

ORIGINAL ARTICLE

New financial statement reporting requirements for healthcare entities and insurers

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Abstract

Since 2010, the Financial Accounting Standards Board issued several Accounting Standards Updates [ASUs] and other Authoritative Standards that affect Health Care Entities and Insurers, requiring them to more consistently account for and disclose their reporting of charitable and other costs. Also, in light of the main portions of Obama Care becoming effective in 2014, the FASB required such entities to more consistently and broadly disclose how they account for their bad debts, especially since the new law will limit such payments in the future. This article summarizes the provisions of the new Standards and provides examples of their application, in order to help health care entities and insurers understand the new provisions and implications.

Key words

Obama care, Accounting, Financial Accounting Reporting Standards

1 Introduction

Since 2010, the Financial Accounting Standards Board (FASB) and other authoritative bodies have issued standards that greatly impacted reporting and disclosures in the healthcare industry and for healthcare insurers. For instance, Accounting Standard Update (ASU) 2010-23 Healthcare Entities (Topic 954): Measuring Charity Care for Disclosure requires healthcare entities to report the cost basis measurement for charity care and amounts of contributions and grants received to fund uncompensated care. ASU 2010-24 Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries also requires health care entities to report estimated malpractice claim liabilities and related insurance recoveries at gross amounts.

In March 2010, President Obama signed the Patient Protection and Affordable Care Act [PPACA] as amended by The Health Care and Education Reconciliation Act (the Acts, or Obama Care) into law. This legislation imposes annual fees on certain health insurers upon these Acts' implementation, i.e., each calendar year beginning after 2013. The fee, based upon providers' market share and discussed in detail later, was imposed to help defray the cost of expanded coverage to health care users. To ensure consistent fee treatment among health insurers, the FASB's Emerging Issues Task Force [EITF] issued ASU 2011-06: Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers, to address how health insurers should recognize and classify mandated fees. ASU 2011-06 also impacts health care entities' financial

statements since many previously uninsured patients will now have insurance coverage, thereby increasing health care providers' activities.

In 2011, the EITF issued ASU 2011-07, Health Care Entities (Topic 954), Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities. This Standard changes how health care entities accumulate and report items such as patient revenues, net accounts receivables, and bad debt expenses. Financial statement preparers, users and analysts of hospitals and other health care providers who issue financial statements and who will provide coverage under the new U.S. health care standards should recognize these standards as they interact with health care providers and health care insurers.

2 Background and requirements of ASU 2010-23

Charity care entities used various methods to measure and disclose their costs, using a cost or revenue measurement basis that impaired comparability among health care entities. Effective in 2011, ASU 2010-23 defined charity care as "uncompensated services provided to patients with a demonstrated inability to pay." To improve comparability, healthcare entities reporting charity care should calculate and disclose their (1) cost basis measurement for charity care; and (2) amounts of contributions and grants received to fund uncompensated care. These disclosures include both direct and indirect costs and the methodology for calculating, costs, e.g., the ratio of cost to gross charges and then multiplying that percentage by the charity care gross charges.

3 Background and requirements of ASU 2010-24

Similarly, a diversity of practice arose in accounting for medical malpractice claims, related liabilities, and anticipated insurance recoveries against such claims and liabilities. Some health care entities netted expected insurance recoveries against claims while others presented the insurance recoveries and claims at their gross amounts. These differing practices impaired any comparability among health care entity disclosures. To develop a consistent method to assess healthcare entities and to broaden required disclosures, ASU 2010-24 forbade such entities from netting anticipated insurance recoveries against their related claims. Also effective in 2011, all claims should be determined without considering any expected insurance recoveries.

The University of Toledo's financial statements showed the following financial disclosures for its charity and uncompensated care. As shown in Figure 1 below, the University of Toledo Hospital properly segregates its total charity and uncompensated care into traditional charity care, unpaid traditional Medicaid programs and unpaid costs of other programs.

Figure 1. University of Toledo's Charity Care and Uncompensated Care Disclosure

	Year Ended 6/30/2012	Year Ended 6/30/2011
Traditional charity care	\$ 5,712	\$ 5,403
Unpaid costs of traditional Medicaid programs	3,452	3,167
Unpaid costs of other programs	6,352	7,576
Total charity and uncompensated care	\$ 15,516	\$ 16,146

4 Background and requirements of ASU 2011-06

In light of the U.S. Supreme Court's recent upholding of PPACA's constitutionality, insurance companies that service Obama Care patients must now prepare to implement the Act's accounting requirements. Financial statement preparers, users and analysts of hospitals and other health care providers who will provide coverage under the Act's new standards should recognize these standards as they interact with health care insurers, because these new provisions can affect financial statement ratios, adherence to debt covenants and the overall ability to attract and retain financial capital.

