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AN ALERT FROM THE BDO HEATHCARE PRACTICE

BDO KNOWS: HEALTHCARE ENTITIES

CONTENTS

PRESENTATION AND DISCLOSURE OF PATIENT SERVICE REVENUE AND THE PROVISION FOR BAD DEBTS

▶EXECUTIVE SUMMARY

In July 2011, the FASB issued ASU 2011-7[1] to require certain healthcare entities to reclassify the provision for bad debts associated with patient service revenue from an operating expense to a contra-revenue item on their statement of operations. The ASU also requires these healthcare entities to disclose patient service revenue net of contractual allowances and discounts, provide qualitative and quantitative information about changes in the allowance for doubtful accounts, and add information about their policies for recognizing revenue and assessing bad debts. The ASU scopes in healthcare entities that recognize significant amounts of patient service revenue at the time services are rendered, even though the entities do not assess a patient's ability to pay at that time. For example, Hospital A is required by law to provide emergency services regardless of a patient's creditworthiness. Accordingly, Hospital A records a significant amount of revenue without concluding that collectibility for services to such patients is reasonably assured, and it must therefore apply the presentation and disclosure requirements of ASU 2011-7. The ASU takes effect in 2012 for public and private healthcare entities (first quarter 2012 for public entities), and the new presentation requirements must be applied retrospectively for all periods presented.

1 ASU 2011-7, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*, is a consensus of the FASB's Emerging Issue Task Force.

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BACKGROUND

Healthcare entities are subject to a number of challenges due to the current economy. These entities are facing reimbursement pressure from their big three payors – Medicare, Medicaid and commercial health insurers. Healthcare entities are also experiencing higher levels of uncompensated care due to elevated unemployment, more uninsured patients and increasing patient responsibility for healthcare costs. As a result, financial statement users have been monitoring revenue and bad debt accounting methodologies for these entities.[2]

Some healthcare entities recognize patient service revenue at the time the services are rendered regardless of whether the entity expects to collect that amount and then separately record a bad debt expense for the portion they do not expect to collect. Financial statement users have raised concerns that such accounting practices result in a gross-up of patient service revenue and the related provision for bad debts. Also, because healthcare entities make their own judgments regarding adjustments to revenue and bad debts, those judgments are different from one healthcare entity to another, impairing comparability. The Emerging Issues Task Force (EITF) added Issue 09-H[3] to its agenda in Nov. 2009 to determine whether bad debt expense should be presented as contra-revenue or whether the collectibility of amounts billed for patient services should be reasonably assured before revenue is recognized.

The EITF considered amending the industry-specific guidance for healthcare entities to require that collectibility be assessed either before recognizing or when measuring revenue. However, there was concern that companies in this industry would be required to change revenue recognition practices twice: once as a result of Issue 09-H, and then upon completion of the FASB and IASB's joint project on revenue recognition.[4] As an interim step, the EITF reached a consensus that changes the presentation of certain patient service revenue. This approach does not resolve the recognition problem originally brought to the Task Force because ASU 2011-7 does not address revenue recognition. However, the Task Force believes that the resulting statement of operations presentation better aligns healthcare entities with the general revenue recognition guidance (ASC 605) applied by other industries.

Gross profit and gross margin percentage will generally decrease and operating margin percentage will generally increase as a result of presenting bad debt expenses for patient services as contra-revenue. EBITDA[5] and operating income for healthcare entities will not be affected by ASU 2011-7. The details of the ASU follow.

SCOPE AND PRESENTATION

ASU 2011-7 applies to entities within the scope of ASC 954 (healthcare entities) that recognize significant amounts of patient service revenue at the time the services are rendered even though they do not assess the patient's ability to pay at that time. As originally proposed, this issue would have applied to all revenue accounted for under ASC 954, including patient service revenue, premium revenue and other revenue. The EITF revised the final scope to limit the issue to patient service revenue, and consequently, the ASU does not change the presentation of bad debt expense related to nonpatient service revenue as operating expense.

