FASB Emerging Issues Task Force

Issue No. 09-H

Title: Selected Healthcare Organization Issues (Revenue Recognition; Presentation of Insurance Claims and Related Insurance Recoveries; and Measuring Charity Care for Disclosure)

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Previously distributed EITF materials: None

Background

1. The Task Force is being asked to consider three issues that affect accounting by Heath Care Organizations (HCOs). The three issues and their related backgrounds are provided concurrently below. The term "gross charge" used throughout this Issue Summary refers to the gross fee established by the HCO for a service before consideration of any available contractual allowances with insurance companies or other discounts. It is sometimes referred to as established rate or list price.

*** The alternative views presented in this Issue Summary are for purposes of discussion by the EITF. No individual views are to be presumed to be acceptable or unacceptable applications of Generally Accepted Accounting Principles until the Task Force makes such a determination, exposes it for public comment, and it is ratified by the Board.**

Accounting Issues and Alternatives

Issue 1: Whether collectibility must be reasonably assured prior to an HCO recognizing revenue.

Background

2. HCOs may perform services for which the ultimate collection of all or a certain portion of the amount billed or billable is not expected at all, is doubtful, or cannot be determined at the time the services are rendered. In some situations, the HCO records no revenue—for example, charity care. Charity care is when HCOs provide services to certain patients without expectation of payment (or cash inflows), and is provided to patients generally who meet certain guidelines established by the HCO, such as prescribed financial criteria of the patient.

3. Amounts charged to patient accounts prior to the application of policy or contractual discounts or adjustments, such as downward adjustments from the gross charge based on a decision to accept the terms of a third-party payor under contract terms or by regulation (for example, commercial insurance carrier or Medicare), generally are recorded as gross revenue in the accounting records but are adjusted downward in determining net revenue reported in the financial statements. Courtesy discounts, such as rates charged to HCO staff members and employees, are similarly deducted from gross revenue to determine net revenue.

4. For billings to self-pay (uninsured) patients, it has been industry practice for the HCO to adopt a revenue recognition policy to record revenue at the gross charge along with a relatively high bad debt provision. The HCOs that adopt this policy also record as revenue the full amount billed for an insured patient and record a relatively high bad debt provision for the portion of the amount due that is not covered by insurance, or for the amount due for deductibles and co-pays. The bad debt provision is generally classified as an expense and not as a reduction to revenue. Other HCOs have adopted accounting policies that require amounts billed to be reasonably assured of collection before recognizing revenue.

5. Gross revenue of an HCO is not generally presented in the HCO's financial statements because of the significance of discounts (contractual allowances) taken to arrive at net patient service revenue, which is usually the starting point of an HCO's statement of income or operations. For example, if a fully insured patient receives services with gross charges of $1,000, but the contract rate with the insurer is $700, then the net revenue line would show $700 as revenue. That differs from the self-pay patient situation where the $1,000 gross charge would be shown as net revenue and a bad debt expense recorded to adjust to the expected amount to be collected.

6. There is a wide spectrum of collection rates for self-pay gross charges. In some facilities, the patient demographics consist of highly insured patients for whom self-pay charges are generally limited to co-payments and deductibles. These facilities may have very high collection rates for self-pay gross charges, in some cases greater than 90 percent. Other facilities have a large population of uninsured patients. These patients may not qualify for the facility's charity care, either because they exceed prescribed financial criteria for charity care established by the facility or because they are unable to provide documentation of their qualification for charity care. These facilities may have a very low collection rate for self-pay gross charges, in some cases less than 10 percent.

7. Section 954-605-25 of the FASB Accounting Standards Codification™ (the Codification), addresses the recognition of revenue by HCOs. Paragraphs 954-605-25-3 through 25-6 state the following:

> In general, gross service revenue is recorded in the accounting records on an accrual basis at the provider's established rates, regardless of whether the health care entity expects to collect that amount.
>
> The provision for contractual adjustments (that is, the difference between established rates and third-party payor payments) and discounts (that is, the difference between established rates and the amount collectible) are recognized on an accrual basis and deducted from gross service revenue to determine net service revenue.

