THERE’S JUST NO ACCOUNTING FOR HEALTHCARE: 
A LOOK AT THE DIFFERENCES BETWEEN STANDARD GAAP ACCOUNTING 
AND ACCOUNTING FOR HEALTHCARE CLIENTS

A thesis submitted to the 
Kent State University Honors College 
in partial fulfillment of the requirements 
for General Honors 

by 
Miranda Allen 

May, 2013
Thesis written by

Miranda Allen

Approved by

____________________________________________, Advisor

____________________________________________, Chair, Department of Accounting

Accepted by

____________________________________________, Dean, Honors College
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iv</td>
</tr>
<tr>
<td><strong>CHAPTER</strong></td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>II. THIRD PARTY Payers AND RELATED ACCOUNTING METHODS</td>
<td>5</td>
</tr>
<tr>
<td>- The Uninsured</td>
<td>5</td>
</tr>
<tr>
<td>- Private Insurance</td>
<td>7</td>
</tr>
<tr>
<td>- Government-Funded Insurance</td>
<td>8</td>
</tr>
<tr>
<td>- Medicaid</td>
<td>9</td>
</tr>
<tr>
<td>- Medicare</td>
<td>12</td>
</tr>
<tr>
<td>- A Transition to Managed Care</td>
<td>14</td>
</tr>
<tr>
<td>III. THE FASB’S PRONOUNCEMENTS ON HEALTHCARE</td>
<td>17</td>
</tr>
<tr>
<td>IV. REVENUE RECOGNITION AND PAYMENT FOR SERVICES</td>
<td>21</td>
</tr>
<tr>
<td>- Generally Accepted Accounting Principles: McDonald’s ®</td>
<td>22</td>
</tr>
<tr>
<td>- Healthcare Industry: Healthcare Providers</td>
<td>23</td>
</tr>
<tr>
<td>V. “BAD” DEBT AND ALLOWANCE FOR DOUBTFUL ACCOUNTS</td>
<td>26</td>
</tr>
<tr>
<td>- Accounting for Bad Debts Using the Receivables Account</td>
<td>27</td>
</tr>
<tr>
<td>- Accounting for Bad Debts Using the Sales Account</td>
<td>28</td>
</tr>
<tr>
<td>- Comparison of the Use of Bad Debts</td>
<td>29</td>
</tr>
<tr>
<td>VI. GOVERNMENT INVOLVEMENT</td>
<td>32</td>
</tr>
<tr>
<td>- Generally Accepted Accounting Principles: McDonald’s ®</td>
<td>36</td>
</tr>
<tr>
<td>- Healthcare Industry: Healthcare Providers</td>
<td>37</td>
</tr>
<tr>
<td>- Where the Healthcare Industry Differs from Other Industries</td>
<td>38</td>
</tr>
<tr>
<td>- Legislation</td>
<td>39</td>
</tr>
<tr>
<td>- Overview of Government Involvement</td>
<td>47</td>
</tr>
<tr>
<td>VII. CONCLUSION</td>
<td>49</td>
</tr>
<tr>
<td>WORKS CITED</td>
<td>53</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

When I began my thesis, I was not fully aware of how much work it would truly take. Although I was warned before the process began that it would take a large amount of focus and attention, I took these statements for granted. It is largely thanks to Dr. Zucca that this thesis was a successful project for me. Without her guidance, I would not have been able to remain motivated to work as much as I did. I would also like to thank the rest of my thesis committee, Dr. Sellers, Dr. Greenhalgh-Stanley, and Dr. Heaphy for their support and help throughout the process. This thesis wouldn’t have been able to become what it is without a single one of them.
CHAPTER I
INTRODUCTION

Every accounting student learns about the generally accepted accounting principles during his or her college career. These principles are aptly named, however, and when dealing with a specialized industry, it is not unusual for these principles to be tweaked to create industry principles that are more specific to that industry’s needs. Consequently, many professors emphasize that every accounting rule has many exceptions. Despite the fact that this is mentioned regularly, it is a difficult concept to grasp until one observes it firsthand. It is for this reason that this paper will show that there are substantial differences between generally accepted accounting principles normally taught in universities and those that must be used in a specific industry. To illustrate this, McDonald’s, a common user of the generally accepted accounting principles, will be compared and contrasted to facilities that provide healthcare services for the population, including doctors’ offices and hospitals.

When most people think about healthcare providers, it is likely that their first thought is related to the healthcare experiences that they, or their loved ones, have had. Others may first think about those who are employed by these facilities including the doctors, nurses, surgeons, and receptionists. Still others’ minds may first jump to all of the stories that they have heard about healthcare providers, both good and bad. A year ago, I could have easily fit into any of these categories. Since then, I have completed an
internship with an accounting firm which has taught me that there is another side of the healthcare industry that few people readily recognize. Even when considering something as personal as healthcare, there is a financial side which requires special attention.

Over the course of the spring 2012 semester, I completed an internship at Howard, Wershbale, & Co. (HW & Co.), a public accounting firm located in Beachwood, Ohio. HW & Co. has a variety of clients across many different industries, but one area where it specializes is the healthcare industry. It has a large number of clients that are long-term care facilities for the elderly and disabled. Accordingly, it has an entire department of staff devoted to these clients. This department performs services that are not necessary for clients outside of the healthcare industry including completing compliance reports of the costs of services provided to be turned in to Medicaid and Medicare. As a member of this department during my internship, I finally began to see for myself the truth of what my professors had said. There are different needs for different industries and this directly affects the kind of accounting that needs to be done.

This idea is a fundamental lesson for all accounting students to learn. The differences that exist between industries make it necessary for an accountant to change how he or she approaches the problem at hand in order to reach a successful conclusion. This fact is especially evident in the healthcare industry because it is truly unlike any other industry. There is more government involvement in the healthcare industry than in other industries, a very clear restriction on competition, a presence of insurance and third party payers, a lack of information available to customers, especially about the price of services, and there is a differing level of demand exhibited by each individual in the
market. Other industries have some of these obstacles to face as well, but no other industry has the same exact mix as the healthcare industry. There is no other industry where it would be as evident that there must sometimes be a different set of rules for different industries.

I have spent the last year investigating the idea that accounting needs of the healthcare industry, specifically the facilities that provide healthcare, are not easily met by the generally accepted accounting principles. Instead, the accounting methods that are used for these facilities are noticeably different from the accounting methods used most commonly. This paper will provide evidence that healthcare providers, a large sector of the healthcare industry, cannot use the same methods of accounting as McDonald’s, an example of a company that follows the generally accepted accounting principles. This will be expressed by the contrasting of the methods of revenue recognition and payment for services, debt collection and allowance for doubtful accounts, and the level of government involvement. This paper will furthermore show that there are substantial differences in all of these areas and that there are important reasons for these differences. Overall, this paper will give concrete evidence to the idea that providers of healthcare use accounting information to assist them in making different decisions than those operating in other industries must make. These decisions typically include which costs can be cut without reducing the health of patients, which patients should be seen to keep an entity profitable, and how to keep costs from getting too low as they directly influence many kinds of reimbursement. Accounting choices greatly impact the providers’ ability to make
these decisions effectively which explains why the healthcare industry must occasionally
deviate from the generally accepted accounting principles.
CHAPTER II
THIRD PARTY PAYERS AND RELATED ACCOUNTING METHODS

Overall, people can be classified into three main groups according to different levels of association with third party payers. The first group consists of people who have no third party coverage and are therefore “uninsured.” The second group consists of people who pay to have third party coverage, either through their employer or through the private market. Finally, the third group consists of people who, because they have a specified need, qualify to have their medical expenses paid for in part or in full by the government. All three groups of people must be treated differently from a financial point of view and therefore affect the overall reporting of revenue.

