FASB Revenue Recognition

Electronic Feedback Form Response

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Respondent information

Type of entity or individual:

Preparer

Contact information:

Organization: Gundersen Lutheran Health System

Name: Gordon T Edwards

Email address: gtedward@gundluth.org

Phone number: 6087751951

Questions and responses

1. Paragraphs 35 and 36 specify when an entity transfers control of a good or service over time and, hence, when an entity satisfies a performance obligation and recognizes revenue over time. Do you agree with that proposal? If not, what alternative do you recommend for determining when a good or service is transferred over time and why?

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2. Paragraphs 68 and 69 state that an entity would apply Topic 310 or IFRS 9 to account for amounts of promised consideration that the entity assesses to be uncollectible because of a customer's credit risk. The corresponding amounts in profit or loss would be presented as a separate line item adjacent to the revenue line item. Do you agree with those proposals? If not, what alternative do you recommend to account for the effects of a customer's credit risk and why?

The requirement to present the impact of credit risk on the face of the income statement is too prescriptive and that entities should be given the option to present this information in the footnotes to the financial statements.

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3. Paragraph 81 states that if the amount of consideration to which an entity will be entitled is variable, the cumulative amount of revenue the entity recognizes to date should not exceed the amount to which the entity is reasonably assured to be entitled. An entity is reasonably assured to be entitled to the amount allocated to satisfied performance obligations only if the entity has experience with similar performance obligations and that experience is predictive of the amount of consideration to which the entity will be entitled. Paragraph 82 lists indicators of when an entity's experience may not be predictive of the amount of consideration to which the entity will be entitled in exchange for satisfying those performance obligations. Do you agree with the proposed constraint on the amount of revenue that an entity would recognize for satisfied performance obligations? If not, what alternative constraint do you recommend and why?

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4. For a performance obligation that an entity satisfies over time and expects at contract inception to satisfy over a period of time greater than one year, paragraph 86 states that the entity should recognize a liability and a corresponding expense if the performance obligation is onerous. Do you agree with the proposed scope of the onerous test? If not, what alternative scope do you recommend and why?

Par. 90 of the ED exempts not-for-profit entities from the requirements to report onerous performance obligations "if the purpose of the contract is to provide a social or charitable benefit." No further elaboration is provided, and the Board's intention regarding the scope exception is not clear. Many not-for-profit organizations (including all 501(c)(3) not-for-profit organizations) have a stated mission of providing some form of social or charitable benefit. Thus, organizations might interpret par. 90 as applying to any contract executed in carrying out their mission, even if that contract is entered into on normal commercial terms (for example, a contract between a not-for-profit HMO and an employer).

According to BC353, the exception was intended to apply to contracts whose purpose is to provide a social or charitable benefit because those types of contracts may not always have a profit-making objective, and recording a liability for future losses under such contracts would be "inconsistent with the objective of financial reporting for not-for-profit entities." This explanation also is too ambiguous to be of use in consistent application of the guidance. Par. 8 of Concepts Statement 4, Objectives of Financial Reporting by Nonbusiness Organizations, states that

"Some [not-for-profit] organizations have no ownership interests but are essentially self-sustaining from fees they charge for goods and services. Examples are those private nonprofit hospitals and nonprofit schools that may receive relatively small amounts of contributions and grants but finance their capital needs largely from the proceeds of debt issues and their operating needs largely from service charges rather than from private philanthropy or governmental grants…..[T]he objectives of Concepts Statement 1 [objectives of financial reporting by business organizations] may be more appropriate for those organizations."

The EP encourages the Board to clarify the situations to which the exception was intended to apply. Does the Board intend it to apply solely to some or all organizations that are organized as not-for-profit (for example, to all entities that meet the definition of a not-for-profit organization in the ASC Glossary; or only to "nonbusiness" not-for-profit entities with the objectives of financial reporting described in CON Statement 4)? Or was the Board's intent more transaction-focused (for example, part-exchange-part-contribution transactions that are structured with charitable intent; transactions involving a price that is established with an expectation that it will be supplemented by charitable gifts or endowment income)? Without this clarification, there cannot be consistency in application.

Furthermore, clarity surrounding how the multi-year contract is evaluate is important. For instance, most providers enroll with Medicare or Medicaid programs. They continue to be considered providers under these programs unless they terminate this relationship. In most cases, these providers continue within the program for multiple years and the payment for services is less than the costs to deliver. However, providers have the opportunity to withdraw or limit who they treat, these types of provisions likely result in a contract that is not viewed as greater than one year. Potentially a clarification that the contract is noncancellable for a period of more than one year, might help.