Paragraph 954-310-05-2 states that amounts realizable from third-party payors for health care services are usually less than the provider's full established rates for those services.

Estimates of contractual adjustments, other adjustments, and the allowance for uncollectibles shall be reported in the period during which the services are provided even though the actual amounts may become known at a later date. This later date may be any one of the following:

a. When the person is discharged
b. Subsequent to discharge or completion of service
c. When the third party is billed
d. When payment or partial payment is received.

View A: Collectibility shall be reasonably assured prior to an HCO recognizing revenue.

8. Proponents of View A believe that the principle that collectibility should be reasonably assured before revenue can be recognized should be applied to all entities including HCOs. That view is consistent with the general guidance for revenue recognition in Topic 605. Specifically, paragraph 605-10-25-1 indicates:

The recognition of revenue and gains of an entity during a period involves consideration of the following two factors, with sometimes one and sometimes the other being the more important consideration:

a. Being realized or realizable. Revenue and gains generally are not recognized until realized or realizable. Paragraph 83(a) of FASB Concepts Statement No. 5, *Recognition and Measurement in Financial Statements of Business Enterprises*, states that revenue and gains are realized when products (goods or services), merchandise, or other assets are exchanged for cash or claims to cash. That paragraph states that revenue and gains are realizable when related assets received or held are readily convertible to known amounts of cash or claims to cash.

b. Being earned. Paragraph 83(b) of FASB Concepts Statement No. 5, *Recognition and Measurement in Financial Statements of Business Enterprises*, states that revenue is not recognized until earned. That paragraph states that an entity's revenue-earning activities involve delivering or producing goods, rendering services, or other activities that constitute its ongoing major or central operations, and revenues are considered to have been earned when the entity has substantially accomplished what it must do to be entitled to the benefits represented by

> the revenues. That paragraph states that gains commonly result from transactions and other events that involve no earning process, and for recognizing gains, being earned is generally less significant than being realized or realizable.

9. Paragraphs 605-10-25-3 and 25-4 go on to state:

> Revenue should ordinarily be accounted for at the time a transaction is completed, with appropriate provision for uncollectible accounts. Paragraph 605-10-25-1(a) states that revenue and gains generally are not recognized until being realized or realizable and until earned. Accordingly, unless the circumstances are such that the collection of the sale price is not reasonably assured, the installment method of recognizing revenue is not acceptable.
>
> There may be exceptional cases where receivables are collectible over an extended period of time and, because of the terms of the transactions or other conditions, there is no reasonable basis for estimating the degree of collectibility. When such circumstances exist, and as long as they exist, either the installment method or the cost recovery method of accounting may be used. As defined in paragraph[s] 360-20-55-7 through 55-9, the installment method apportions collections received between cost recovered and profit. The apportionment is in the same ratio as total cost and total profit bear to the sales value. Under the cost recovery method, equal amounts of revenue and expense are recognized as collections are made until all costs have been recovered, postponing any recognition of profit until that time.)

10. Proponents of View A do not believe recognition of revenue by HCOs should be different from other industries. Proponents of View A also believe that a strict reading of paragraph 954-605-25-4's phrase "that is, the difference between established rates and the amount collectible," requires collectibility to be considered in the initial measurement of net revenue.

11. Opponents of View A note that the unit of accounting for revenue recognition under Topic 605 is the individual contract (patient level). Opponents of View A note that unlike other businesses, in HCOs there is not always a decision to extend credit to the patients. When a patient arrives at a facility, the facility may know very little about the patient. Nonetheless, the patient may require immediate medical attention that is provided without consideration of the patient's ability or willingness to pay for those services. Opponents of View A believe that

delaying revenue recognition until collectibility is reasonable assured at the patient level does not appropriately reflect the economics of a particular transaction.