The Uninsured

The group without insurance, which makes up about 15% of the U.S. population (Greenhalgh-Stanley, 2013a), is the easiest to understand. These people must buy insurance from the private market because they do not get insurance through their employer. Due to the fact that such a large portion of the people who don’t receive insurance through their employer is younger, they typically get sick less often. As a result, the benefit that they expect to get out of an insurance policy is not very high. This causes them to have a lower willingness to pay for healthcare insurance than someone
who is commonly sick and therefore has a higher expected benefit. Private insurance companies, because they cannot tell if the person calling and requesting insurance is healthy or sick, have created a formula that helps calculate the price that a customer should pay the insurance company in order to receive coverage. This formula calculates the expected cost that the insurance company will incur if it covers the customer. The formula initially assumes that there is an even distribution of sick people and healthy people in the market and is therefore weighted accordingly. Based upon this calculation, the insurance company then determines the amount to charge the customer calling as a premium. Those who are healthy have a lower expected benefit for this insurance than what the insurance company asks them to pay as a premium. This leads to healthy people being “priced out” of the market because they are not willing to pay more for the insurance than their expected benefit. Healthier people decide not to purchase the insurance which drives premiums higher until only sick people are left in the market. (Greenhalgh-Stanley, 2013a).

It is shown that because this group of people doesn’t have insurance, they are less likely to go to a primary care physician for their care when they become sick. These people actually obtain the majority of their medical care through emergency rooms and clinics because these facilities cannot turn them away just because they do not have medical insurance. Unfortunately, the price of care at emergency rooms and clinics is, on average, two to three times more expensive than getting the same care from a primary care physician (Greenhalgh-Stanley, 2013c). Those without insurance are unlikely to pay for the healthcare that they have received because the price that they will be charged is
astronomical. As a result, the provider must make an adjustment for revenues that it will never collect, a process called “writing off bad debts.” This is something that will be discussed further in a later section.

Private Insurance

The privately insured group, which is made up of about 175 million people in the United States, relies on the third party payers that they have paid to insure them to take care of the bulk of their medical expenses (Greenhalgh-Stanley, 2013c). Only about 15% of the cost of healthcare is paid directly by the person who is receiving the care (Greenhalgh-Stanley, 2013a). About 160 million of the people in this group receive health insurance as a benefit from their employer while the remaining 15 million obtain it from the private market (Greenhalgh-Stanley, 2013c).

When individuals are covered by private insurance companies, they must make regular payments called “premiums” to the insurance company. These premium payments give the insured individual the right to undergo any procedures that are on the insurance company’s list of procedures that are “covered” by the insurance company. In addition to paying the premium, some insurance companies also require their customers to pay a “deductible,” or a certain amount of money before they will begin to cover part or all of their healthcare expenses. Finally, many insurance companies require their customers to pay “copayments” which are fixed sums of money that must be paid every time that they receive healthcare. The premiums that the insured individuals pay reduces
the amount of risk associated with the high costs that they will potentially have to pay for the healthcare that they will receive. They are therefore assured by the insurance company that they will not have to pay the full amount owed for the procedures that they receive provided that they are on the insurance company’s formulary.

Before the individuals are even insured by the insurance company, the insurance company has already bargained with specific healthcare providers to set up an amount that the insurance company will pay the provider for each procedure. Occasionally, the amount that the insurance company is willing to pay and the amount that the provider is willing to accept for the services is not equal, which results in the insured sometimes having to pay a severely reduced portion of the cost on their own. Other times, the insurance company is able to convince the provider to further lower its prices by agreeing to limit the number of providers that their customers can see. These insurance company practices typically assure that the provider of the services will not receive an amount equal to what it originally recognized as revenue at the “point of sale.” This is another situation where the provider will have to make an adjustment for the difference between what it expected to receive and what it did receive.

Government-Funded Insurance

Finally, although the United States does not have a universal healthcare system, a substantial portion of healthcare costs are paid by the government. About 25% of the insured people in the United States are covered by an insurance company that is mainly
financed by the tax dollars that are raised by the government. About 46% of the healthcare costs in the United States are paid for out of four insurance plans that the government runs (Greenhalgh-Stanley, 2013b). These are Medicaid, Medicare, TRICARE, and Veterans Administration. TRICARE and Veterans Administration are only available to those who have served in the United States armed forces and their immediate family members, covering about 9.6 million Americans. Similarly, Medicaid and Medicare have restrictions on eligibility, but as of 2011, Medicaid covered about 69 million Americans (“Eligibility”), Medicare covered about 48 million Americans (Medicare.gov), and about 9 million Americans were covered by both programs (“Eligibility”). Due to the great variance in TRICARE and Veterans Administration plans, these will not be discussed at great length in this paper, but more detail will be provided about both Medicaid and Medicare.

**Medicaid**

Medicaid is a government funded insurance company that is solely available to the indigent and the children of these individuals. Although Medicaid is a Federal program, each state is in charge of its own Medicaid program and is responsible for financing between 25 and 50% of the funds to assist its population. This amount is based on the overall wealth of the individuals that are in the state and averages around 43%. This segment of the population makes very little money and can therefore not afford to pay for insurance in the private market. In addition, many people who are eligible for Medicaid are either not employed or are part-time workers. In both cases, this means that
they are, usually, not able to receive healthcare insurance through their employers. To qualify for assistance through Medicaid an individual cannot make more than a specified amount, which, in the state of Ohio, is calculated as 90 to 200% of the Federal Poverty Level (FPL). The FPL is determined by the Department of Health and Human Services and is a set minimum amount of income that a family must make in order to pay for basic needs such as food, clothing, transportation, and shelter. It varies according to the size of the family and is adjusted for inflation. This percentage fluctuates between the two amounts based on whether or not the insured individual has children or is pregnant. In 2012, the FPL was $11,170 per year for an individual (“Eligibility”). The following chart posted on the Ohio Department of Job and Family Services (ODJFS) Medicaid Fact Sheet, which was last updated in 2009, depicts the different levels of income that one can make a month in order to remain eligible for Medicaid.

![Monthly Income Guidelines](image)

In addition to the income requirement, the beneficiary must be a U.S. citizen and fall into one of the following categories: children, women who are pregnant, the disabled, parents,
and the elderly. The table below, which can also be found in the ODJFS’ Medicaid Fact Sheet, further explains who is eligible to be covered by Medicaid.

### Eligibility At A Glance

<table>
<thead>
<tr>
<th>Who’s Covered</th>
<th>Income Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Former foster youth age 18 to 21</td>
<td>No income guidelines. Restrictions apply.</td>
</tr>
<tr>
<td>Children to age 19 and Pregnant Women</td>
<td>200% FPL</td>
</tr>
<tr>
<td>Parents</td>
<td>90% FPL</td>
</tr>
<tr>
<td>Disabled Persons</td>
<td>~ 64% FPL**</td>
</tr>
<tr>
<td>Workers with Disabilities</td>
<td>250% FPL*</td>
</tr>
<tr>
<td>Persons 65 &amp; over</td>
<td>~ 64% FPL**</td>
</tr>
<tr>
<td>Medicare beneficiaries in need of premium assistance</td>
<td>200% FPL</td>
</tr>
</tbody>
</table>

* Exceptions and calculations will affect final amount counted toward eligibility. Actual determination of eligibility is done at a county department of job & family services office. Some eligibility categories consider resources other than income and health insurance.

** Deductions and exceptions apply: this is an approximate guide. Persons with incomes higher than 84% of the FPL may have medical expenses deducted from income calculations to “spenddown” to this level.