5. The Boards propose to amend Topic 270 on interim reporting and IAS 34, Interim Financial Reporting, to specify the disclosures about revenue and contracts with customers that an entity should include in its interim financial statements. The disclosures that would be required (if material) are: A. The disaggregation of revenue (paragraphs 114 through 116) B. A tabular reconciliation of the movements in the aggregate balance of contract assets and contract liabilities for the current reporting period (paragraph 117) C. An analysis of the entity's remaining performance obligations (paragraphs 119 through 121) D. Information on onerous performance obligations and a tabular reconciliation of the movements in the corresponding onerous liability for the current reporting period (paragraphs 122 and 123) E. A tabular reconciliation of the movements of the assets recognized from the costs to obtain or fulfill a contract with a customer (paragraph 128). Do you agree that an entity should be required to provide each of those disclosures in its interim financial statements? In your response, please comment on whether those proposed disclosures achieve an appropriate balance between the benefits to users of having that information and the costs to entities to prepare and audit that information. If you think that the proposed disclosures do not appropriately balance those benefits and costs, please identify the disclosures that an entity should be required to include in its interim financial statements.

The proposal requires too many disclosures in both interim and annual financial statements. There is a risk of obscuring useful information due to the volume of disclosures required. A simplified or reduced disclosures will better balance the objectives of users and the burden on preparers. I do not agree with the inclusion of predictive and forward-looking disclosures, as they present significant challenges and could be based on assumptions that are difficult to support.

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6. For the transfer of a nonfinancial asset that is not an output of an entity's ordinary activities (for example, property, plant, and equipment within the scope of Topic 360, IAS 16, or IAS 40), the Boards propose amending other standards to require that an entity apply the proposed guidance on control to determine when to derecognize the asset and apply the proposed measurement guidance when determining the amount of gain or loss to recognize upon derecognition of the asset. Do you agree that an entity should apply the proposed control and measurement guidance to account for the transfer of nonfinancial assets that are not an output of an entity's ordinary activities? If not, what alternative do you recommend and why?

A1. Do you agree that the proposed amendments that codify the guidance in the proposed Update on revenue recognition have been codified correctly? If not, what alternative amendment(s) do you recommend and why?

A2. Do you agree that the proposed consequential amendments that would result from the proposals in the proposed Update on revenue recognition have been appropriately reflected? If not, what alternative amendment(s) do you recommend and why?

ClarifyingComments. Please provide any additional comments on the proposed Update:

Recognition of revenue for indigent self-pay patients

The FASB and EITF invested significant time in developing ASU 2011-07, Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities. This ASU was intended to be an interim step in addressing revenue recognition for uninsured self-pay patients who do not qualify for charity care until the Board's joint project on revenue recognition could be completed (ASU 2011-07, BC4). Despite the time and attention focused on the indigent self-pay revenue recognition issue at that interim point in the joint revenue recognition project, the ED is not clear on whether or how health care entities should recognize revenue associated with services provided to those patients. For example:

•One HCO might conclude that the contract criteria of paragraph 14 are met and that the amount of consideration to which the entity expects to be entitled would be based on the HCO's policy for pricing services to uninsured patients, with collectability concerns addressed by reflecting contra-revenue (bad debt). That view is consistent with the ASU 2011-07 model.

•Another concludes that the contract criteria of paragraph 14 have been met, but interprets the transaction price requirements differently. For example, it might conclude that the amount of consideration to which it expects to be entitled should be estimated in the aggregate for a portfolio of self-pay patients with similar characteristics using the provisions for estimating variable consideration (i.e. reflecting either the expected value of the portfolio or the most likely amount for the portfolio), since it typically does not know which specific patient will pay or how much they will pay.

•A third HCO might conclude that the contract criteria in paragraph 14 cannot be met with respect to this class of patient, because the significant doubt at contract inception about the collectability of consideration from the patient would indicate that the patient is not committed to perform his/her obligations to pay or that the contract does not have commercial substance. That HCO presumably would report revenue from this class of patient on a cash basis

As a result, for a hypothetical group of self-pay patients that in the aggregate has gross charges of $10,000 and a collection history of 5%, the first HCO would accrue revenue of $10,000 and recognize contra-revenue of $9,500; the second HCO would accrue revenue of $500 and recognize little or no bad debt expense/contra revenue; and the third HCO would accrue zero revenue at the time of service and instead, recognize $500 of revenue in the periods the cash payments are received. Without further clarification of how the revenue recognition criteria should be applied for this type of "customer," HCO financial statements will be less comparable and less useful to users than they are under the interim guidance of ASU 2011-07. The Boards should either clarify the principles or provide implementation guidance illustrating how the principles should be applied in this situation.

Use of "most likely amount" in estimating variable consideration

In the health care industry, the amount of revenue earned under arrangements with government programs (for example, Medicare or Medicaid) is determined under complex rules and regulations that subject the health care entity to the potential for retrospective adjustments in future years. Several years may elapse before all potential adjustments related to a particular fiscal year are known and before the amount of revenue to which the health care entity is entitled is known with certainty. As a result, revenue from contracts with government payers typically contains a variable element that requires providers to estimate the cash flows ultimately expected to be received for services provided during a contract period. Under current GAAP (ASC 954), management generally makes its “best estimate” of the third-party settlement adjustments required based on its knowledge and experience about past and current events. Paragraph 55 of the ED indicates that when an element of consideration is variable, an entity's estimates shall either be based on the expected value (derived from a probability-weighted calculation) or the most likely amount (derived from the "best estimate”). An entity should

select the method which it expects to provide the best prediction of the amount of variable consideration. Paragraph 55 goes on to state that "an expected value may be an appropriate estimate of the transaction price if an entity has a large number of contracts with similar characteristics," and that "the most likely amount may be an appropriate estimate of the transaction price if the contract has only two possible outcomes (for example, an entity either achieves a performance bonus or does not)."