12. Proponents of View A reject the argument that there isn't a decision to extend credit to patients. Rather, proponents of View A believe that the decision to extend credit to patients is inherent in the business model of HCOs. Proponents of View A believe that depending on the patient demographics and the facility's history with self-pay individuals, a HCO may be able to evaluate collectibility at the individual patient level by considering the characteristics of the pool of patients the HCO typically serves. For example, Facility X might consider the pool of patients it typically serves and its history of a very high level of collection of self-pay charges and conclude that collectibility is reasonably assured. Proponents of View A believe that Facility X should recognize 100 percent of self-pay charges and perhaps a small reserve for bad debts. Conversely, proponents of a HCO without a high level of collection of self-pay charges would not be able to conclude collectibility is reasonably assured and would defer recognition until collectibility is determined to be reasonably assured.

View B: Collectibility does not have to be reasonably assured prior to an HCO recognizing revenue.

13. Proponents of View B believe that, other than for cases known from the outset to be charity care, there is an initial expectation of collection at the time services are rendered to an individual, including a self-pay individual. When an individual arrives at the HCO for treatment, the HCO does not necessarily always have enough information to determine whether or not the patient qualifies for charity care or what level of payment they will make. View B proponents assert that the guidance does not allow an HCO to consider whether collection is reasonably assured before recognizing revenue. They rely primarily on paragraphs 954-605-25-3 and 25-6 in reaching that conclusion; in other words, they focus on the concepts in the literature that gross revenue is reported regardless of whether the HCO expects to be paid, and that collectibility is often not known in the period services are provided.

14. Proponents of View B believe that bad debt allowances are recorded timely and appropriately, but note that these allowances are determined on a portfolio basis, rather than on an individual account basis. They believe that HCOs generally lack the information to assess collectibility on an individual basis, and if HCOs were required to evaluate collectibility prior to the initial recognition of revenue, that revenue often would not be recognized until cash was collected. These proponents believe that recording revenue and estimating and recording bad debts on a portfolio basis is more reflective of the ultimate economics than not recognizing any revenue until collectibility for an individual case is known.

15. Opponents of View B reject the argument that recording revenue and a large bad debt reserve is more reflective of the ultimate economics because it results in the HCO recording revenue on charges that are not expected to be collected.

View C: Collectibility does not have to be reasonably assured prior to an HCO recognizing revenue. Collectibility should be considered in measurement, rather than initial recognition

16. Proponents of View C believe that HCOs with a history of serving a given community may be able to make reasonable estimates of collectibility at the portfolio level. Proponents of View C consider, by analogy, the guidance in Section 605-10-25 regarding product sales when a right of return exists.

17. Proponents of View C believe that the assessment of collectibility should be considered in measurement rather than initial recognition. Proponents of View C believe that a HCO should be allowed to recognize revenue for the portion of charges it expects to collect from the portfolio of self-paying individuals. For example, proponents of View C believe that a HCO that historically collects 40 percent of self-pay gross charges should recognize 40 percent of the gross charge when the services are performed.

18. Proponents of View C note that requiring collectibility to be a consideration in measurement, rather than initial recognition, is consistent with the tentative conclusion in the current FASB and IASB joint project on revenue recognition. While the unit of accounting in

the joint revenue recognition project is the individual contract, proponents of View C believe that the historical experience with the portfolio of customers may be used to determine the expected value of revenue.

19. Opponents of View C do not believe that healthcare services are sufficiently different from other service providers to warrant industry-specific guidance. They believe that if collectibility is required to be considered in measurement rather than initial recognition, it should be allowed for all industries. Opponents of View C also believe that there are other issues that will need to be addressed if collectibility becomes a measurement consideration, such as re-measurement (Day 2) accounting. They believe that these changes should be considered in the FASB's current joint project on revenue recognition for all industries.

Staff Recommendation

20. The staff recommends View A. The staff does not believe that there should be industry exceptions to the revenue recognition guidance on collectibility.

Recurring Disclosure

21. HCOs are required by paragraph 954-60-50-1 to disclose their methods of revenue recognition.

22. The FASB staff does not believe any additional recurring disclosures would be required as a result of the resolution of this Issue.

Transition Method and Transition Disclosures

23. Paragraphs 250-10-50-1 through 50-3 are applicable for any change in accounting principle, including a change in the method of applying an accounting principle. As such, companies will be required to follow the disclosure requirements in Section 250-10-50. The staff recommends that the Task Force not require any additional disclosures other than the requirements in Section 250-10-50.

