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Reviewing the Current Expected Credit Losses (CECL) In Healthcare

Background

As a response to recent financial crises that occurred in the U.S., the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-13 – Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments. Subtopic 326-20 of the ASU sets forth the Current Expected Credit Loss (CECL) model that applies to financial assets held at amortized cost basis, and Subtopic 326-30 amended the impairment model for available-for-sale (AFS) debt securities. The FASB believes that adopting this ASU will result in more timely recognition of expected credit losses.

The amended credit losses model for AFS debt securities, under FASB Accounting Standard Codification (ASC) Subtopic 326-30 requires an allowance for credit losses (and potentially direct write-off) if the AFS debt securities' fair value is less than amortized cost and there are indications that credit losses are present. This model replaces the prior other-than-temporary impairment accounting model.

This article will not go into depth on this part of ASC 326, as the implications are industry agnostic and dependent upon an organization's investment holdings. Organizations that hold AFS debt securities should familiarize themselves with the guidance under ASC Subtopic 326-30 in order to evaluate the impact this change might have on their accounting and financial presentation. For example, the potential impact to the financial statement presentation of unrealized losses in the "other changes in net assets" section of a not-for-profit (NFP) entity's statement of operations and changes in net assets.

The focus of this article will be on the implementation of the CECL model under ASC Subtopic 326-20 (financial assets held at amortized cost basis) within the healthcare industry.

Introduction to the CECL model

The CECL model under ASC 326-20 applies to most financial assets or groups of financial assets that are measured at amortized cost basis. These include, but are not limited to:

- Financial assets measured at amortized cost basis, including:
  - Financing receivables
  - Held-to-maturity debt securities
  - Receivables that result from revenue transactions within the scope of ASC 605 on revenue recognition, ASC 606 on revenue from contracts with customers and ASC 610 o n other income
  - Reinsurance recoverables that result from insurance transactions within the scope of ASC 944 on insurance
  - Receivables that relate to repurchase agreements and securities lending agreements within the scope of ASC 860
- Net investments in leases recognized by a lessor in accordance with ASC 842 on leases
- Off-balance sheet credit exposures not accounted for as insurance. Off-balance-sheet credit exposure refers to credit exposures on off-balance-sheet loan commitments, standby letters of credit, financial guarantees not accounted for as insurance and other similar instruments, except for instruments within the scope of ASC 815 on derivatives and hedging.

The CECL model replaces the previous incurred loss model under ASC Topics 310 and 450 with an expected loss model, where entities recognize an allowance for lifetime expected credit losses at the date of the transaction, rather than waiting for actual loss or default events to occur. While the lending industry has been significantly impacted by this new standard, most non-lenders, including healthcare organizations, have financial assets subject to the CECL model (e.g., patient receivables, held-to-maturity (HTM) securities, etc.).

CECL does not apply to financial assets that are measured at fair value through net income (or excess of revenue over expenses), AFS debt securities (which are addressed in ASC Subtopic 326-30), loans by defined contribution employee benefit plans to participants, policy loans of insurance companies, pledges to nonprofit entities, and loans and receivables between entities under common control.

ASU 2016-13 was effective for public business entities that are Securities and Exchange Commission (SEC) filers, excluding entities eligible to be smaller reporting companies as defined by the SEC, for fiscal years beginning after Dec. 15, 2019, including interim periods within those fiscal years. For all other entities, the ASU was effective for fiscal years beginning after Dec. 15, 2022, including interim periods within those fiscal years (i.e., 2023 calendar year-end).

Subtopic 326-20 of the ASU may impact the accounting, financial statement presentation and disclosure of healthcare entities that have receivables arising from patient service revenue, HTM debt securities or other financial assets held at amortized cost basis.

This article will provide an overview of the new standard, discuss some common impacts seen within the healthcare industry, evaluate the interplay between CECL and patient receivable recognition for healthcare entities, and provide some practical considerations for implementation.

Overview

OVERVIEW OF ASC SUBTOPIC 326-20

The first step in evaluating the impact of CECL for healthcare organizations is identifying the financial assets or group of financial assets, which are measured at amortized cost basis on their balance sheet.

Amortized cost is defined in FASB's Master Glossary as follows:

> "The amortized cost basis is the amount at which a financing receivable or investment is originated or acquired, adjusted for applicable accrued interest, accretion, or amortization of premium, discount and net deferred fees and costs, collection of cash, write-offs, foreign exchange, and fair value hedge accounting adjustments."