For those who are covered by Medicaid, a small amount of the cost of their healthcare is expected to be paid for by the insured person. This amount is deemed to be reasonable based on the income of the individual. In order to keep the cost incurred by those insured by Medicaid low, each state must determine what will be covered in addition to the healthcare that must be covered due to federal mandates. In addition, each state can control the cost of the federally mandated services its covered individuals can consume by limiting the overall dollar amount of the service, the number of times that the individual can visit a healthcare provider a year, or by restricting the healthcare providers that they can see. By setting limits on these services, the system effectively reduces not
only their cost, but also constrains the amount that they will pay the providers of these services by bargaining over prices. This is similar to the methods used by the private insurance companies to reduce costs. Medicaid reimburses providers less than any other insurance company, so providers must decide whether or not to serve this population on an all or nothing basis. If a provider decides to accept Medicaid, it must again make adjustments to its previously recognized revenue amount.

**Medicare**

Similar to Medicaid, Medicare is an insurance provider that targets a specific group of people, the elderly. It, too, has requirements for eligibility. Medicare is available exclusively to three groups of people: those over 65 years old who have worked in Medicare-covered employment for 10 years or are married to someone who has, those who are under 65 and are disabled, and those of any age who have end-stage renal failure (Medicare.gov). Due to the work requirement, there is no income restriction placed on those who receive Medicare benefits. The Medicare program is also split into three main divisions: “traditional” Medicare, Medicare Advantage, also called “part C”, and “part D.” “Traditional” Medicare is split into two parts, part A and part B. Part A covers hospital bills and specific long-term care bills if they meet certain criteria. Part B pays for outpatient healthcare such as visits to doctors’ offices and medical supplies. Medicare Advantage, part C, is a form of traditional insurance in which people who qualify for Medicare can choose to enroll. Most of the costs of part C are paid for in the same way that traditional Medicare’s costs are paid for. Part C offers both the benefits of parts A
and B as well as prescription drug coverage. Finally, part D covers prescription medications and requires separate enrollment.

In contrast to Medicaid, Medicare is financed primarily through the taxes paid by all individuals who are currently working in Medicare-covered employment and can ordinarily only be received by someone who also worked in this capacity for at least 10 years. People who have worked for 10 years in Medicare-covered employment do not have to pay any premiums for part A, but, as of 2012, will have to pay a deductible of $1,156 for their hospital visits for up to 60 days and an additional copayment of $289 per day for the next thirty days after this. Those who do not meet the work requirement or are not married to someone who meets the work requirement are able to obtain part A coverage, but they must pay a monthly premium. To receive the benefits of part B coverage, a beneficiary is first responsible for a deductible of $140 and then must pay a coinsurance amount of 20% for most medical services. Part C and part D coverage charges vary from plan to plan (Medicare.gov).

For healthcare providers, Medicare has set up a lump-sum fee schedule which defines which services they will cover and at which rates they will pay for these services. These set fees are usually at rates lower than what a provider would wish to earn in return for the service. As a result, there are providers who accept Medicare, those who accept Medicare for most services, and those who do not accept Medicare insurance as a form of payment. Regardless of whether or not a provider decides to accept Medicare, it is easy to see that it is the simplest form of payment to work with. There are few, if any, adjustments to be made to revenue after the fact because providers know at the time of
service how much they will be paid for their work. Therefore, it is very simple for a provider to initially record the correct net amount on the books.

A Transition to Managed Care

In an effort to reduce the costs and uncertainty in the healthcare market, many insurance companies have made an effort to emulate Medicare’s lump-sum payment method. This type of insurance is often referred to as a managed care plan. These insurance plans encompass a range of flexibility that varies between standard Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plans, and Point of Service (POS) plans. HMOs are further divided into three models with varying levels of options on which providers a patient is allowed to see: staff, network, and Independent Practice Association (IPA).

HMOs are the least flexible type of managed care plan as they require patients to designate a primary care physician who acts as a “gatekeeper” and restricts access to specialists in addition to limiting the doctors that they are allowed to see. Staff model HMOs, such as Kaiser Permanente or Summa, are the most restrictive type of HMO. The doctors are employed by the insurance company and the insurance company owns the hospitals. In a network model HMO, the HMO contracts with different physicians and providers to form a network. The HMO will pay for any services that are approved and provided by the “in-network” doctors, but will not pay for any services rendered by doctors who are not in the network. Finally, the IPA form of HMO contracts with
physicians to form a network, but will allow its patients to see out of network doctors, but will not cover as much of the cost.

Similar to the IPA model of HMO, the PPO forms a network of doctors that a patient can see and hospitals to which a patient can go, but will still pay for a portion of the patient’s expenses if he or she chooses to see an out-of-network provider. Unlike an HMO, however, a PPO plan will not require the patient to select a primary care physician who must be seen to get a referral to a specialist. Also, PPOs pay doctors at a fee-for-service reimbursement rate instead of a lump-sum. The PPO plan manages to keep costs low while using this reimbursement method by setting a rate with the doctors in its network which is reduced from what a traditional insurance company using a fee-for-service reimbursement rate would have paid. PPOs also commonly require prior-authorization for more expensive services, require concurrent utilization reviews for hospital stays, and require a second opinion before surgeries are performed.

Finally, POS managed care systems are a mix of HMO and PPO plans. Like PPO plans, they also create a network of doctors and set lump-sum payment rates for services, but they allow patients to see doctors both in and out of the network. Like HMO plans, they also require patients to choose a primary care physician and get a referral before seeing any specialists. POS systems, as well as HMOs and PPOs, cut costs by inspiring providers to provide less care to their patients because they know that since they are being reimbursed at a reduced rate, they have to incur fewer costs in order to earn a profit.
As insurance companies move toward managed care, especially HMO and POS plans, the uncertainty of revenue recognition is reduced. When doctors are “in the network,” they have pre-negotiated the rate at which they will be reimbursed. As a result, they can record revenue at the correct amount and no adjustments will be necessary.

Although PPO plans still use a fee-for-service reimbursement model, they make the doctors who are “in network” aware of the reduced rate at which they will be paid which reduces uncertainty. The only drawback in terms of revenue recognition for providers is that if they are not “in network,” there is a large amount of uncertainty in how much revenue they can recognize. In this situation, there is no set rate at which the providers are to be reimbursed, and the insurance company has already notified the patient that it will not be covering as much of the care received. This means that any care received that the insurance company will not cover must be paid for by the patient, from whom collection of payment is always uncertain.
CHAPTER III
THE FASB’S PRONOUNCEMENTS ON HEALTHCARE

The Financial Accounting Standards Board (FASB) is a non-governmental accounting standard setting body. It was created in 1973 to provide guidance in the accounting field. The standards that are released by the FASB are regarded by the Securities and Exchange Commission (SEC) as the governing standards of the profession. The FASB not only sets standards that relate to accounting as a whole, but also sets standards for individual industries (“Facts about FASB”). There are five basic areas in the process of accounting for healthcare entities in which the FASB has provided specific guidance. These include the presentation of financial statements, segment reporting, receivables, revenue recognition, and other expenses.

The special attention awarded to the presentation of financial statements in the healthcare industry is due to the prominence of nonprofit organizations that exist in the field. One example of a difference between the financial statements of typical corporations and the financial statements that are distributed from some healthcare entities is the presence, or lack thereof, of “shareholder’s equity.” This is an account that is commonly seen on most balance sheets, but in the case of nonprofit healthcare entities, it is not shown. This is because nonprofit organizations do not have shareholders. In addition, nonprofit healthcare organizations are likely to have a “contributions” account on their balance sheet which holds all of the donations that have been given to the
organization over time. Overall, there are not many differences between typical financial statements and financial statements that are prepared by healthcare entities, but the differences that do exist are worth noting.

Segment reporting in the healthcare industry requires further explanation due to the existence of third party payers. Occasionally, entities are required to disclose information about their reliance on major customers. As a result, the FASB felt that it was necessary to distinguish between the party who pays for services in a healthcare transaction and the party that is the customer. This led to information presented that expressed the idea that insurance companies are not the customer of the healthcare entity (FASB ASC 954-280-45-1). Due to this fact, when a healthcare organization discloses its major customers, it is not allowed to include any insurance companies.