24. If a consensus is reached on View B, the staff does not believe transition will be an issue as entities will likely continue to follow their existing policies. However, a consensus for View A or View C would result in a change in accounting for some entities. As such, the transition considerations below are focused on a View A or View C consensus. As a consensus would eliminate diversity in practice, the FASB staff believes early adoption should be permitted.

View A: This consensus should be applied prospectively from the date of adoption.

25. Proponents of View A believe that HCOs that have not historically assessed collectibility in determining revenue recognition, should not be required to retrospectively apply a consensus that requires collectibility to be assured prior to recognizing revenue. Proponents of View A believe that it would be difficult to differentiate information that would have been available at the time services were rendered from information that was subsequently learned in collection efforts.

View B: This consensus shall be applied retrospectively to all prior periods upon adoption with an adjustment to beginning retained earnings for the earliest period presented.

26. Proponents of View B note that although a HCO may not have assessed collectibility as a criterion for revenue recognition, collectibility would have been assessed in determining the allowance for doubtful accounts. They believe that HCOs can make reasonable judgments, estimates, and assumptions regarding the amount of bad debt expense previously reported that relates to these patients if collectibility were assessed as a criteria to recognize revenue.

27. Opponents of View B believe that it would not be possible to assess collectibility retrospectively without using hindsight. The opponents believe that prospective application should be required.

Issue 2: How HCOs should record liabilities for medical malpractice and other similar claims and related insurance recoveries.

Background

Note: References to U.S. GAAP prior to the release of the Codification, are used in this issue to better demonstrate how diversity has developed in practice.

28. EITF Issue No. 03-8, "Accounting for Claims-Made Insurance and Retroactive Insurance Contracts by the Insured Entity" (Subtopic 720-20), addresses issues related to the accounting by an insured entity for claims incurred under claims-made insurance and retroactive insurance contracts. Under a claims-made policy, an entity is insured for any claims reported during the term of the policy—in many cases those policies include a retroactive provision that will cover events that occurred prior to the policy effective date, but after a date specified in the policy. In paragraphs 15, 20, and 24 of Issue 03-8, the EITF observed that "unless the conditions of Interpretation 39 are met, offsetting prepaid insurance and receivables for expected recoveries from insurers against a recognized IBNR [incurred but not reported] liability or the liability incurred as a result of a past insurable event would not be appropriate."

29. Questions have been raised as to whether this observation applies to HCOs because the AICPA Audit and Accounting Guide, *Health Care Organizations* (the Guide), includes language that could be interpreted as requiring or permitting the netting of prepaid insurance and insurance recoveries with an organization's estimated accrual for medical malpractice claims. Specifically, paragraphs 8.04 and 8.05 of the Guide state,

> The extent of risk transfer is key in determining whether a liability should be recognized in a provider's financial statements pertaining to malpractice claims. The existence of an insurance policy, by itself, is no assurance that the risk of financial loss is transferred.
>
> If the entity has purchased a claims-made insurance policy (see paragraph 8.14), there is no transfer of risk for claims not reported to the insurance carrier within the policy term. With regard to retrospectively rated insurance policies (see paragraphs 8.15–.16) and policies by captive insurance companies (see paragraphs 8.17–.18), the economic substance of the terms of the insurance policy may more closely resemble a claims funding mechanism than an instrument that transfers risk of loss to an external third party. If the health care organization has not transferred risk to an external third party, it should evaluate its exposure to losses arising from malpractice claims and record a liability, if appropriate.

Some HCOs viewed the guidance presented above from the Guide as a "risk transfer" model, and were supportive of the recording of accrued medical malpractice claims net. It should be noted that paragraph 8.04 is not included in the Codification. However, parts of paragraph 8.05 are included in the Codification in the guidance for contingencies for HCOs in paragraph 954-450-25-2, which follows:

> The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, shall be accrued when the incidents that give rise to the claims occur. **If the health care entity has not transferred risk to an external third party, it should evaluate its exposure to losses arising from malpractice claims and recognize a liability, if appropriate.** Subtopic 944-40 discusses accounting for claims costs, including estimates of costs relating to incurred-but-not-reported claims. [Emphasis added.]