For in-scope financial assets or groups of financial assets that are identified by an organization, ASC 326-20 requires entities to consider the following when estimating expected credit losses:

1. Portfolio segmentation
2. Methodology or methodologies for estimating expected credit losses
3. Contractual terms of financial assets
4. Historical losses and life of loss rates
5. Adjustments to historical losses for current conditions, asset-specific risk characteristics and reasonable and supportable forecasts

The consideration of these requirements will be different for each class of financial asset, or group of financial assets, and for each entity depending on the nature of the financial assets, but the underlying concepts of each should be consistently considered as part of the estimation process.

IMPACTS TO CONSIDER IN THE HEALTHCARE INDUSTRY

While entities need to consider all financial assets, or groups of financial assets, held at amortized cost basis as noted above, patient receivables and HTM debt securities will likely have the most relevance in the healthcare industry. In considering both of these, HTM debt securities will likely share many characteristics, as an investment asset, with HTM debt securities in other industries, while patient receivables will have many industry-specific characteristics to consider.

As NFP organizations are required to carry all debt securities at fair value by ASC 958-320, NFPs must classify their debt securities as "trading" or as "available for sale" (or "other than trading"); NFPs cannot use the HTM classification. Therefore, the new AFS impairment model under ASC 326-30 will apply to those entities which have debt securities classified as other-than-trading.

HTM DEBT SECURITIES: GUIDANCE DIFFERENCES EXPLAINED

The table below highlights the most significant differences for HTM debt securities between the legacy guidance (ASC Subtopic 320-10) and the new guidance (ASC Subtopic 326-20). *

Legacy guidance (ASC 320-10-35)	New guidance (ASC 326-20)
Securities were required to be evaluated individually	Assets with similar risk characteristics are required to be evaluated collectively
Loss was recognized (through a direct write down) only if the fair value of the security was less than the carrying amount and either: **1** The entity intended to sell the security **2** It was more likely than not that the entity would be required to sell the security before it recovered **3** The entity did not expect to recover the amortized cost basis of the security	• Recognize expected credit losses through an allowance • No consideration is given to intent or more likely to sell requirement or the relationship of the security's fair value to its amortized cost basis
Expected credit losses were based on management's best estimate. In certain circumstances, a conclusion could be reached qualitatively that expected losses are zero	Even remote risks of loss need to be considered when estimating expected credit losses
Discounted cash flow (DCF) approach was required when quantifying expected credit losses	DCF approach may be used when quantifying expected credit losses (though other approaches are acceptable) and is required for beneficial interests within scope of ASC 325-40
After recognizing a credit loss, improvements in expected cash flows were accreted into interest income over the remaining life of the security	Favorable and unfavorable changes in expected cash flows are recognized immediately through an adjustment to the allowance and credit loss expense

*Based on FASB guidance.

An allowance for credit losses on HTM debt securities should be deducted from the securities' amortized cost basis and presented separately on the balance sheet. An accounting policy election can be made at the major security-type level to present accrued interest (net of any allowance for credit losses) separately on the balance sheet or within another line item (e.g., other assets), rather than with the security to which it relates. ASC 326-20-30-1 indicates that changes in the allowance should be recognized through credit loss expense. Entities that use a discounted cash flow (DCF) approach when estimating expected credit losses are permitted by ASC 326-20-45-3 to report the entire change in present value as an increase or decrease to credit loss expense or report the change in present value attributable to the passage of time as interest income with appropriate disclosure.

In certain unique situations, such as U.S. Treasury securities that are discussed in the examples from FASB in the "patient receivables" section below, organizations may determine they hold securities with an expected default risk above zero

(i.e., a probability of default); however, based on the evaluation of the underlying asset, the nonpayment risk (i.e., loss given default) may be zero. In these cases, there would not be an allowance of credit loss recorded on those assets. In general, outside of assets backed by government agencies, a determination of zero nonpayment risk would be rare.

Healthcare organizations that have HTM debt securities in their investment portfolios will need to review their policies and procedures for evaluating potential credit losses relating to those investments.

PATIENT RECEIVABLES

Patient receivables requires deep industry considerations in evaluating expected credit losses. While the adoption of ASC Subtopic 326-20 may have resulted in significant changes on receivable balances in other industries, the explicit and implicit price concession principles of ASC Topic 606 *(Revenue from Contracts with Customer)*, already consider many factors that determine the net patient service revenue that healthcare organizations expect and are willing to collect for the services that they provide.