Moreover, starting in 2014, per Section 3133, 10316, of the PPACA, Disproportionate Share Hospital (DSH) Medicare payments will be cut by 75 percent, while additional payments to all U.S. hospitals will be based on:

- a. The percentage by which the uninsured population decreases, as determined by the Secretary and not subject to review. The formula is "1 minus the percent change in the percent of individuals...who are uninsured [since 2013]...minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of the fiscal years 2015 [through 2019]." Using current DSH payments and CBO estimates of the reduction in the uninsured population, the aggregate pool will be about \$3.96 billion; and,
- b. Uncompensated care costs as a percentage of all PPS hospitals' uncompensated care costs.

Thus, healthcare facilities' DSH reimbursements depend upon all such facilities lowering total unreimbursed health care costs, which will also affect their insurance company negotiations for such reimbursement payments. These new, critical rules require more uniform financial disclosures, which forms a key impetus for the issuance of ASU 2011-06. Holahan and Headen of the Kaiser Commission (May 2010, <http://www.scribd.com/doc/99236333/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-by-State-Results-for-Adults-at-or-Below-133-FPL>) add that while the PPACA will bring states increased federal dollars, they will also likely receive reduced payments for uncompensated care. States not reaching implementation expectations will face reduced federal support for uncompensated care.

Moreover, since U.S. Generally Accepted Accounting Principles [GAAP] focus on accruing fairly and consistently similar types of accounting transactions among health care insurers, the provisions of ASU 2011-06 will change how health insurers recognize, classify and report the newly mandated fees, which affect insurers serving Obama Care patients each calendar year starting on January 1, 2014. The fee is not tax deductible and is payable to the US Treasury no later than September 30 of each calendar year. Health care providers should now allocate such fees to their financial statements based upon prior year metrics: the ratio of net premiums written to the amount of health insurance for any US health risk written. The liability arises in any calendar year that any health care insurer covers any Obama Care expense.

ASU 2011-06 provisions require healthcare insurers to recognize both, a: (1) liability for the annual fee when first providing qualifying health insurance during the calendar year; and (2) corresponding deferred cost to be amortized to operating expenses over the calendar year that the annual fee is payable. Health care providers should use a straight-line methodology to amortize such costs, unless another method, such as in proportion to revenues or the contracts estimated gross profit is more appropriate. Although the costs are to be amortized similar to insurance acquisition costs, such fees do not meet the definition of acquisition costs, per ASU 2010-26, *Accounting for Costs Associated with Acquiring or Renewing Insurance Contracts*.

5 Implementation guidance under ASU 2011-06

Examples of proper accounting under the new standard appear below. First, typical journal entries associated with ASU 2011-06 include:

- a. To initially recognize the mandated health insurer fee:

	Deferred mandated fee	XXX
	Liability for deferred mandated fee	XXX
b.	To amortize the deferred mandated fee to expense	
	Mandated fee expense	XXX
	Deferred mandated fee	XXX
c.	To submit payment to the US Treasury	
	Liability for deferred mandated fee	XXX
	Cash	XXX

Several health insurer financial statement impacts arise from this accounting. For example, ASU 2011-06 requires recording a current liability for such transactions that will lower the current ratio (current assets/current liabilities) and could cause debt covenant violations. The mandated health fee expense will also cause a permanent difference between financial reporting income and taxable income since the mandated health fee is not tax deductible. Permanent differences never reverse.

6 Background of ASU 2011-07

Similar to ASU 2011-06, ASU 2011-7 also affects health care entities' financial statements. Such entities often provide services of undeterminable collection at the time that they render services. Two methods of recognizing patient revenues were permissible: (1) a gross charge amount along with a provision for bad debts where the bad debt provision was generally classified as an operating expense; or (2) only the amounts billed where collectability is reasonably assured. Due to the allowable alternatives and latitude in setting gross charge rates, discount policies, and charity care policies, inconsistent and incomparable results arose among health care entities' financial statements. Entities should also match revenues and associated expenses in the same period. However, the alternatives often lead to overstated current period revenues, resulting in restated prior periods' income when collections were less than expected.

7 Significant changes and additional disclosure requirements under ASU 2011-7

ASU 2011-7 requires health care entities that previously used the gross method to record patient service revenue with a corresponding bad debt expense in operating expenses to reclassify the bad debt expense to a deduction from patient service revenue. That is, they should disclose this provision as a separate line item to net with patient service revenue to now approximate the amount expected to be collected. To determine the provision, an entity should perform an aging of each major payor source (e.g. third party payors or self-pay patients). The newly presented net patient service revenue will improve comparability across health care entities.