30. Paragraph 7 of FASB Interpretation No. 39, *Offsetting of Amounts Related to Certain Contracts* (Subtopic 210-20), states,

> Various accounting pronouncements specify accounting treatments in circumstances that result in offsetting or in a presentation in a statement of financial position that is similar to the effect of offsetting. This Interpretation does not modify the accounting treatment in the particular circumstances prescribed by any of the following pronouncements: …AICPA Audit and Accounting Guides…

31. The guidance included in the Guide, which established the health care industry practice of balance sheet offsetting of receivables for expected recoveries from insurers against the recognized accrual for medical malpractice claims (including the accrual for both known and incurred-but-not-reported claims), was in existence at the time Interpretation 39 was issued. As a result, paragraph 7 of Interpretation 39, noted above, did not change this industry practice. In addition, prior to FASB Statement No. 168, *The FASB Accounting Standards Codification™ and the Hierarchy of Generally Accepted Accounting Practices*, Issue 03-8 was Category (*c*) GAAP in the GAAP hierarchy while the Guide was Category (*b*) GAAP. Therefore, Issue 03-8 also did not change industry practice with respect to netting.

View A: Net presentation should be permitted.

32. Proponents of View A believe that the intent in purchasing an insurance policy for medical malpractice or similar claims is to transfer the risk for those insured events. They believe that net presentation should be allowed because it recognizes the economics of the transfer of risk and is consistent with how the malpractice claim is ultimately paid. Industry practice is currently focused on the type of insurance policy in force (as described in paragraph 8.05 of the Guide) and the validity of the claim made. Some HCOs may consider the solvency of an insurance entity, while others may assume solvency absent contrary information coming to their attention.

33. Opponents of View A believe that all of the risks have not been transferred. For instance, if the insurance company were insolvent and unable to pay the malpractice claim, the HCO would still be liable for the claim. Opponents of View A believe that HCOs should apply Interpretation 39 and, as there are three parties involved, netting would not be permitted.

View B: Net presentation should not be permitted.

34. Proponents of View B are the opponents of View A and do not believe that there are any special characteristics of the HCO industry that warrant different accounting from what is required for entities in other types of industries, and that the determination of presenting assets and liabilities gross or net should be consistent with Interpretation 39 (Subtopic 210-20). Proponents of View B believe that the industry-specific guidance related to these liabilities should be eliminated. These proponents note that in most cases, the HCO is still primarily liable for payment of the claim and retains the risk of loss for that claim. The HCO should, however, evaluate whether a receivable from the insurance company can be recognized and reported separately from the claim liability. Gross presentation reflects that the HCO remains primarily obligated for the claim.

Staff recommendation

35. The staff recommends View B. The staff does not believe that HCO claims are different from claims made by other types of entities such that they should warrant different accounting.

Recurring Disclosure

36. If the liability relates to a contingency, an entity would be required to provide the disclosures in Section 450-20-50 (formerly FASB Statement No. 5, *Accounting for Contingencies*). Also, HCOs are required by Section 954-450-50 to provide information about their medical malpractice coverage and their accounting policy for discounting medical malpractice claims. The staff does not believe any additional recurring disclosures would be required as a result of the resolution of this Issue.

Transition Method and Transition Disclosures

37. The staff believes that if a consensus is reached that net presentation is not permitted, then a HCO should have the available information to adopt a consensus retrospectively. The staff notes that this Issue should only affect balance sheet classification and should not be costly to apply retrospectively. The staff therefore recommends that this consensus be applied retrospectively to increase comparability. As a consensus would eliminate diversity in practice, the staff believes early adoption should be permitted.

38. Paragraphs 250-10-50-1 through 50-3 are applicable for any change in accounting principle, including a change in the method of applying an accounting principle. As such, companies will be required to follow the disclosure requirements in Section 250-10-50. The staff recommends that the Task Force not require any additional disclosures other than the requirements in Section 250-10-50.