The existence of third party payers also influenced the FASB’s decision to make a special accounting rule, Accounting Standards Update 2011-07 released on July 25, 2011, regarding the receivables of a healthcare entity. Due to the fact that many payments received by healthcare organizations are for less than the provider’s established rates, a provider is very likely to overstate their receivable amounts. This would potentially make a provider look much more profitable than it really is and would lead to inaccurate financial statements. To prevent this from happening, the FASB requires healthcare organizations to provide a reasonable estimate of the amount that they are actually expecting to receive from third party payers in the same period as the services are rendered. Providers are later allowed to further adjust these amounts when payment is received and they are able to provide a correct revenue amount.
The FASB’s guidelines discussed in Accounting Standards Update 2012-04 released on October 1, 2012 that pertain to the recognition of revenue are similar to those that it puts forth regarding receivables. Again, the existence of third party payers introduces a large element of financial uncertainty into the healthcare industry. Providers cannot be sure how much they are going to receive for their services until they have received the payment. Due to this fact, the FASB has developed instructions for recognizing revenue. These are important and will therefore be discussed further in a later section.

Finally, the FASB has provided guidance to the sector of the healthcare industry that includes these third party payers regarding their other expenses with the Accounting Standards Update 2010-24 released on August 27, 2010. One common third party payer is an insurance company. Insurance companies must find a way to convince prospective customers that it is necessary to buy an insurance plan from them. These costs are not related to patient services and are typically called “acquisition costs.” These costs are reported separately from standard marketing costs which make further instruction from the FASB necessary.

Overall, the majority of guidance that is provided regarding accounting for a healthcare entity is necessary because of the large influence of third party payers. There is not a large amount of explicit instruction provided for the healthcare industry, but the existing information shows that there is a need for rules beyond standard GAAP. There are differences between the financial statement presentation when comparing standard GAAP and the healthcare industry which are worth noting. In addition, the way that
revenue is recognized and receivables are accounted for differs from the standard methods. The FASB provides a sufficient amount of necessary guidance in these areas that help make the accounting methods for healthcare entities more clear.
CHAPTER IV

REVENUE RECOGNITION AND PAYMENT FOR SERVICES

The revenue recognition principle is one of the main cornerstones of accounting. The principle states that revenue recognition involves the consideration of two factors (a) being realized or realizable and (b) being earned (FASB SFAC 5-84). Revenue is realized when cash is received and it is earned when all of the tasks needed to be performed in order to receive cash have been completed. This is normally the point of sale. As a result, there are many different rules determining when a business should recognize revenue which are directly related to the type of business in which it participates. Examples of these different types of recognition include point of sale, percentage of completion, and the installment method.

Each specialized industry has a revenue recognition method that is best suited to its needs. For example, many construction projects result in the use of the percentage of completion method. Construction projects are typically very long and the revenue is actually earned gradually over the course of the project. The revenue from the project is considered to be realized based on the costs that have been incurred up to that point. Similarly, if the company is operating in an industry where it is not certain that the entire amount of revenue will be collected, such as real estate sales, the company should use the installment sales method. In this case, the revenue is recognized as it is received so that the amount of revenue earned from the sale is not overstated. The method of revenue
recognition changes from industry to industry, and affects the overall bottom line of the company involved.

Generally Accepted Accounting Principles: McDonald’s®

The two conditions for revenue recognition (being realized or realizable and being earned) are usually met at the time the merchandise is delivered or services are rendered to customers. Revenues from manufacturing and selling activities and gains and losses from sales of other assets are commonly recognized at time of sale (FASB SFAC 5-84). This describes the point of sale method for recognizing revenue. When the point of sale method is used, the revenue is realized and earned at the point of sale. This is because simultaneously, the customer pays for the goods or services that they are to receive and then receives the good or services. Most companies can use this method of revenue recognition including those companies in the service restaurant industry such as McDonald’s.

As a service restaurant, McDonald’s provides food to its customers in an expedient way. When the customers arrive at the counter and place their order, their payment is collected. Shortly after, the customer receives his or her food. Because of the way that the industry operates, the point of sale method of revenue recognition works to ensure that McDonald’s revenue is stated properly on their financial statements. It is easy to trace every sale back to the register and to match the cost of making each item that was
sold to the revenue received. As a result, the point of sale method makes revenue recognition for McDonald’s simple.

When McDonald’s asks its customers for payment, the individual receiving the food is the one who pays for the food that they are about to consume. Occasionally, a second person will pay for the food, for example, a father buying Happy Meals for his children. In this example, the second person acts only as an agent for the others. In theory, the children could pay for the food that they are going to consume if the father gave them the money to do so. It is easy to see that the customer who is getting the benefit from the company is paying for the benefit.

In addition, when a customer steps up to the register, he or she has no bargaining power. In this situation, whatever the menu lists as the price, the customer must pay. The only other option that the customer has is not to purchase, and therefore not to consume, the food. Even if the customer regularly dealt with the McDonald’s restaurant in her town she would not be able to “strike a deal” which allowed her to pay anything less than the stated price of the food. Overall, what every customer reads on the menu, including the deals that are available that day, are the same for all customers regardless of each customer’s financial position.

Healthcare Industry: Healthcare Providers

Similar to the service restaurant industry’s most common method of revenue recognition, the healthcare industry also recognizes its revenue at the “point of sale.”
Revenue usually is recorded when coverage is provided to an enrollee or the service is provided to a patient or resident. An enrollee is an individual who is a subscriber or an eligible dependent of a subscriber in a prepaid healthcare plan (FASB ASC 954-605-25-2). Despite this definition, things are not as simple in the healthcare industry as they are in the service restaurant industry. This is because a small portion of the cost of healthcare is received at the point that services are rendered. Only 15% of the costs of healthcare are paid out of pocket and about 80% of healthcare costs are paid for by third party payers of some kind which results in payment often being received after services has been rendered (Greenhalgh-Stanley, 2013b). As a result, although revenue is recognized at the “point of sale,” not all of the amount will be collected so an adjustment to gross service revenue will need to be made.

Although the healthcare industry does recognize revenue for covered patients at the time that the services are rendered, the fact that the healthcare entity is not paid directly by the patient is a large factor in calculating net revenue. A healthcare entity calculates its expected revenue at its predetermined rates at the time of sale even if it does not expect to collect that amount. This amount is recognized and recorded on an accrual basis. Because the predetermined rates are usually more than what the entity will receive from the insurance company, an additional calculation must be made later. The healthcare organization should only report the amount that it actually collects on its financial statements. To do this, the organization reduces its recognized revenue to the amount of payment received by both patients and third party payers.
In conclusion, the amount that healthcare providers actually receive is often very different from the revenue that they record in their books when the services are rendered. This is true whether or not a patient has insurance coverage or must pay out of pocket for their healthcare. Due to this, an additional calculation must be made to determine the amount of revenue that the healthcare provider has earned over the period and on an accrual basis. The difference between what the provider expected to collect for his services and the amount that he did receive from the third party payer must be subtracted from the gross service revenue to arrive at the amount of net service revenue that the provider can disclose (FASB ASC 954-605-25-4). In addition to this, the amount of bad debts that the provider must write off shows up in the financial statements as expense that ultimately offsets the amount of revenue that it has earned.
CHAPTER V

“BAD” DEBT AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

Almost all companies offer the advantage of credit sales. This practice began around 1850 with the invention of the sewing machine. Targeted at housewives who made their own clothing, the sewing machine greatly reduced the amount of time that the sewing of a garment took which was, at the time, very exciting. In order to entice more women to buy the machines, the companies selling them offered installment loans (“The History of Credit and Debt”). The installment loans allowed the purchasers to make payments every week while still getting the benefits of owning the machine now instead of paying at the time that they received the merchandise. This, of course, had a major impact on accounting.

