Impact of the new revenue standard on the healthcare sector

This article aims to:
- This article aims to highlight the key impact of Ind AS 115 on healthcare service providers.

Summary

While assessing existence of an enforceable contract, specific facts and circumstances need to be evaluated to determining whether and when an agreement with a patient creates legally enforceable rights and obligations.

Variability in transaction price may be explicit or implicit, arising from customary business practices e.g. price concessions.

For principal versus agent evaluation all the indicators are considered in making the assessment.

There are detailed disclosure requirements under Ind AS 115 along with the transition options.
Introduction

Ind AS 115, Revenue from Contracts with Customers is the standard on revenue recognition that is converged with IFRS 15, Revenue from Contracts with Customers.

The core principle of Ind AS 115 is that revenue should be recognised when an entity transfers control of goods or services to a customer at the amount to which an entity expects to be entitled. To achieve the core principle, the new standard establishes a five-step model that entities would need to apply to determine when to recognise revenue, and at what amount. Therefore, a single model applies to contracts with customers across all industries.

The new revenue standard is likely to throw up challenges from an accounting perspective in the healthcare sector, out of which we have attempted to provide our insights on specific issues confronting the companies in this sector.

Existence of an enforceable contract

Under the new standard, a contract is an agreement between two or more parties that creates enforceable rights and obligations. Contracts can be written, oral or implied by an entity’s customary business practices. Enforceability is a matter of law.

A healthcare service provider should also consider specific facts and circumstances in determining whether and when an agreement with a patient creates legally enforceable rights and obligations. The agreement with a patient can be written, oral or implied by an entity’s customary business practices. An entity is generally unable to recognise revenue if an enforceable contract does not exist.

This issue is relevant when services are provided before obtaining information from the patient e.g. emergency services provided to an unconscious patient.

Transaction price

An entity estimates the transaction price at the inception of the contract, including any variable consideration. Under the new standard, price concessions, discounts, etc. constitute ‘variable consideration’. The transaction price includes amounts that are not paid by the customer e.g. a healthcare service provider may include amounts to be received from the patient and third-party payer in determining the transaction price.

Under Ind AS 18, Revenue healthcare service providers recognised revenues for the amounts billed to patients. Often, this resulted in recognition of an amount of revenue for which collectability was doubtful. In practice, this led to recognition of provision for doubtful debts or bad debt expense at a future date.

The new model is expected to lower the volume of bad debt expense which were historically reported in such situations, and also result in a corresponding reduction in revenues. The reduction in revenues are likely to occur due to ‘implicit price concession’ while ‘estimating the amount of variable consideration’.

Implicit price concessions: An implicit price concession does not have to be specifically communicated or offered by the healthcare service provider to the patient. Healthcare service providers need to use judgement to determine whether they have implicitly provided price concession to their patients.
Estimating the amount of variable consideration:

In our experience, the healthcare service providers in India have a huge amount of bad debts on the amounts billed under the government administered schemes e.g. Central Government Health Scheme (CGHS), Employees’ State Insurance Corporation (ESIC), etc. Under these schemes, payments for services provided to the patients are determined as per the arrangement entered into by CGHS/ESIC with the healthcare service provider (generally, the prices for services rendered under the aforementioned schemes are lower than that charged to other patients). Often, they may subject the healthcare service provider to retrospective adjustments on the revenue; thus, the amount ultimately earned may not be known with certainty for several months.

As a result of the uncertainty, a portion of the amounts earned from providing services to government administered scheme beneficiaries often represent ‘variable consideration’ under the new standard.

The new guidance uses a different model than the practice followed in the past that the transaction price is the amount billed to the patient. Under the new guidance, the transaction price is the amount the healthcare service provider ‘expects to receive’.

Where services are provided to uninsured patients, the transaction price for revenue recognition purposes is likely to be less than the amount billed. In certain cases, hospitals providing services to uninsured patients do so knowing that on an average, they will not collect a certain percentage of the amount billed.

As a result of the uncertainty, amounts earned from providing services to uninsured patients often represent a ‘variable consideration due to implicit price concessions’.

An implicit price concession may be estimated based on historical collection experience from similar patients. If on a subsequent reassessment of the estimated implicit price concession, a healthcare service provider expects to collect more than originally estimated, it recognises the additional amount as patient service revenue in the period the change is identified. If it expects to collect less than originally estimated, it recognises the shortfall as a reduction of patient service revenue. An exception would be if there is a specific event known to the healthcare service provider that suggests that the patient no longer has the ability and intent to pay the due amount e.g. patient is bankrupt. In that circumstance, the healthcare service provider recognises the change in the estimate as a bad debt expense and not as a reduction of patient service revenue.

Example:

A hospital treats an uninsured patient and does not access the patient’s ability to pay at the time of service. The hospital bills the patient INR100,000. Although hospital expects to pursue collection of that amount, its experience with similar patients indicates that it will collect only INR90,000.