Issue 3: How the disclosure of charity care provided by HCOs should be measured.

Background

39. HCOs provide services to certain patients without expectation of payment (or cash inflows). This is charity care and it is generally provided to patients who meet certain guidelines established by the HCO, such as prescribed financial criteria of the patient. Guidance provided in paragraphs 954-605-25-10 through 25-11 of the Codification discusses charity care in the HCO industry as follows:

> Charity care does not qualify for recognition as revenue in the financial statements. Distinguishing charity care from bad-debt expense requires the exercise of judgment. Only the portion of a patient's account that meets the entity's charity care criteria shall be recognized as charity.
>
> Although it is not necessary for the entity to make this determination on admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care.

40. Paragraph 954-605-50-3 describes the disclosure requirements for charity care.

> Management's policy for providing charity care, as well as the level of charity care provided, shall be disclosed in the financial statements. Such disclosure generally is made in the notes to financial statements and is measured based on the provider's rates, costs, units of service, or other statistical measure.

41. Some preparers and users believe that disclosure about management's policy for providing charity care, as well as the level of charity care provided, is useful as it provides an understanding of the level of community benefit provided by the HCO. Donors, regulators, and others may be interested in the level of community benefit provided by a HCO. The disclosure regarding charity care may also be helpful when comparing HCOs with different polices or other HCOs serving different patient demographics.

42. Other users may consider charity care disclosures when considering trends in patient account write-offs. HCOs generally have discretion in setting the criteria for charity care and, as a result, a more generous charity care criteria can mask an increase in write-offs.

43. Additionally, some HCOs may receive funding from state and local governments, or other sources, to compensate for services provided to patients who meet criteria to receive charity care. While these funding sources may require their own reporting based on their own criteria, some may utilize information disclosed in the financial statements.

44. Under the current requirements, measurement of charity care for disclosure may be presented using a variety of options. Measurement of charity care using the provider's standard

rates (as an indication of charges foregone) has been the most prevalent. Some have used cost in their disclosure. Other measures are used less frequently in practice. Questions have been raised about whether the measure used in providing this disclosure should be standardized to improve comparability of reporting by HCOs.

45. The staff conducted outreach by contacting a state regulator responsible for overseeing and distributing a pool to cover uncompensated care. This regulator told the staff that for his state's reimbursement purposes they did not use the financial statement disclosures of charity care; rather, the state required its own reporting. The regulator indicated that he was familiar with other state's requirements and he was not aware of any that relied on the financial statement disclosures. He indicated that he thought it would be helpful for the disclosures to be based on a consistent requirement, and he thought that the requirement should be cost. However, because of prescribed eligibility requirements to receive money from the pool he was responsible for, he did not expect that he would ever be able to rely exclusively on the financial statement disclosures.

46. The level of community benefit is important to the IRS in evaluating a HCO's continuing eligibility for tax exempt status. The staff conducted outreach and talked to six IRS staff members in the exempt organization division. Many of these IRS staff members were involved in the recent re-design of Form 990, which included some changes specifically related to Schedule H, which is required for HCOs. The IRS staff members indicated that they did not use the financial statement disclosures for this purpose but, rather, relied on the information in Form 990. They also indicated that they thought requiring a consistent measurement in the footnotes might enhance the usefulness of the disclosure. They also indicated that they believed that if the EITF moved towards requiring a consistent disclosure, they could use the same measure as required for Schedule H. Schedule H requires that the measurement be based on the direct and indirect costs of providing the charity care. It does not prescribe specifically how to compute this but, rather, allows the provider either to use data from a cost system or to estimate the cost by using the ratio of costs of patient care to gross charges and applying that ratio to gross charges written off to charity care.

View A: Charity care should be measured based on the cost of charity care provided.