As was discussed in the previous section, most companies recognize revenue at the point of sale. The addition of credit sales created a wrinkle in this process because while the original idea behind extending credit was to increase sales, there is an unforeseen underlying problem. Although there is a universal expectation that when selling goods and services that the seller will receive payment in return, when customers are given the option of receiving the goods or services before they are required to pay for them, this is not always the case. Unfortunately, discrepancies can occur as a result of many things including customer dishonesty, general economic conditions and communication errors between all of the parties involved in the transaction. Because of
this, those who offer credit sales must also put accounting policies in place that help account for sales for which they never receive payment. Therefore, some percentage of sales is considered uncollectible and is colloquially called “bad debts.” As there are many companies who must deal with this issue, there is a standard accounting process in place.

The method of accounting for bad debts begins with the calculation of how many receivables the company expects to become uncollectable. There are two accounts on which this estimate can be based: the receivables account, and the sales account. Regardless of which account is being used, management must estimate the percentage of accounts for which it believes it will not receive payment. This percentage is generally based on the experiences that the company has had with receivables in the past.

Accounting for Bad Debts Using the Receivables Account

When using the receivables account, the total receivables amount is multiplied by the percentage that is considered to be uncollectable. The result of this determines the ending balance of an account created for this purpose called the “allowance for doubtful accounts.” In order to get the balance to equal this estimated amount, the current balance in the allowance for doubtful accounts account is compared to the required balance. The difference is then appropriately debited to an account called “bad debt expense” and credited to the allowance for doubtful accounts account. The following is an example of a bad debt calculation using the receivables account.
A company has an accounts receivable balance of $175,000 and believes that 2% of its accounts receivable will be uncollectible. The allowance for doubtful accounts account currently has a credit balance of $700.

**Calculation of Allowance for Doubtful Accounts Balance:**

\[
\text{Allowance for Doubtful Accounts} = \text{Accounts Receivable} \times \text{Percentage Uncollectible}
\]

\[
\text{Allowance for Doubtful Accounts} = \$175,000 \times 0.02
\]

\[
\text{Allowance for Doubtful Accounts} = \$3,500
\]

**Journal Entry:**

<table>
<thead>
<tr>
<th>Credit</th>
<th>Debit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad Debt Expense</td>
<td>2,800</td>
</tr>
<tr>
<td>Allowance for Doubtful Accounts (3,500 – 700)</td>
<td></td>
</tr>
<tr>
<td>2,800</td>
<td></td>
</tr>
</tbody>
</table>

This means that the net realizable value, the amount of cash the company expects to receive, of the company’s accounts receivable is $172,200.

**Accounting for Bad Debts Using the Sales Account**

If instead the sales account is used to estimate bad debt expense, the procedure is very similar. The total of the sales account is multiplied by the percentage of sales expected to be uncollectible. This determines the amount of bad debt expense for the accounting period. In this case, it is much easier to determine the entry that needs to be made because temporary expense accounts are cleared at the end of every accounting period. Therefore, it is only necessary to debit the bad debt expense account for the entire amount that it should hold and to credit the allowance for doubtful accounts account for the same amount. The following is an example of a bad debt calculation using the sales account.

The same company has net credit sales of $80,000 and estimates that 2% of its credit sales will be uncollectible. It has an accounts receivable balance of $175,000.
**Calculation of Bad Debt Expense Balance:**

Bad Debt Expense = Net Credit Sales x Percentage Bad Debt  
Bad Debt Expense = $80,000 x .02  
Bad Debt Expense = $1,600

**Journal Entry:**

<table>
<thead>
<tr>
<th>Debit</th>
<th>Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad Debt Expense</td>
<td>1,600</td>
</tr>
<tr>
<td>Allowance for Doubtful Accounts</td>
<td>1,600</td>
</tr>
</tbody>
</table>

This means that the net realizable value of the company’s accounts receivable is $173,400.

In both cases, the final step is to deduct the debts that actually become uncollectible during the period from the allowance for doubtful accounts account at the point which they are deemed uncollectible. There is no expense recorded at this point. The following is an example of the entry made when a specific account is determined to be uncollectible.

A customer of the same company has not made any payments on her account although the debt was created over a year ago. The balance on the account is $500. The company believes that this debt will be uncollectible.

**Journal Entry:**

<table>
<thead>
<tr>
<th>Debit</th>
<th>Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowance for Doubtful Accounts</td>
<td>500</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>500</td>
</tr>
</tbody>
</table>

Comparison of the Use of Bad Debts

The accounting process used to calculate the estimate of bad debt expense and subsequently write off an account is the same regardless of the industry in which a company operates. The difference exists, however, when one looks into the number of
accounts that are typically written off and the number of receivables that are on the books. For example, many stores offer store credit cards. These companies have many receivables, but they likely do not have a large amount of bad debt expense. In comparison, banks, which offer large loans to customers, have a lot of receivables and are more likely than stores to need to write off these receivables when their customers face times of economic stress. Finally, there are other companies including restaurants which have very few receivables and therefore do not accumulate very much bad debt expense.

Overall, the largest difference in the use of the “bad debt” account and “allowance for doubtful accounts” account between McDonald’s and a healthcare provider is the frequency with which they are used. For a company such as McDonald’s, it is very impractical for the company to regularly extend credit to its customers. The prices charged are small and it is likely unnecessary to break up the payment for these prices into multiple periods. This is evidenced by the consolidated listing of accounts and notes receivable on McDonald’s balance sheet which shows that accounts do not often fall into these classifications. In contrast, healthcare providers regularly offer “credit sales” to their customers. Healthcare costs are much higher and variable than the cost of many other services. The fact that 15% of patients seen do not have healthcare insurance, paired with the fact that healthcare costs are extremely high, results in many of these accounts becoming uncollectible. This fact is not as common when there is a third party payer involved, but is very common when there is a lack of insurance coverage. Therefore, the “bad debt” and “allowance for doubtful accounts” accounts and the methods of
accounting that are used to account for them are much more common in the healthcare industry.
CHAPTER VI

GOVERNMENT INVOLVEMENT

Every country, regardless of which type of government it is formed under, experiences some level of government involvement in what occurs within its borders. The government has an especially large amount of influence on the type of markets that exist within a country and what can happen within these markets. Although the way in which a government exerts its influence over the economy varies greatly depending upon which type of government it is, a republic, dictatorship, monarchy, etc., all governments are involved in their country’s economy. One way that governments are involved is by determining under which type of economy the country’s markets will run. The most clear-cut division in economic ideology is between capitalism and socialism. There are many divisions of both and combinations between the two, but it can be agreed that the fundamental beliefs of each are different. By deciding which economic ideology that a country will employ, many decisions are made.

A government can choose to create a system based on the capitalist ideology for its economy, which is a typical choice of many of the more participative types of government. If the government determines that this ideology is the best outline for creating a system for its country, it is inherently agreeing that individuals will own the wealth-producing components of the economy. The government is also agreeing that the purpose of this capital is to create profit for the owners of that capital. By choosing this
economic ideology, the government will follow the principles of “lassiez-faire” and therefore will not interfere in the markets in the country unless there are severe market inefficiencies or failures. In general, a system built around the capitalist ideology leads to a free-market economy.

In contrast, the government can also choose to employ a system based upon socialist ideals for its economy, something that is typical of the more restrictive forms of government. If the government believes that a system whose framework is built around socialism is better for its country, it is instead agreeing that the society as a whole will have ownership of the economy’s wealth-producing components. It also agrees that the profits of the society should be shared evenly throughout the society in addition to the wages that individuals receive. In a system that runs according to the socialist ideology, the government has a much larger involvement in the way the economy behaves and must regulate it. Overall, creating a system based in socialism means that the government will have a large amount of participation in the economy.

