude that the first criterion doesn't apply because it's unlikely that it will receive all, or substantially all, of the consideration from a self-pay patient. It also is unclear when an arrangement with a self-pay patient would be terminated. Health care entities will need to make judgments based on their own facts and circumstances.

Portfolio of contracts

A health care entity may use a portfolio approach to apply the new model to classes of self-pay patients if it reasonably expects that the effects will not differ materially from applying the guidance to individual contracts. An entity may choose to apply the portfolio approach to certain aspects of the new model such as the collectibility threshold and the evaluation of implicit price concessions.

To take such an approach for the self-pay payor class, health care entities will need to determine whether self-pay patients constitute a single customer class that share similar characteristics. For example, health care entities will need to consider whether they should distinguish between self-pay patients with insurance (i.e., deductibles and copayments) and self-pay patients without insurance. This distinction will become more important as patient deductibles and copayments increase.

Reimbursement for government programs

Revenue from contracts with governmental payors contains variable consideration because reimbursements under the Medicare and Medicaid programs may be subject to adjustment for several years. Health care entities often record valuation allowances to account for the likelihood that payments or settlements due to or from payors may be adjusted during cost report audits or payor audits of medical records.

The new revenue standard limits the amount of variable consideration an entity can include in the transaction price to the amount for which it is probable that a significant revenue reversal will not occur when the uncertainties related to the variability are resolved. That is, the standard requires an entity to apply a constraint on variable consideration. Under current guidance, a health care entity generally makes its "best estimate" of the revenue it will collect from third-party payors. While these estimates may not change under the new revenue standard, health care entities will have to review their processes to make sure they properly address the new guidance on estimating variable consideration (and applying the constraint) and appropriately document their conclusions.

Next steps

- Entities should perform a preliminary assessment on how they will be affected as soon as possible so they can determine how to prepare to implement the new standard. While the effect on entities will vary, some may face significant changes in revenue recognition. All entities will need to evaluate the requirements of the new standard and make sure they have processes and systems in place to collect the necessary information to implement the standard, even if their accounting results won't change significantly or at all.
- Entities also may want to monitor the discussions of the Boards, the Securities and Exchange Commission (SEC) staff, the TRG and the health care industry task force formed by the AICPA to discuss interpretations and application of the new standard to common transactions.
- Public entities also should consider how they communicate the changes with investors and other stakeholders, including their plan for disclosures about the effects of new accounting standards discussed in SEC Staff Accounting Bulletin Topic 11.M. The SEC staff has indicated it expects an entity's disclosures to evolve in each reporting period as more information about the effects of the new standard becomes available, and the entity should disclose its transition method once it selects it.

Endnotes:

[1] Accounting Standards Update 2014-09, *Revenue from Contracts with Customers*.

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