47. Proponents of View A believe that few if any payors of health care services pay the established rates to an HCO today and that charges foregone would not likely be collected for those services had the patient's services been paid for personally or by a third party (insurance or government program). Further, gross revenue of an HCO is not generally presented in the HCO's financial statements because of the discounts (contractual allowances) taken to arrive at net patient service revenue, the starting point of an HCO's statement of income or operations. Charity care measured as charges foregone has no reference point to the net service revenue presented in the statements and is currently the only element in the financial statements presented on an established rate basis.

48. Proponents of View A believe that cost is the most relevant measure of charity care. They believe that costs can be reliably measured and provide consistency when comparing amounts of charity care provided by different HCO's. Some HCO may value the cost of charity care differently than others. For instance, some may only include the incremental costs in determining the cost of charity care, while others may use a loaded cost. The regulators the staff spoke to are using a loaded cost to measure charity care and include all direct and indirect costs (either from a cost accounting system or estimated by using a ratio of patient care expenses to gross charges). The staff believes that a loaded cost is more indicative of the level of resources consumed in providing charity care. If the Task Force reaches a consensus to require disclosure based on cost, the FASB staff believes that this cost should be defined to include all direct and indirect costs.

View B: Charity care should be measured based on an average rate charged to paying patients for similar services.

49. Proponents of View B agree with proponents of View A that the use of standard rates as an indication of charges forgone is not meaningful because few payors pay established rates to an HCO. However, they believe that the cost of providing those services also may not be meaningful because the cost structure of HCO's may not be comparable. For instance, suppose HCO X services a relatively small number of charity cases and has existing capacity to absorb

charity care patients. HCO X's costs of proving charity care may only include a very minor amount of indirect costs. However, HCO Y might serve a larger population of charity care patients and HCO Y's cost of charity care may include a larger amount of indirect costs. Proponents of View B believe that the most meaningful and comparable measure of charity care would be based on an average rate charged for paying patients for similar services. Unlike charity care measured at standard rates, charity care measured at an average rate charged for paying patients for similar services would be comparable to the net service revenue presented in the statements. By using an average rate, proponents of View B believe that an HCO would not be overstating its foregone revenue as it would be if it was using standard rates.

View C: The requirement to disclose a measure of charity care should be eliminated.

50. Proponents of View C generally agree with the views and arguments made by proponents of View A. However, proponents of View C believe that charity care should not be a required disclosure because it only represents one component of an organization's community benefit, and charity care is an organization's policy election that varies significantly throughout the industry. Because of that diversity, one HCO might classify a particular write off as charity care while another HCO might classify a similar write off as bad debt. Proponents of View C do not understand why only one component of community benefit is required to be disclosed, and they do not understand how disclosing charity care alone improves the financial statements users' ability to assess an organization's financial position and financial operations. They believe that users who rely on this measure (regulators or donors) can access this from other sources.

51. If the Task Force were to reach a consensus for View C, the Task Force may consider whether guidance is needed for the measurement of charity care by HCOs that wish to provide optional disclosure.

Recurring Disclosure

52. If a consensus is reached to require disclosure of charity care, the staff recommends that the basis for that measurement and the amount of charity care provided each period should be provided on a recurring basis.

Transition Method and Transition Disclosures

53. The FASB staff considered two transition alternatives, retrospective application and prospective application. Depending on the view chosen by the Task Force above, retrospective application may be difficult.

54. The FASB staff believes that if a consensus is reached to require that charity care be measured at cost, retrospective application should be required to allow for comparability. HCO's likely have already been tracking charity care costs to improve management oversight over the use of these resources, or for regulatory reporting, or both. Therefore, the data would exist to apply the consensus retrospectively. The staff notes that paragraph 250-10-45-5 has an exception to retrospective application if it is impracticable to apply retrospectively.

55. The staff believes that if a consensus is reached to require that charity care be measured at an average rate charged to paying patients for similar services, prospective application should be required. HCOs may not have had the systems in place to measure an average rate charged for paying patients for similar services provided in prior years. The staff does not believe that requiring HCOs to apply the consensus retrospectively would be burdensome and not justified by the benefits.

56. As a consensus would eliminate diversity in practice, the staff believes that early adoption should be permitted.

57. The staff does not believe that transition disclosures would be required as this issue relates only to disclosures.