Despite the fact that there are vast differences in these two ideologies, there are few, if any, pure examples of either in existence. Almost every system around the world has some features of each ideology. For example, the United States is generally considered to be a free-market economy governed by capitalist ideals. Despite this, there are many socialist policies in place in the United States. This fact is true of all industries with a stake in the economy and is extremely evident in the government’s role in the country’s markets.
Although the United States is categorized as a republic which should put the United States in the “free market” category, the government has made an attempt to regulate businesses in order to protect its citizens since the United States became its own self-governing country in 1776. In 1789, the adoption of the Constitution allowed the government to regulate interstate commerce. The government’s power to regulate interstate commerce increased in 1824, when it was given the ability to regulate the licenses that they required businesses to have in order to sell goods across state lines. The Sherman Antitrust Act passed in 1890 increased the government’s power over the market and gave the government the right to break up monopolies. This was followed by the Clayton Act, passed in 1914, which created the Federal Trade Commission. The FTC was put in charge of preventing unfair trade acts. The Pure Food and Drug Act of 1906 also regulated businesses by requiring that they become more sanitary. In 1938, the Fair Labor Standards Act regulated businesses by disallowing child labor and by increasing employee protection. In the early 1970s, three new agencies were formed to regulate various aspects of businesses: the Environmental Protection Agency, the Occupational Health and Safety Administration, and the Consumer Protection Agency. In addition, from 1971 to 1974, the government imposed several wage and price controls on businesses in the United States. All of these acts created by the government led to a period of deregulation in the business sector during the 1980s and 1990s. This period of deregulation ended in the early 2000s after many accounting scandals occurred including those surrounding Enron and WorldCom. Due to these events, the government began
taking measures to return to the levels of regulation exhibited prior to the 1980s by enacting new legislation (Gale Encyclopedia of US History).

One organization that was created by the government to regulate businesses is extremely important to the accounting discipline. In the United States, there is an organization called the Securities and Exchange Commission, or the SEC. The SEC was created by the Securities Exchange Act of 1934 and is responsible for enforcing the federal laws regulating the securities industry, especially the sale of securities, and all corporate reporting. Upon its inception, the SEC immediately became a key player in the accounting discipline due to its requirement that all publicly traded companies must report specific financial information to the agency. This includes submitting 10-K’s, which include financial statements and are filed on an annual basis, 10-Q’s, which include financial statements and are filed on a quarterly basis, and S-1’s, which include a prospectus and audited financial statements and are filed when a company intends to become public and seeks permission to make an initial public offering of stock.

The SEC became increasingly influential as many laws were passed from 1933 to 1940 outlining the agency’s responsibilities. In 2002, it was given even more responsibility when the United States Congress and President George W. Bush signed the Sarbanes-Oxley act, or SOX. Due to recent frauds that were primarily caused by actions that occurred during the period of deregulation from 1980 to 2000, the government decided that there needed to be stricter guidelines regarding financial information that investors used to make decisions about where to invest their money. First, SOX required top management, specifically the CEO and CFO, of all publicly traded companies to
certify that the financial information that they present to the public is accurate. Next, it required that public companies put in place an internal control system to ensure that financial reporting was accurate, operations were effective and efficient, laws were followed, and assets were safeguarded against theft. Third, it required that public companies’ financial statements and systems of internal controls were audited by an external auditor every year in order to ensure that the financial statements were complete and accurate and the internal control system was working properly. Finally, SOX required an increased level of oversight on the company from the company’s board of directors.

In addition to these requirements that were placed on public companies, accounting firms were also given new rules under which they were to operate. They were required to have an increased level of independence from the companies that they audited. The SEC also created the Public Company Accounting Oversight Board, or the PCAOB, to oversee the auditors of public companies. The PCAOB regulates the auditing practices of the accounting firms who audit public companies. In order to ensure that SOX was effective, penalties for producing fraudulent financial information or participating in fraudulent financial activities were made more severe.

Generally Accepted Accounting Principles: McDonald’s

United States’ government involvement in most companies, including McDonald’s, is generally limited to regulation that is intended to protect its citizens from
the reckless nature of a free market. Outside of this protective regulation, McDonald’s is essentially left to its own devices and is allowed to earn its owners a profit. The SEC and the Food and Drug Administration are two governmental agencies that both separately regulate McDonald’s to ensure that the company is not causing harm to the public. The SEC protects current and potential investors by ensuring that the financial information that is presented by McDonald’s financial statements is fairly presented and complete which protects them from making poor investment decisions. Also, the SEC protects any creditors that McDonald’s has by requiring the company to disclose accurate financial information. The Food and Drug Administration also helps protect United States citizens by preventing McDonald’s from selling food to customers that may contain ingredients that are potentially harmful.

Healthcare Industry: Healthcare Providers

In contrast to the vast majority of the “free market” that is comprised of corporations such as McDonald’s, the healthcare industry does not have a high concentration of public companies. Although healthcare entities that are publicly owned are becoming more common, the majority of healthcare entities are privately held companies, many of which are nonprofit organizations. Many healthcare entities decide to have this distinction because since the profits are not distributed to shareholders, as they are in a for-profit firm, there are many tax deductions that are available. These include being exempt from paying state or federal tax on income earned in the ordinary
course of business. Out of the approximately 4,973 community hospitals in the United States, there are around 2,903 that are not-for-profit and about 1,045 hospitals that are owned by the government (American Hospital Association). As a result, the government involvement in the healthcare industry doesn’t usually consist of oversight from the SEC. Despite this fact, the government plays an immensely large part in the healthcare market and the extent of government involvement is only expected to grow in the future.

The government is involved in many aspects of the economy and it is very easy to pinpoint their involvement in the healthcare industry. The government is not only involved in the regulation of the industry by creating industry-wide laws, but it is also a participant. The vast level of government intervention in the industry would be seen as wildly inappropriate in almost any other industry, but here, it is, for the most part, considered acceptable. This is likely attributable to the fact that healthcare is so different from all other industries.

**Where the Healthcare Industry Differs from Other Industries**

The healthcare industry differs from other industries for several reasons. First, as was discussed previously, the involvement of insurance companies and their reimbursement policies cause a great deal of uncertainty for health care providers when recognizing revenue. This uncertainty has been greatly reduced by efforts from the insurance company to manage care, but this is still a large issue. In addition to creating this problem for providers, it has led to an asymmetric information problem for patients. The influence of insurance companies makes it so that neither patients nor providers have
any idea how much care costs. In addition, even if the patients were aware of the amount that their care cost, they lack both the time and knowledge required to “shop around” for the cheapest care. A lack of knowledge of the price of a good or service being provided to a customer and an inability to find the good or service with the lowest price is something that is not found in many other industries. Second, competition and many other aspects of the industry are restricted by the government itself. Third, the role of need is a very prominent issue in the healthcare industry. This is true because of two reasons. First, no two people need the same amount of care. Second, despite the fact that there is a varying level of need from person to person, the need for healthcare is a universal need; every individual will need some level of healthcare at some point in her life. This is not an occurrence that is seen in many other industries.

The fact that insurance is so prominent in the healthcare industry creates issues that go well beyond causing confusion about revenue recognition, although that is a large accounting problem. The prominence of insurance also creates an asymmetric information problem for patients that results in the majority of patients having no idea what their care costs or what care they actually require. When insurance companies use a fee-for-service reimbursement system, it influences doctors to do more procedures so that they will make a larger profit. This results in the creation of one of many market failures in the healthcare market. Because the United States’ economy operates under the assumption that it is a “free market” economy, it is typically proposed that the government should intervene as infrequently as possible. Despite this, it is typically agreed that when there are market failures, the government should intervene to make
things more efficient in the market. As a result of its market failures, the healthcare industry is one industry where it is necessary for the government to be very involved.