If a healthcare entity has significant patient service revenues for which it has not assessed the patient's ability to pay, the entity should present the provision for all bad debts related to all patient service revenue as contra-revenue on the statement of operations. Specifically, if the entity has significant patient service revenue for which it has not assessed collectibility, separate line items should be provided on the face of the statement of operations for:

- Patient service revenue (net of contractual allowances and discounts);
- The provision for bad debts (the amount related to patient service revenue and included as a deduction from patient service revenue); and
- The resulting net patient service revenue less the provision for bad debts.

If a healthcare entity determines that the patient service revenues for which it does not assess the patient's ability to pay are insignificant, the entity must present the full provision for bad debts related to all patient service revenue as an operating expense. The ASU does not define "significant," and a healthcare entity will be required to exercise judgment to determine whether the level of the patient service revenue for which it has not assessed the patient's ability to pay meets this hurdle.[6]

2 The rating agencies have monitored the revenues of healthcare entities in recent years. For more recent rating agency reports, see Fitch Ratings June 8, 2011 report, *For-Profit Hospital Insights: A Review of Bad Debt Accounting Policies and Practices* at www.fitchratings.com. See also Moody's August 9, 2011 report, *Hospital Revenues in Critical Condition; Downgrades May Follow* at www.moodys.com.

3 See footnote 1.

4 See Revenue Recognition-Joint Project of the FASB and IASB for further information.

5 Earnings before interest, taxes, depreciation and amortization.

6 It is generally accepted in practice that a "significant level" is a percentage beginning in the single digits.

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BDO Comment: In order to determine its presentation of bad debt expense associated with all patient service revenue, a healthcare entity will need to determine whether it has a significant amount of patient service revenue for which it does not assess the patient's ability to pay. A significant amount = contra-revenue; An insignificant amount = operating expense.

To implement this presentation, healthcare entities will need to separately track bad debt expense for patient service revenue and other sources of revenue. Bad debt expense for all nonpatient revenues will continue to be presented as an operating expense. Generally, we do not believe significant system changes will be necessary to implement the ASU. An illustration of the new presentation requirements is provided in Appendix I, Example 3.

▶DISCLOSURES

The ASU requires a healthcare entity within its scope to provide the following disclosures for interim and annual periods:

a. Policy for assessing the timing and amount of uncollectible patient service revenue recognized as bad debts by major payor source of revenue. The major payor source categories should be consistent with how the entity manages its business. For example, one entity's accounting system may classify patient accounts receivables arising from deductibles and coinsurance as part of third-party receivables, another may classify deductibles and coinsurance as self-pay receivables, and another may classify deductibles and coinsurance as either third-party or self-pay receivables on the basis of which party has the primary remaining financial responsibility.

b. Qualitative and quantitative information about significant changes in the allowance for doubtful accounts related to patient accounts receivable. This may include information such as:
   - Significant changes in estimates and underlying assumptions;
   - The amount of self-pay writeoffs;
   - The amount of third-party payor writeoffs; and
   - Other unusual transactions impacting the allowance for doubtful accounts.

BDO Comment: The EITF's Issue 09-H consensus for exposure would have required healthcare entities to rollforward the allowance for doubtful accounts by major payor source of revenue. Based on respondent comments to the consensus for exposure, the Task Force decided to replace the rollforward by major payor source with qualitative and quantitative information about significant changes in the allowance for doubtful accounts related to patient accounts receivable. Now healthcare entities will need to provide insight into how and why the allowance for doubtful accounts changed. An example of this disclosure is provided in Appendix I, Example 1.

c. Policy for assessing collectibility in determining the timing and amount of patient service revenue (net of contractual allowances and discounts) to be recognized by major payor source of revenue; and

d. Patient service revenue (net of contractual allowances and discounts) before the provision for bad debts by major payor source of revenue.

BDO Comment: The ASU does not define major payor categories. As noted above, these categories should be consistent with how an entity manages its business. An example of this disclosure is provided in Appendix I, Example 2.