A health care entity's contracts with government programs such as Medicare or Medicaid—the largest purchasers of health care in the U.S.—do not have characteristics similar to either of the examples provided in par. 55. A health care entity initially signs an agreement with a government program which renews on a year to year basis unless the entity voluntarily withdraws or is disbarred from participating in the program. As a result, it represents a single contract with many years of renewals. In many cases, institutional providers' experience in estimating settlements associated with these contracts will extend back more than 40 years. Many health care entities are likely to conclude that the best predictor of the variable consideration is continued use of their best estimate. However, it's not clear whether paragraph 55 is intended to create a rebuttable presumption that the best estimate method should only be used when outcomes are binary. Without clarification of whether this is intended to be a rebuttable presumption, it will create tension between an entity and its auditor related to judgments in this area. The method selected should be based solely on the entity's judgment.

Revenue transactions involving multiple contractual relationships

A unique aspect of health care operations is that revenue transactions primarily involve more parties than the traditional “buyer” and “seller.” As many as four parties may be associated with a revenue transaction involving an institutional health care entity such as a hospital. These include: (1) the individual who receives the medical care; (2) the physician who orders the required services on behalf of the patient; (3) the hospital that provides the setting or administers the treatment; and (4) a third-party payer that pays the hospital on behalf of the patient (for example, Medicare, Medicaid, or a managed care plan).

As a result, the provision of services to the patient may involve a network of contractual relationships, illustrated as follows. A hospital admits a Medicare patient. The hospital will have an overall contract with Medicare (the primary payer) setting forth the terms and conditions of payment for services provided to any Medicare beneficiaries treated by the hospital, and will also execute a contract with the patient related to his or her specific admission. The contract with Medicare will indicate the services which are covered or not covered, the amount that can be charged for the services, and the amount of the patient's responsibility for the services provided. Historically, the contract with the primary payer has driven the timing and amount of revenue recognized. Other contractual relationships will affect the hospital's ability to collect the agreed-upon sales price from among the various parties. These include the portion payable by Medicare (as the primary payor), the portion due from one or more secondary payors (for example, an AARP Medicare supplement policy that pay certain costs that otherwise would be the responsibility of the patient, based on a contract between the patient and AARP), and the remaining patient responsibility. Each contract referenced above would have been entered into at different times and on different terms.

Furthermore, the contracts with insurance entities (e.g. medicare, Blue Cross, Medicaid, etc), have expanded to include a pay for performance provisions, such that the insurance entity not only clarifies the payment for the services provided to its members, but payments may also be contingent on the overall metric scores for a group of patients (their own or others), such readmission rates, documentation of smoking cessation, utilization of services provided at other organizations, and many other provisions. Finally, the patient may have a greater and greater responsibility to pay for the services with deductibles that can be as high a $10,000 prior to any insurance payment (however the insurance contract with the provider will dictate the payment amount even if all of it falls under the deductible).

Paragraphs 13–15 of the proposed ASU would indicate that all of these arrangements are "contracts," as they are in writing, have commercial substance, and identify each party’s rights

and payment terms. However, guidance in ASC 954-280-45-1 states that third-party payors are not "customers" of a health care organization for purposes of providing disclosures by segment and provides the following rationale:

"When providing information about major customers pursuant to paragraph 280-10-50-42, an insuring entity shall not be considered the customer of a health care facility. The fact that an insuring entity is a paying agent for the patient does not make the insuring entity the customer of the health care facility because the insuring entity does not decide which services to purchase and from which health care facility to purchase the services. The latter two factors are important in determining the customer."

As a result of the guidance in ASC 954-280, different conclusions could be reached regarding whether third-party payer contracts can be considered "contracts with customers" for purposes of applying the ED. Differences in interpretation would result in differences in applying the revenue recognition process described in ED as well as in applying the onerous contract provisions.

In addition, the ED's provisions around combining of contracts—which did not contemplate the health care situation—is likely to present challenges to health care providers attempting to interpret and apply the guidance in light of the transaction structures described above. For example, one of the criteria is that the contracts are entered into at relatively the same time. Potentially, expanding the provisions such that the timing of the contract is less important, but that if the two contracts pay for the same services they must be combined. This could limit some of the interpretation issues.

Similar challenges are likely to arise with respect to accounting for the effects of a customer's credit risk on a contract asset (because multiple payers are involved) as well as on grouping of performance obligations for evaluation of onerous contracts.

Implementation Guideance

The Board has done a nice job in outreach with various groups throughout this process. However, after a final standard is developed, partnering with different industry groups such as AICPA expert panels, HFMA P&P Board, or others allowing those organizations to develop the implementation guidance that could be "reviewed" by the FASB for the most common transactions could be very helpful to preparers, auditors and other users of the financial statements.

OtherComments. Please provide any comments on the electronic feedback process:

Form was easy, suggest the boxes are bigger for reviewing comments, and ideally spell check.
