November 15, 2010

Jeffrey D. Mechanick
Assistant Director
Financial Accounting Standards Board
401 Merritt 7
Norwalk, Connecticut 06856-5116

Dear Mr. Mechanick:

File Reference No. 1820-100 Exposure Draft of a Proposed Accounting Standard Update - Revenue from Contracts with Customers

Thank you for the opportunity to attend the Revenue Recognition Roundtable. I support the Board’s overall goal of creating a single revenue recognition model. While the Board has made considerable progress since issuance of the 2008 Discussion Paper, I believe further consideration and deliberation is warranted. I therefore respectfully request that the boards and their respective staffs consider the following observations:

Scope

Within the not-for-profit healthcare industry, entities may receive grants and/or donations from individuals, foundations, corporations, not-for-profit organizations, and government agencies. These organizations may require the entity to perform certain activities and/or achieve specific targets. Typically, an entity submits an application outlining the proposed activities/targets, timelines, and requested amounts. Even philanthropic donations may subject the health care entity to performance obligations, such as naming the building, achieving specified outcomes, or other expectations to earn the donation. In the current accounting guidance, determining whether these transactions represent an exchange in which the granting organization expects to receive commensurate value is unclear. As a result, organizations may account for similar activities differently. Given the goal of creating a single revenue recognition model, clarifying when activities represent an exchange transaction in which each party receives and sacrifices commensurate value would be beneficial.
Identifying the contract(s) with a customer

Within the healthcare industry, there are many contracts that apply to the services provided. A provider (e.g. hospital, physician) enters into contracts with various insurance companies to compensate the provider when services are provided to their members. These contracts may be executed years prior to services being provided. Sometimes, these contracts maybe executed after the service was provided. For government programs, a provider may enroll in the Medicare and Medicaid program and that enrollment will remain in effect for decades. In addition, at the time the service is rendered the provider will enter into an agreement with the patient who will be responsible for payment regardless of any insurance coverage they may have. A patient may have multiple insurance carriers responsible for compensating the provider and/or patient for services received. For example, a patient has a specific procedure performed at the hospital. The hospital may receive payment from the patient, multiple insurance companies, and government agencies for that single service. Sometimes these payments are based on the relative prices within those insurance contracts, but sometimes they may not (e.g. different coverage limits). Currently, revenue recognition is driven based on the contract with the patient who receives the service and is not triggered based on the insurance contracts and/or government programs. The contracts with insurance carriers or government agencies impact the estimated consideration received.

The exposure draft only allows for the combination of contracts when the prices are interdependent and when contracts are executed at similar times. As a result, a provider may be required to account for the contract with the insurance carrier separately from the contract with the patient receiving the services. From an economic standpoint, only one surgery was performed, while multiple contracts may be relevant to determine the consideration to be received for that service. The proposed guidance only allows for combination when price is interdependent, which could result in accounting for these contracts separately.

The governing principle for accounting for contract combinations should be based on the economics of the transaction and not simply on price considerations or timing of contract execution. When the facts and circumstances surrounding the negotiation of the contract indicate they are economically or functionally interdependent, then combining those arrangements seems reasonable. The indicators of interdependence should be amended to include price and also address the additional concepts of economic and functional interdependence.

In situations where multiple contracts are applicable to a single unit of service, identifying a primary contract for recognition purposes would be helpful. Under the exposure draft, revenue recognition begins with entering into a contract with a customer. For a health care entity, there are multiple contracts that apply. These contracts are primarily segregating the individual receiving the service from the entity compensating for the service. Thus, determining the event that triggers revenue recognition is difficult. The contract with the person receiving the service (e.g.
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surgery, x-ray), seems like the appropriate event to trigger revenue recognition when compensated based on the specific service. The other contracts are focused on compensating for that service rather than contracting for the provision of that service. Alternatively, if the provider is compensated based on a fixed rate to provide services for all members of a health plan over a given period of time, then recognition of revenue should be triggered with the contract with the health plan. Given these complexities guidance that determines a primary contract when multiple contracts are applicable to determine the revenue recognition event would be helpful. The economic independence approach discussed above might address this concern.