The United States’ government restricts competition in the healthcare market through its regulation of doctors and hospitals. The government restricts the number of doctors in the market on a state by state basis with State Boards of Medicine. Each State Board of Medicine sets the requirements of education and creates licensing tests to ensure that the applicant has been aptly prepared to practice medicine. The government also regulates hospitals through many different agencies including ones that, like the State Board of Medicine, are state specific. These agencies include OSHA, the Center for Disease Control, and the National Fire Protection Agency. Through these agencies, the government sets requirements for its hospitals including attaining accreditation from The Joint Commission, requiring hospitals to have a system for disposing of hazardous waste, and requiring hospitals to maintain a specified level of cleanliness.

The government’s involvement in the healthcare industry is not limited to regulation. The government is a large provider of care and insurance in the healthcare market. 1,045 of the 4,973 community owned hospitals are owned by local and state government and an additional 208 hospitals are owned by the federal government which makes up about 22% of the hospital market (American Hospital Association). Also, as was mentioned previously, the US government runs four different healthcare insurance companies: Medicare, Medicaid, Veteran’s Assistance, and TRICARE. Together, these four healthcare insurance plans make up 25% of the insurance market. Although the
United States does not explicitly provide universal healthcare to its citizens at this time, it does make up a very large portion of the healthcare market.

Legislation

The government has also commonly intervened through the passage of legislation. Three laws in particular have greatly affected the health care industry. In 1996, the government passed the Health Insurance Portability and Accountability Act, HIPAA. In 2009, the Health Information Technology for Economic and Clinical Health Act, the HITECH Act, was passed. Finally, in 2010, the Patient Protection and Affordable Care Act, PPACA, was signed into law. These three laws have all significantly changed how the healthcare industry operates and are increasing the level of government involvement in the industry.

In 1996, HIPAA changed many things about the healthcare industry. First, it created the ability to transfer and continue the health insurance coverage for American workers who were changing or who had lost their jobs. Second, it greatly reduced healthcare fraud and abuse by creating an entity to audit healthcare programs administered by the Department of Health Care Services, a hotline for individuals who witnessed fraud, and providing more information about how to protect patient information. Third, it mandated that there would be industry-wide standards put into place for the use of healthcare information in electronic processes including insurance billing. Finally, it largely increased the level of protection over confidential health
information. The protection of health information is the aspect which has been made most famous about HIPAA as it changed not only the way that protected health information is stored or transmitted between providers, but also restricted providers from sharing personal health information with anyone except for the person it regarded (California Department of Healthcare Services).

In 2009, the HITECH Act continued to change the face of the healthcare industry and essentially built off of the previously enacted HIPAA. It required the government to develop standards that allowed for the electronic exchange and use of health information that improved the quality and coordination of the care received by patients in the United States. It also required the government to invest $20 billion to improve transmission technology in the healthcare industry and to give doctors an incentive to use the technology which would result in $10 billion of savings for the government in reduction of costs. The Act stated that if this was done, there would be increased privacy in the healthcare sector and a decreased level of misuse of personal health information which was intended to be taken care of by HIPAA (“HITECH Act Enforcement Interim Final Rule”).

Finally, in 2010, arguably the largest healthcare act in existence since the creation of Medicare and Medicaid in 1965 was passed, the PPACA. The PPACA is set to become effective over the course of five years, from 2010 to 2015. The act was written in an effort to combat the current market failures that exist in the healthcare market. The PPACA was primarily intended to increase the number of Americans who had access to insurance as well as decrease the overall costs of healthcare. It also seeks to improve
health outcomes, something that is greatly needed in the United States’ healthcare market.

In 2010, the PPACA began reforming the healthcare market in many ways. It created a small business tax credit that could be redeemed for up to 35% of the employer’s contribution to its employees’ healthcare insurance costs. It also sought to improve Medicare and Medicaid by providing federal funding to states so that they could cover more people on Medicaid, offering a $250 tax-free rebate check to 4 million Medicare beneficiaries who fell into a coverage gap, and investing new resources to reduce fraud and waste in Medicare and Medicaid. Next, it began to expand access to coverage by allowing early-retirees to keep their employer insurance coverage until they were 65, providing insurance for at least 6 months to those who have been denied insurance due to having a pre-existing condition, prohibiting insurance companies from denying coverage due to having a pre-existing condition to patients under 19 years old, allowing young adults to stay on their parents insurance plans until they were 26 if they didn’t have access to insurance through their employers, and making rescinding insurance coverage illegal. It also mandated that insurance plans cover certain preventative services, eliminated lifetime dollar limits on healthcare, regulated annual dollar limits on healthcare, and prohibited insurance companies from unjustifiably increasing premiums. It also sought to improve patients’ understanding of insurance by creating a website where patients could easily compare healthcare insurance and by providing patients with a way to appeal coverage determinations and claims to their insurance companies. Finally, it began trying to stimulate the primary care workforce by offering scholarships
and loan repayments to doctors and nurses who agreed to work in primary care
(“Timeline of the Affordable Care Act”).

In 2011, the ways that the PPACA affected the healthcare market continued to expand. It further attempted to help patients understand the healthcare insurance market by creating assistance programs for those who were confused about the private health insurance system. It also mandated that at least 85% of the dollars spent on premiums were required to be spent on healthcare services. It sought to increase access to care by providing increased payments to doctors who operated in underserved areas while it simultaneously sought to increase prevention of disease by creating funds to invest in prevention and public health programs and support construction and expansion of community health centers with the intention of keeping Americans healthy. Finally, it further reformed Medicare by offering a 50% discount on prescription drugs to seniors who have reached their coverage gap, offering free preventative services to seniors on Medicare, improving care for seniors who have been recently released from the hospital and increasing access to home care in place of nursing homes. It also reduced overpayment from Medicare to Medicare Advantage insurance plans, created a Center for Medicare and Medicaid Innovation which will test new ways of delivering care that will reduce costs and increase the quality of care for patients, and created the Independent Payment Advisory Board that is supposed to find ways to cut costs, improve health outcomes, and expand access to care so that Medicare can continue in the future ("Timeline of the Affordable Care Act").
In 2012, the PPACA focused even more on reducing costs and the quality of care provided to patients. It encouraged doctors to form “Accountable Care Organizations” which are intended to help them better coordinate patient care and improve the quality of care for patients as well as decrease hospital stays. It required standardization of billing and required healthcare providers and insurance plans to keep secure and confidential electronic records which are intended to cut costs of retaining paper forms and reduce confusion. The PPACA also required any new or ongoing federal health programs to collect racial, ethnic, and language data to reduce the disparities in care that exist between different groups. Finally, it helped continue to improve Medicare by creating a Value-Based Purchasing Program that offers financial incentives to hospitals that improve the quality of care for Medicare patients and are readily available to the public (“Timeline of the Affordable Care Act”).