In this example, the hospital determines that the transaction price is INR90,000. The INR10,000 that it does not expect to collect is an implicit price concession as opposed to a bad debt because the hospital did not perform credit assessment of the patient before providing the service. Accordingly, hospital recognises revenue of INR90,000.

Subsequently, the hospital collects only INR85,000. The difference of INR5,000 (INR90,000 less INR85,000) is recorded as a reduction in patient service revenue.
Currently, management makes its best estimate of the third-party settlement adjustment based on its knowledge and experience about past and current events. The new standard specifically provides guidance in relation to estimation of the consideration using either of the following methods:

**Expected value**

The sum of the probability-weighted amounts in a range of possible amounts. An expected value may be an appropriate estimate of the amount of variable consideration if an entity has a large number of contracts with similar characteristics.

**Most likely amount**

The single most likely amount in a range of possible consideration amounts. The most likely amount may be an appropriate estimate of the amount of variable consideration if the contract has only two possible outcomes.

**Principal versus agent**

Ind AS 115 has introduced specific guidance on principal versus agent considerations, which represents a change in approach from Ind AS 18. While Ind AS 18 was based on the risks and reward approach, Ind AS 115 is based on the transfer of control approach. Further, credit risk is no longer an indicator that an entity is a principal.

Careful evaluation may be needed of certain contracts such as arrangements with consultant doctors and operation and maintenance arrangements of healthcare service providers with other persons.

For instance, the primary responsibility to provide necessary treatment to the patient in most of the cases is of the hospital and not the consultant doctors. If a particular consultant doctor who was treating the patient would not be available henceforth, then it is the responsibility of the hospital to ensure that another consultant doctor is identified to provide necessary treatment to the patient. In cases of professional negligence also, the hospital has to make good the losses to patients and not the consultant doctors. Further, if the pricing for services provided by the hospital, are also decided by the hospital then the hospital is acting as a principal.
Healthcare service providers should also evaluate the various operation and maintenance arrangements they have entered into with other persons. If the primary obligation to provide the services is of the hospital and the pricing for services are also decided by them, then hospital will become the principal.

### Transition options

Ind AS 115 provides the following transition options:

a. Retrospective method: Under this method, entities recognise the cumulative effect of applying Ind AS 115 at the start of the earliest comparative period presented. As part of this method, an entity could use certain practical expedients for a smooth transition.

b. Cumulative effect method: Under this method, an entity recognises the cumulative effect of applying Ind AS 115 at the date of initial application, with no restatement of the comparative periods presented i.e., the comparative periods are presented in accordance with Ind AS 18. Entities using this method are required to disclose the quantitative effect of Ind AS 115 and an explanation of the significant changes between the reported results under Ind AS 115, and those that would have been reported under Ind AS 18. Both these approaches have their pros and cons and hence, would require a careful evaluation.

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**If hospital is acting as a principal**

- Revenue will be recognised at gross amount paid by patient/third-party payer
- Amount paid to consultant doctor will be recorded as an expense
- Any other cost incurred in providing services to patient will be recorded.

**If hospital is acting as an agent**

- Revenue will be recognised as the net of consultant doctor fees.

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**Example:**

A hospital treats a patient registered under a state government scheme (scheme). For the treatment given to patient, the price for the services is pre-agreed at INR180,000. This is price as per the arrangement between the scheme and the hospital. The pre-agreed price has cap on various services/goods that can be rendered/consumed for treating the patient. One such cap is on the number of visits of a consultant doctor (the cap is of one visit). However, due to complexity of the case the consultant doctor had to make two visits. The hospital bills of the patient amounted to INR190,000; increase of INR10,000 (INR190,000 less INR180,000) from the agreed price. This is on account of incremental visit of the consultant doctor.

From the past experience, hospital expects to collect INR10,000 from the scheme in 60 per cent of the cases. Therefore, INR186,000 (INR180,000 plus INR6,000 (INR10,000 * 60 per cent)) is the transaction price.

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Disclosures:
The stated objective of the revenue disclosures is to enable users to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers.

To meet this objective, the entity is required to provide the following disclosures about its contracts with customers:

- Disaggregation of revenue into categories that depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors. Examples of disaggregation include: type of good or service, geography, market, type of customer and type of contract. The entity is also required to disclose sufficient information to enable users to understand the relationship between the disclosure of disaggregated revenue and revenue information that is disclosed for each reportable segment.

- Narrative disclosure to describe changes in contract assets, contract liabilities and contract costs.

- Impairment losses recognised on any receivable or contract assets.

- Information about the entity’s performance obligations in its contracts with customers.

- Amount of the transaction price allocated to remaining performance obligations and an explanation of when the entity expects to recognise the allocated amounts.

(Source: Revenue for healthcare providers, KPMG LLP, U.S. publication, November, 2016)