These considerations may already include, but are not limited to:

1. Legal obligations to provide emergency services regardless of a patient's ability to pay
2. Customary practices of collecting less than gross charges from uninsured or under-insured patients
3. Contractual adjustments for commercial and governmental payers
4. Historical collection experience
5. Payer classifications (segmentations)

Much of the information that healthcare organizations use in determining their explicit and implicit price concessions, under the principles of ASC Topic 606, is based on contractual terms and historical collection information gathered from the high volume of transactions/patient visits that occur every day in their organization.

Implementing ASC Subtopic 326-20 requires healthcare organizations to evaluate if any portion of the implicit price concessions or bad debt expenses historically recorded should be recorded as an allowance for expected credit losses. This evaluation requires significant judgment in making that determination of expected credit losses versus implicit price concessions, and also with consideration if the entity elected to apply collection estimates on a portfolio basis.

DIFFERENCES BETWEEN CREDIT LOSSES AND IMPLICIT PRICE CONCESSION

The following information outlines the differences between expected credit losses and implicit price concessions. *

Credit loss	Implicit price concession
Represents loss on amount provider believed they were entitled to, but ultimately unable to collect	Represents decrease in the amount provider is willing to collect for services provided (implicitly)
Changes in credit loss estimates recorded to expense	Changes in estimates recorded to revenue
For integrated healthcare systems, the majority of amounts ultimately not collected for patient services are likely classified as implicit price concessions. Significant judgment will be required by healthcare organizations that have services provided over multiple visits with larger ongoing patient responsibilities (e.g., orthodontia, cosmetic services). Healthcare organizations should consider the factors outlined in Chapter 7 of the AICPA Revenue Recognition Guide in evaluating implicit price concessions.	

*Based on FASB guidance.

A credit loss represents a financial loss when a payer fails to fulfill their payment and the amount is deemed to be unrecoverable. This is likely to occur in the event of bankruptcy, insolvency or possibly economic downturns. Under the CECL model, organizations need to estimate and record an allowance for such future credit losses at the transaction date. A change in final settlement between parties based on updated patient information would not be considered a credit loss. The flow of information between healthcare organizations and payers that is required before reaching a final payment amount can result in multiple changes in the estimate to revenue and receivable balance recorded by an organization. This is unique to revenue cycle, and the volume and nature of the changes to receivable balances results in a need to exercise significant judgment when considering potential credit losses. Healthcare organizations need to ensure that they document their policies and procedures to allow them to consistently apply their defining criteria and to support their conclusions on what is deemed to be a credit loss or an implicit price concession.

In determining potential credit losses within patient receivables, it is important to consider portfolio segmentation as prescribed by ASC Subtopic 326-20. As a reminder, allowances should be estimated on a pool basis whenever similar risk characteristics exist. The segments identified by the organization are the pools used for calculating expected credit losses. This segmentation may be the same or comparable to the payer classification portfolios under ASC 606 that organizations include in historical financial statement disclosures.

Portfolio segmentation is defined in FASB's Master Glossary as:

> "The level at which an entity develops and documents a systematic methodology to determine its allowance for credit losses."

The following are characteristics that are outlined in ASC 320-20-55-5 that organizations may include in their determination of segments (not intended to be all inclusive nor a requirement to look at all characteristics listed):

- Internal or external (third-party) credit score or credit ratings
- Risk ratings or classifications
- Financial asset type

- Collateral type
- Size
- Effective interest rate
- Term
- Geographical location
- Industry of borrower (patient)
- Vintage
- Historical or expected credit loss patterns
- Reasonable and supportable forecast periods

Ultimately, healthcare organizations should segment at a level that is reasonable and that reflects the risk of default and, ultimately, loss. For some entities, this determination may be more or less disaggregated based on the nature of operations and payers.

Typically, for purposes of financial statements reporting under ASC 606 and now under ASC 326, healthcare organizations will look at governmental payer, commercial payer and self-pay patient receivable balances as separate segments and possibly break those further into classes of financial receivables. For each of these segments, ASC Subtopic 326 requires organizations to consider the possibility of a default, even if it is remote. To determine any potential allowance for credit loss, an organization needs to assess the potential loss upon such a default occurring.