In 2013, the PPACA is attempting to continue to reduce healthcare costs and expand access to healthcare for patients in various different ways. First, it is providing new funding to state Medicaid programs that choose to cover preventative care services at little or no cost. In addition, it requires states to pay 100% of the Medicare payment rate to primary care doctors when they serve Medicare or Medicaid patients. It also encourages doctors, hospitals and other providers to coordinate care and increase the quality of care provided to patients. Doctors, hospitals, and other providers who “bundle” services in this way will be reimbursed per episode of care instead of per service. Finally, and possibly most importantly, at the end of 2013, a newly transparent and competitive public marketplace for insurance will be created (“Timeline of the Affordable Care Act”).
Finally, in 2014 and 2015, the final changes implemented by the PPACA will be made to the healthcare market. Beginning in 2014, employees who do not get insurance through their employers will be able to purchase health insurance through the newly formed Health Insurance Marketplace. Unlike the current private healthcare insurance market, nobody will be “priced out” of the market because the costs are too high. All patients who can afford healthcare will be required to enroll in an insurance plan that meets minimum standards which will help pay for those who are not able to afford insurance. If a patient does not enroll in an insurance plan, and does not have a legitimate reason for not doing so, including religious beliefs, income restrictions, or a similar reason, he or she will have to pay a penalty. The PPACA will also increase access to Medicaid by increasing the maximum income amount to 133% of the poverty line. In addition, it will create a tax credit for those who are between 100% and 400% of the poverty line to help those individuals pay for their health insurance as well as increase the small-business tax credit to 50% of the employer’s contribution. The PPACA will increase regulation of insurance companies by prohibiting them from discontinuing coverage when individuals participate in clinical trials, prohibiting them from placing annual limits on the dollar amount of care received, and prohibiting them from refusing to sell coverage or continue coverage because a patient has a pre-existing condition as well as prohibiting them from charging more based on gender or health status. Finally, in 2015, a new provision will tie physician payments to the quality of care that they provide which will create an incentive for doctors to provide a higher level of care to their patients (“Timeline of the Affordable Care Act”).
Overall, the most influential legislation that has been passed affecting the healthcare industry has significantly increased the level of government involvement in the industry over time. With the passage of HIPAA in 1996, the government began to regulate the way that providers were protecting patients’ private health information. In 2009, this effort increased when the HITECH Act was passed in an attempt to further regulate the protection of private health information by regulating the electronic transmission of patients’ information. Finally, the PPACA passed in 2010 has attempted, and will continue to attempt, to significantly regulate the healthcare market by increasing access to care and decreasing the cost of care nationally.

**Overview of Government Involvement**

Comparatively, it is easy to see that the government is much more involved in the healthcare industry than in other industries. It competes in the healthcare industry, both as a provider of care and insurance, and it provides regulation, both through the requirements to run a hospital or become a doctor and the passage of laws. When contrasting the government’s involvement in the healthcare industry and the government’s involvement in the service restaurant industry, it is evident that the government is much more involved in the healthcare industry. The government does not actively operate a fast food restaurant or regularly offer assistance in purchasing food from one, two things that it can be said it does in the healthcare industry. In addition, it is clear that the government provides a much larger amount of regulation in the healthcare industry than the service restaurant industry.
Although it doesn’t seem that the level of government involvement in an industry directly affects the accounting practices of the company, it does. A key factor that must be considered when doing the accounting for, completing the audit for, or completing the tax return for a company is the environment in which it operates. When a company operates in an environment that has a high level of government involvement, it is necessary to pay additional attention to any laws or standards that may affect the company financially. Also, when giving consulting advice, it is necessary to be aware of any rules or regulations that may affect the company as it continues to exist in the future. When considering the environment that healthcare providers operate in, it is necessary to keep in mind the fact that the government is highly involved in the healthcare industry. As was discussed previously, the FASB has issued pronouncements on special reporting requirements that apply solely to the healthcare industry. Also, because so many healthcare organizations are nonprofit organizations, there are additional requirements that must be met in order to maintain this nonprofit status. These include not having shareholders, keeping detailed and accurate records for the organization, not providing funds to political organizations or engaging in any extensive lobbying, and not making substantial profits from unrelated activities. It is important for all of these aspects of the industry to be at the forefront of an accountant’s mind when he or she is making any kind of decisions about the company.
CHAPTER V
CONCLUSION

When I began writing this paper, I believed that there would be a much more obvious difference between the accounting rules that are used in the healthcare industry and the U.S. GAAP. I was surprised to find that though there were differences, they were not as large as I originally thought. As a result, though I still believe that this paper provides evidence which shows that not every industry can strictly follow GAAP guidelines, it also shows that the differences are not always large ones. The results that I found for the differences between standard GAAP, using McDonald’s, and the accounting rules used in the healthcare industry, illustrated by using healthcare providers, were very large in the area of government involvement and the payment for services. Aside from this area, the differences between standard GAAP and the accounting rules used in the healthcare industry were much smaller.

The differences between GAAP and the accounting rules used in the healthcare industry to recognize revenue appear to be small. As with all industries, revenue that is recognized is frequently adjusted if sales are made on credit. I believe that it is clear that adjustments are much more frequent in the healthcare industry than the service restaurant industry, but essentially this is the only difference between the two in the way that revenue is recognized. As was illustrated, there is a very large type of “credit” system in place in the healthcare industry in the form of insurance and third party payers. Due to
this fact, there is quite a large difference in the method of the payment of services between the healthcare industry and the service restaurant industry. Unlike the service restaurant industry, most of the customers in the healthcare industry do not directly pay for their services. Instead, they commonly pay an insurance company who in turn pays for their services. This is a large difference between the two industries which illustrates why decisions made when considering the accounting for a healthcare provider are different than those made when considering the accounting for McDonald’s.

The differences in debt collection and the use of allowance for doubtful accounts between a healthcare provider and McDonald’s are also small. The main difference, similar to the differences in the recognition of revenue, is the fact that there is a much larger use of allowance for doubtful accounts in the healthcare industry and there are many more instances of “credit sales.” Costs in the healthcare industry are much higher and are much more variable than in most other industries, especially the service restaurant industry. As a result, most patients do not pay for their services at the time that they are received which leads to those who do not have insurance against the high and varying costs not being able to pay for their services. Because it is more common for someone not to be able to pay for the astronomical cost of healthcare services than for a meal, many healthcare providers have many uncollected accounts and their allowance for doubtful accounts account is therefore much larger and used more frequently.

Finally, the difference in the level of government involvement between the healthcare industry and the service restaurant industry is very evident. McDonald’s is generally allowed to act however it deems necessary to earn a profit as long as it does not
harm its customers or blatantly provide false information to its shareholders. The government does not run a service restaurant and it does not widely provide assistance to people who are interested in purchasing food. In contrast, the government is involved in almost every aspect of the healthcare industry. The government runs four healthcare insurance plans that cover about 25% of Americans and even owns about 22% of the hospitals that operate in the country. It also heavily regulates the healthcare industry by placing limitations on who can be a doctor and what can be considered a hospital as well as by passing legislation that further mandates what can and cannot be done in the healthcare market. It is clear how involved the government is in the healthcare industry, and this directly affects the types of accounting decisions that need to be made and the choices that are available to healthcare providers.

Unfortunately, I did not manage to show that there were substantial differences in GAAP and accounting rules used in the healthcare industry in any area except for government involvement. Despite this fact, I do think that by completing this paper, I have learned that differences, no matter how small they end up being, do affect the accounting process overall. Even if the nuances do not overtly affect the accounting choices that are made, they do affect the overall decisions that the accountant helps the company make which are sometimes reflected in the financial statements. The differences that exist between the healthcare industry and all other industries do affect decisions made about the company’s future, which is a very substantial factor. Overall, I believe that I was successful in showing that there are differences between the healthcare industry and other industries which proves that different accounting methods must be
used in order to accurately make decisions. I therefore think that this paper has been beneficial not only to me, but will continue to be beneficial to future students to show them these facts as well.
WORKS CITED:


<https://asc.fasb.org/section&trid=2289372&analyticsAssetName=subtopic_page_section&nav_type=subtopic_page>.


<http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/1.00WhatisHIPAA.aspx>.

<http://www.diffen.com/difference/Capitalism_vs_Socialism>.


<http://www.medicare.gov/MedicareEligibility/home.asp?dest=NAV%7CHome%7CGeneralEnrollment&version=default&browser=IE%7C9%7CWindows+7&language=English>.

<http://www.kff.org/pullingittogether/medicaid_medicare_multiplier.cfm>.