The Standard also requires new financial reporting disclosures such as how they assess the timing and amount of uncollectible patient service revenue recognized as bad debts by major payor revenue source and their policies for assessing collectability in determining the timing and amount of patient service revenue (net of contractual allowances and discounts) to recognize; and patient service revenue (net of contractual allowances and discounts) before the provision for bad debts. Other required disclosures relate to qualitative and quantitative information about changes in allowances for

doubtful accounts such as significant changes in estimates and underlying assumptions, amounts of self-pay write-offs, amounts of third-party payor write-offs, and other unusual transactions affecting the allowance for doubtful accounts.

8 Implementation Guidance under ASU 2011-07

As Reinstein and Churyk ^[1] previously discussed, ASU 2011-07 provides examples of the new required disclosures, recognizing that differences in how health care entities manage their businesses (e.g., assess credit risk) could change such disclosures. We present below adaptations of these examples.

Example 1: Third Party Coverage Provision Policy Disclosure

Healthcare Inc. with third-party covered analyzes contractually due amounts and provides an allowance for doubtful accounts and any necessary provision for bad debts (e.g., unpaid from third parties' expected uncollectible deductibles and copayments on accounts, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely).

Example 2: Self-Pay Patient Provision Policy Disclosure

Healthcare Inc. with self-pay patient receivables (including both patients without insurance and patients with deductible and copayment balances due), analyzes and records a significant provision for bad debts in the period of service based of past experiences, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. Health care entities should charge off against the allowance for doubtful accounts differences between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted.

Example 3: Provision Disclosure

Healthcare Inc's allowance for doubtful accounts for self-pay patients increased from 80 percent of self-pay accounts receivable at December 31, 2012 to 90 percent of self-pay accounts receivable at December 31, 2013. In addition, Healthcare Inc's self-pay write-offs increased by \$2,000,000 from \$7,000,000 for fiscal year 2012 to \$9,000,000 for fiscal year 2013. Increases were the result of negative trends experienced in the collection of amounts from self-pay patients in fiscal year 2013. Healthcare Inc did not change its charity care or uninsured discount policies during either fiscal year. It does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

Example 4: Income Statement Presentation (Separate Key Sources of Revenue)

Patient service revenue (net of contractual allowances and discounts)	\$ 90,300
Provision for bad debts	<u>(8,300)</u>
Net patient service revenue	82,000
Premium revenue	20,500
Other operating revenue	<u>17,800</u>
Total revenue	<u>\$120,300</u>

Example 5: Income Statement Disclosure

Healthcare Inc recognizes third-party payor coverage patient service revenue on the basis of the contractual rates for the services rendered. For non-charity uninsured patients, Healthcare Inc 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). Based upon historical experience, a significant portion of Healthcare Inc's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Healthcare Inc records a 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, appears below (in millions of dollars):

	Third-Party	Self-Pay	Total-All Payors
Patient service revenue (net of contractual allowances and discounts)	\$42.400	\$11.300	\$53.700

Actual application of ASU 2011-07 is located in Providence Health & Services 12/31/11 Annual report Footnote F, p. 23,

"In 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities, which provides financial statement users with greater transparency about a health care entity's net patient service revenue and the related allowance for doubtful accounts. The amendments require health care entities to present the provision for bad debts related to patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) on their statement of operations. This standard is effective for the 2012 fiscal year. The adoption of ASU 2011-07 will not have a material impact on the Health System's consolidated financial statements."

9 International Financial Reporting Standards implications

While International Financial Reporting Standards do not yet require healthcare insurers to comply with these standards, in deliberating the Revenue Recognition Exposure Draft, the FASB and International Accounting Standards Board [IASB] have tentatively agreed to present bad debts resulting from customer contracts as a separate line item. Both bodies are also moving towards converging standards, and IASB Chair Hans Hoogervorst stated that the IASB needs U. S. support to achieve a truly global standard in a July 5 2012 IFRS Report IASB Chair Urges SEC to Move Forward on IFRS (<http://www.journalofaccountancy.com/News/20125815.htm>).

10 Conclusion

Impact of ASU 2010 -23, 2010-24, 2011-06 and 2011-07

ASUs 2010 -23, 2010-24, 2011-06 and 2011-07 significantly affect current healthcare provider and insurer reporting. They will report more comparable revenues, liabilities and expenses, and investors will see more transparent disclosures. Health insurer mandated fees could cause ratios such as the current ratio and return on equity to decline, potentially impairing debt covenant violations. Health insurers will receive no tax benefits from the newly recorded expense. Despite potential declines in financial statement ratios and non-tax deductibility of the mandated fee, health insurer financial statements could improve if an increased number of healthier patients become insured. The government [under PPACA], insurance companies and investors can now better compare bad debts, charity care, malpractice claims, and patient revenue disclosures across health care entities due to the consistent measurements that the new ASUs require.

References

- [1] Alan Reinstein & Churyk. N. FASB's ASU 2011-07 Changes Financial Statement Reporting Requirements. *Healthcare Financial Management*. 2012 Feb; 66(2): 40-42.