In assessing the potential loss, organizations need to develop a methodology to estimate the potential loss for their financial assets. This methodology can vary depending on the size of the organization, the range of the organization's activities, the nature of the organization's financial assets and other factors. The standard does not specify a particular methodology to be applied but rather places the requirement on each organization to determine the methodology (or combination of methodologies) that is appropriate for their business. Some of the examples of methodologies that are described with ASC 326-20-55 include a loss-rate approach, vintage-year basis or aging schedule, among others. These may be considered when looking at individual financial assets or collectively at groups of financial assets. The loss-rate approach, which is consistent with how most healthcare organizations evaluate revenue, will likely be used most frequently in healthcare organizations, though it will need to be modified to address the requirements of ASC Subtopic 326-20 such as segmentation and reasonable and supportable forecasts.

While there may be a presumed risk of default even on a government payer, organizations might reach a conclusion that the expected loss is zero. ASC 326-20-30-10 does not require a reporting entity to measure an expected credit loss on a financial asset (or group of assets) if the historical information, adjusted for current conditions with reasonable and supportable forecasts would result in a zero expected loss.

ASC 326-50-55 includes multiple examples that organizations can consider in adopting this standard for payers where healthcare organizations feel there is zero expected loss. "Example 8: Estimating Expected Credit Losses When Potential Default is Greater than Zero, but Expected Nonpayment is Zero," which is listed in paragraphs 326-20-55-48 through 326-20-55-50, could possibly be interpreted to apply to receivable balances from government agencies.

The example in ASC 326 states:

> "Although U.S. Treasury securities often receive the highest credit rating by rating agencies at the end of the reporting period, Entity J's management still believes that there is a possibility of default, even if that risk is remote. However, Entity J considers the guidance in paragraph 326-20-30-10 and concludes that the long history with no credit losses for U.S. Treasury securities (adjusted for current conditions and reasonable and supportable forecasts) indicates an expectation that nonpayment of the amortized cost basis is zero, even if the U.S. government were to technically default. Judgment is required to determine the nature, depth, and extent of the analysis required to evaluate the effect of current conditions and reasonable and supportable forecasts on the historical credit loss information, including qualitative factors. In this circumstance, Entity J notes that U.S. Treasury securities are explicitly fully guaranteed by a sovereign entity that can print its own currency and that the sovereign entity's currency is routinely held by central banks and other major financial institutions, is used in international commerce, and commonly is viewed as a reserve currency, all of which qualitatively indicate that historical credit loss information should be minimally

affected by current conditions and reasonable and supportable forecasts. Therefore, Entity J does not record expected credit losses for its U.S. Treasury securities at the end of the reporting period. The qualitative factors considered by Entity J in this Example are not an all-inclusive list of conditions that must be met in order to apply the guidance in paragraph 326-20-30-10."

Healthcare organizations likely have receivable balances from various government agencies for which credit loss of zero could be concluded that are similar to the example provided in the standard above. The assessment should be based on each agency and should be updated at each reporting period for potential changes; however, it seems likely that healthcare organizations may reach a conclusion that the expected loss is zero when government payers are from certain agencies.

Commercial payers typically include any private insurer, managed care plan, health benefit plan, health maintenance organization, preferred provider organization, employer-sponsored health plan or any other payer programs. For these payers, healthcare organizations need to assess the potential risk of credit loss on their financial assets, or groups of financial assets. This segment of patient receivables may require further separation into multiple classes to properly assess an organization's risk of credit loss. For example, commercial health insurance companies might be deemed to have a low risk of default given the regulated industry requirements that are designed to protect the insured members (patients). However, unlike certain government agencies, there would likely still be a risk of loss in the event of a default.

While healthcare organizations have a great deal of historical data on each of their payers, which can serve as the historical losses foundation for the estimate of the allowance for expected credit losses, assessing the risk of future credit loss requires healthcare organizations to consider more than just historical losses as a proxy for the future. Healthcare organizations will need to use judgment in determining an estimate of future expected credit losses that includes considerations of historical losses as well as adjustments for current conditions, asset-specific risk characteristics and reasonable and supportable forecasts.