**Determination of transaction price**

I agree with the proposal that when consideration is variable revenue recognition should be based on the overall estimation of the transaction price. However, there are a few aspects that I would like the Board to reconsider:

- **Credit risk.** In the US, hospitals are required to provide services to patients for emergent conditions without regard to their ability to pay. As a result, the extension of credit occurs without any decision made by the organization. The transaction price should reflect the credit risk when such risk is reliability measured. However, subsequent changes to the original estimates should be reflected as an adjustment to revenue versus as income or expense as proposed.

- **Time value of money.** Given the collection process, the receipt of payment on a specific patient account may take considerably longer than originally estimated. While this is likely immaterial, having a practical expedient methodology to permit organizations to appropriately reach such conclusion would be appreciated.

- **Allow for “best estimate” versus probability weighted methodology.** In the current environment, many providers make an assumption as to the insurance carrier who covers the individual patient. Patients forget to communicate that their coverage changed or unable to communicate insurance coverage, some patients receive retrospective coverage, and multiple insurance carriers or government agencies may be responsible for portions of these bills. As a result, the patient account may change carriers and estimated transaction price frequently. Applying a probability weighted methodology, will likely increase the complexity of estimating the transaction price. A best estimate would be more consistent with current practice. Either way, changes in this estimate are adjustments to revenue.

**Performance Obligation**

As discussed above, a health care entity has multiple contracts that may be associated with the specific service being provided. The onerous performance obligation guidance creates a unique challenge within the industry. For many organizations, the compensation from Medicare and Medicaid programs do not cover the direct costs (as defined in the exposure draft) of providing care to these patients.
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Health care entities charge commercial insurance companies substantially more to cover the uncompensated costs of government programs. Cost shifting between government programs and commercial insurance carriers (e.g. US employers) is commonly known within the industry. The onerous performance obligation guidance would imply that a health care organization record a loss associated with these programs for future services not yet rendered. This would become problematic to estimate. The number, types of services, and even future compensation amounts may not be known at the reporting date. The compensation associated with these government programs are driven based a variety of factors including available tax revenues, and political environment within federal, state and local governments. Furthermore, the cost to provide those services change over time as well as, technological changes that modify how services are performed. As mentioned previously, if the contract is defined based on the contract with the patient receiving the care this is unlikely an accounting issue. If the contract is defined based on enrollment with government programs, this would become a significant accounting issue within the industry and unsure what value this would provide the users of the financial statements.

Disclosures

The proposed disclosures described in the exposure draft are excessive in scope and require a level of detail that may confuse the readers of the financial statements further. In particular, the inclusion of forecasted information within the financial statement footnotes present significant challenges. Beyond the limitations of preparers to support key assumptions about future events, this creates legal exposure to the organizations. Predictive disclosures are more appropriate when include in other documents that have appropriate Safe Harbor provisions.

Implementation guidance

The implementation guidance provided is too simplistic to meet the needs of all industry groups. I strongly encourage the FASB work with industry groups such as the HFMA Principles and Practices Board, AICPA Industry groups and others to provide better guidance. For example, use these groups to interpret the “final” standard for common transactions with in their industries. Those interpretations could be reviewed by the FASB to ensure there are no unintended consequences of the new standard as well as ensure consistent implementation across the industry.

Transition

The FASB is proposing many changes to generally accepted accounting principles. There is no consistency in the application approach among these proposed standards. For revenue recognition, the FASB is proposing retrospective application. However, given the complexity and duration of contracts, preparers may be unable to accurately determine the appropriate amounts. Retrospective application may not be practicable in many circumstances.
I would recommend that the Board consider adopting a single transition guidance for all convergence standards. Such transition guidance may require organizations to adopt all of the proposed standards contemporaneously on a prior to specified date. In general, retrospective application will be problematic.

I would recommend that the Board re-expose this standard after your re-deliberation.

Once again thank you for allow me to attend this event and share my perspective. Enjoy the holiday weekend.

Sincerely,

Gordon T. Edwards, CPA, FHIMA
Vice President & Controller