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EFFECTIVE DATE AND TRANSITION

For public healthcare entities, the ASU is effective for fiscal years and interim periods within those years beginning after Dec. 15, 2011. For nonpublic entities, the ASU is effective for the first annual period ending after Dec. 15, 2012, and interim and annual periods thereafter. Early adoption is permitted. Upon adoption, healthcare entities should present patient service revenue retrospectively for all periods presented. The new disclosures are required only on a prospective basis from the date of adoption.

OTHER RECENT HEALTHCARE ENTITY ASUs

Two other ASUs affecting healthcare entities became effective in 2011:

Measuring Charity Care for Disclosure – ASU 2010-23[7] was issued to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. Some entities determined their charity care disclosures on the basis of a cost measurement, while others used a revenue measurement since no guidance existed. Healthcare entities disclose the amount of charity care provided in their financial statement footnotes, not in their statement of operations. The ASU requires that healthcare entities use the cost basis of measurement for the charity care disclosures and that they identify cost as the direct and indirect costs of providing the care. Healthcare entities are also required to disclose the method they use to identify or determine such costs, such as obtaining the information directly from a costing system or through reasonable estimation techniques. The ASU was effective for fiscal years beginning after Dec. 15, 2010, and must be applied retrospectively to all prior periods presented.

Presentation of Insurance Claims and Related Insurance Recoveries – ASU 2010-24[8] was issued to address diversity in practice related to accounting by healthcare entities for medical malpractice claims and similar liabilities and their related anticipated insurance recoveries. Most healthcare entities have netted anticipated insurance recoveries against the related accrued liability, although some entities have presented the anticipated insurance recovery and related liability on a gross basis. The ASU clarifies that a healthcare entity should not net insurance recoveries against a related claim liability. Also, the entities should determine the amount of the claim liability without considering the insurance recovery. The ASU was effective for fiscal years, and interim periods within those years, beginning after Dec. 15, 2010. A cumulative-effect adjustment should have been recognized in opening retained earnings in the period of adoption if a difference existed between any liabilities and insurance receivables recorded as a result of applying the amendments in the ASU. The ASU permitted retrospective application.

7 ASU 2010-23, *Measuring Charity Care for Disclosure*, is a consensus of the FASB Emerging Issue Task Force.
8 ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*, is a consensus of the FASB Emerging Issue Task Force.

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APPENDIX I

EXAMPLE 1 – POLICY DISCLOSURE AND QUALITATIVE AND QUANTITATIVE INFORMATION ABOUT CHANGES IN THE ALLOWANCE FOR DOUBTFUL ACCOUNTS

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, Entity A analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, Entity A analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), Entity A records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Entity A's allowance for doubtful accounts for self-pay patients increased from 90 percent of self-pay accounts receivable at Dec. 31, 20X1, to 95 percent of self-pay accounts receivable at Dec. 31, 20X2. In addition, Entity A's self-pay writeoffs increased $1,000,000 from $8,000,000 for fiscal year 20X1 to $9,000,000 for fiscal year 20X2. Both increases were the result of negative trends experienced in the collection of amounts from self-pay patients in fiscal year 20X2. Entity A has not changed its charity care or uninsured discount policies during fiscal years 20X1 or 20X2. Entity A does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant writeoffs from third-party payors.

EXAMPLE 2 – POLICY FOR ASSESSING COLLECTIBILITY

Entity A recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. Entity A recognizes significant amounts of patient service revenue at the time services are rendered even though it does not assess the patient's ability to pay. For uninsured patients who do not qualify for charity care, Entity A recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of Entity A's uninsured patients will be unable or unwilling to pay for the services provided. Thus, Entity A records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Third Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 50,000	$ 10,000	$ 60,000

EXAMPLE 3 – PATIENT SERVICE REVENUE BY MAJOR PAYOR SOURCE OF REVENUE

On the statement of operations:

Patient service revenue (net of contractual allowances and discounts)	$ 60,000
Provision for bad debts	(9,600)
Net patient service revenue less provision for bad debts	50,400
Premium revenue	23,000
Other operating revenue	14,000
Total revenue	**$ 87,400**

Note: The examples in Appendix I have been reproduced from ASU 2011-7.