Current conditions and asset-specific risk characteristics adjustments are used to account for the fact that conditions today may differ from that of the historical loss period used. Reasonable and supportable forecast adjustments are used to account for future conditions that may differ from the historical loss period used. The reasonable and supportable forecasts are truly what makes the estimate "lifetime" in nature, though the consideration and impact of reasonable and supportable forecasts will vary depending on the timing of expected collection on patient receivable balances. Reasonable and supportable forecasts may not be relevant or impactful for short-term patient receivables (i.e., those that resolve or collect within a short duration); however, for longer-term receivables, healthcare organizations will need to consider and incorporate necessary adjustments for how future conditions would impact collectability. To do so, healthcare organizations will want to consider what drives collectability (i.e., loss drivers) and any internal or external trends that would indicate that the historical losses are not indicative of future expectations. This information may include trends in commercial default rates for insurance companies or other economic trends available through rating agencies or public data.

As an example, a global default trends report issued by Moody's in March of 2023 noted that the default rate of speculative-grade financial and non-financial companies rose to 4.3% in December 2022 and that it would likely rise to 4.4% in 2023 and peak at 4.6% in early 2024 before dropping down to 4.2%. This report also included data on the overall insurance industry commercial debt, including the annual default rates for the industry from 1980 to 2022. The information in this report and others might be useful to healthcare organizations in their consideration in developing their reasonable and supportable forecasts for future expected credit losses.

Self-pay or private pay balances within patient receivables requires consideration of the same principles as governmental and commercial payers; however, the type of healthcare organization and the magnitude of the self-pay balance may influence how an organization breaks down the balance of self-pay patients into further classes of financial assets.

It is important to evaluate the class of financial assets at the appropriate risk level that is shared. For example, a NFP healthcare organization may have 2% of total patient

receivable that are self-pay patient balances whereas a for-profit specialty clinic may have 40% with longer periods of service with multiple payment plans. In this example, the NFP organization might look at their self-pay as a single financial segment, whereas the for-profit specialty clinic may need to further break down their self-pay balance into separate classes to properly evaluate the risk in determining the estimated credit losses on their financial assets. As the proportion of self-pay patient receivables increase, likely with for-profit organizations that have processes in place to assess individual patient's credit for elective procedures, healthcare organizations will need to ensure that they consider all relevant inputs in evaluating credit risk. The credit risk associated with these self-pay patient receivables will likely be different for each type of healthcare organization and will require significant judgment in determining the proper estimated allowance for credit loss.

Once a healthcare organization evaluates the estimated credit loss for each segment of its patient receivable balance, along with any other financial assets that it might have subject to ASC Subtopic 326-20, such as HTM debt securities, it will need to determine the overall estimated impact on its financial statements in order to determine the proper level of disclosures. For any financial asset, or group of financial assets, that has estimated allowances that are significant and meet the organization's thresholds for disclosure in their financial statements, the organization will need to add or update disclosures for each class of financial asset in accordance with ASC 326-20. In the year of adoption, additional disclosures on transition and implementation should be included to inform the users of any cumulative effect adjustments that may be required upon the adoption of the standard as well as for the changes to the estimation approach or methodology to comply with ASC Subtopic 326-20.

Overall, the disclosures requirements of allowance for credit losses are designed to provide an understanding of the methods used by management along with the financial activity recorded within the financial statements for the year. These disclosures can be presented in narrative or tabular format based on what the organization determines will be most useful to the users of the financial statements. This evaluation could result in varying levels of disclosures depending on each healthcare organization's unique considerations.

In addition to implementation disclosures, healthcare organizations need to consider updating or adding additional disclosures for any financial assets (or group of financial assets) that are compliant with the disclosure requirements of ASC 326-20.

As public companies were required to implement ASC 326 before other reporting entities, organizations that are completing their adoption can utilize multiple public sources to research implementation and ongoing disclosure changes for comparable healthcare organizations.

Conclusion

Adopting ASC Subtopic 326-20 will require significant consideration and may have a major impact on the accounting, financial statement presentation and disclosure of healthcare entities that have trade receivables arising from patient service revenue, HTM debt securities and other financial assets that require evaluation under the standard. Healthcare entities will need to use judgment in adopting the new expected loss model for their financial assets or group of financial assets held at amortized cost basis under ASC Subtopic 326-20. Healthcare organizations will need to implement new policies and procedures for estimating expected credit losses, segmenting their receivables portfolios, calculating historical losses, developing adjustments to historical losses and accounting for subsequent changes in expected credit losses. Even in scenarios where an organization may reach a conclusion that there is no significant impact to its financial reporting, it is still necessary to complete a thorough initial analysis of compliance with the standard, to develop a new set of policies and procedures and to ensure that the analysis, policies and procedures are updated on a regular basis moving forward.

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