Health Savings Accounts, High Deductible Health Plans, and Hospital Bad Debt

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Health Savings Account Basics

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the creation of Health Savings Accounts (HSAs) to fund expenses for medical care. HSAs allow before-tax contributions by employers, employees, or individuals and tax-free investment returns. In addition, HSA plan withdrawals are not taxed, as long as the funds are used to pay for qualified medical expenses. Employment-related HSAs are fully portable for employees.

An HSA, like its precursor the Archer Medical Savings Account (MSA), is similar to a flexible spending arrangement (FSA) or a health reimbursement arrangement (HRA), in that it allows the purchase of out-of-pocket medical expenses with before-tax dollars. However, it differs in some important ways. Funds held in an HSA are invested to earn investment income, and they can be carried over from year to year. FSA contributions do not earn investment income and must be completely expended during the tax year. The carryover feature of HSAs eliminates some of the adverse end-of-year health care spending incentives created by FSAs. It also allows an HSA to be used as a savings vehicle to fund future health care needs. In the latter respect, HSAs are analogous to Individual Retirement Accounts (IRAs), combining the tax deductibility of contributions as allowed for traditional IRAs with the tax-free withdrawal feature of Roth IRAs, provided that withdrawals are spent for eligible health care expenses. Compared with HRAs, the primary differences are that HRAs are limited to tax-advantaged employer contributions –

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employee contributions cannot supplement or replace employer contributions. While HRA contributions are not subject to the minimum levels of cost-sharing or the maximum ceiling on total contributions that apply to HSAs (see below), most employers do not allow HRA dollars to be portable post-employment with the firm.

In order to qualify for favorable tax treatment, an HSA must be combined with a "high deductible health plan" (HDHP) that meets specified coverage standards, and the account holder must not be participating in any other health insurance plans, including FSAs and HRAs. The current minimum deductible for an HDHP is $1,100 for single coverage and $2,200 for family coverage. However, specified types of preventative care can be covered by the policy on a first-dollar basis (i.e., without being subject to the deductible), and many plans provide coverage for such care.

The HDHP must include a maximum annual stop loss (the most that the covered person or family must pay from the HSA or out-of-pocket). The current maximums are $5,600 for self-only coverage and $11,200 for family coverage. Annual HSA contributions currently are subject to limits of $2,900 for self-only coverage and $5,800 for family coverage, with annual catch-up contributions of up to $900 for those policyholders who attain age 55 by the end of the tax year. The self-only limits are indexed for inflation and the family limits are double the self-only coverage and contribution limits. Catch-up contributions increase to $1000 in 2009, at which time they are scheduled to remain at that level thereafter.

The Tax Relief and Health Care Act of 2006 modified the prior law's limit on annual deductible contributions, so that the maximum tax-deductible contribution is not limited to the annual deductible under the HDHP. The 2006 Act also allows individuals who join a plan mid-year to utilize the full maximum contribution for that year. It also includes provisions for a one-time rollover to an HSA from an IRA, and for a direct transfer from a health FSA or HRA (if made before January 1, 2012).

According to the most recent Kaiser-HRET survey of employers, 7 percent of surveyed firms offering health benefits offered an HSA/HDHP in 2007. Eighteen percent of firms with 1,000 or more workers offered such plans. One-fifth of firms not currently offering such plans indicated that they were "very likely" or "somewhat likely" to offer one in the next year.[1] Based on a survey of most of the current HSA custodians, Information Strategies Inc. reported that the total number of HSA accounts reached 3.6 million in 2006, with $5.1 billion under management. The number of custodians is expected to double this year, resulting in 8 million HSAs and $13.6 billion in deposits by the end of 2007.[2] America's Health Insurance Plans (AHIP), an industry group, reported that 4.5 million people were covered under HSA/HDHP plans as of January 2007, an increase of 40% over the prior year's survey.[3] The U.S. Department of the Treasury predicts 14 million accounts (policies) covering 25 to 30 million people by 2010.

Effects on Health Industry

Supporters of the HSA/HDHP concept stress the potential for such plans to achieve more cost consciousness among consumers of health care, thereby promoting more efficient utilization of services (i.e., reducing "moral hazard"), providing more efficient incentives for the investment and diffusion of new technology, increasing competition among health care providers, reducing the number of persons without any health insurance, and perhaps increasing utilization of preventative care in plans that provide such coverage. If successful, the results would include lower health care costs and slower cost growth.

Opponents of HSAs argue that consumers are ill equipped to play a greater role in decisions regarding their health care, and that information about price and quality is inadequate for this purpose. They also argue that HDHPs under HSAs will do little to reduce moral hazard,

[1] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007.
[2] Researching HRAs, HSAs, FSAs, and Health Spending Accounts, *Consumer Driven Market Report*, 2007, Issue #1.
[3] "January 2007 Census Shows 4.5 Million People Covered by HAS/High-Deductible Health Plans," America's Health Insurance Plans, http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf

because much of medical spending is for households with expenditures greater than the minimum deductibles and/or maximum stop losses. HSAs also are criticized because their tax advantages increase with marginal tax rates, thus favoring higher income persons.[4] Moreover, it is alleged that HSAs will disproportionately attract healthier people, thus undermining the pooling of health risk under traditional health plans.

The potential effects of HSA/HDHPs and other "consumer-directed" health plans that make consumers bear more of the direct cost of medical care on provider credit risk, especially hospital bad debt, is also controversial. Some observers argue that growth in consumer-directed plans with higher deductibles and other forms of consumer cost-sharing has significantly increased the amount of uncompensated care provided by hospitals, thus contributing to financial difficulties at many hospitals, requiring them to charge more to paying customers, and undermining their ability to provide charity care and related "community benefits."

This paper's objective is to consider the likely scope of the credit risk problem associated with HSA/HDHPs and related high deductible plans and to briefly consider possible "solutions" if such problems are sufficient to warrant additional legislation. The focus is on two questions: (1) Will greater cost-sharing under consumer-directed plans in general and HSA/HDHPs in particular significantly increase uncompensated care, and (2) what is being done, or might be done in the future, to manage credit risk associated with such plans?

How Bad Is the Bad Debt Problem?

Figure 1 shows American Hospital Association (AHA) estimates of the cost of uncompensated care for registered community hospitals during 1980-2005 (the latest available

[4] A study of its accountholders by UnitedHealth Group found that HSA account adoption for eligible employees varied only from 80% to 84% for all income ranges, with 80 percent of eligible individuals with earnings below $25,000 annually opening an account. However, the study found that income was strongly related to account adoption for plans where the employer made no contributions, ranging from 23 percent take-up for those with earnings below $25,000 to 58 percent take-up for those earning at least $100,000. See UnitedHealth Group, Health Savings Account Adoption and Spending Behavior, January 29, 2007.

data). In order to improve comparability across hospitals, the AHA combines charity care (the cost of care provided with no expectation of repayment) and bad debt (unpaid charges for care for which payment in principle was expected when the care was delivered). It also converts charity care charges to estimated costs using cost-to-charge ratios. The total cost of uncompensated care increased by nearly one-third from 2001 to 2005 ($21.5 billion vs. $28.8 billion). However, other community hospital expenses also grew rapidly during this period. As a percentage of total hospital expenses, uncompensated care was fairly stable during that time. It was approximately the same in 2001 and 2005 (5.6 percent) and lower than in the late 1980s and 1990s.

Directly comparable information on uncompensated care costs as a proportion of total operating expenses is not available for for-profit hospitals. Figure 2 shows the average value of two ratios for the years 2002-2006 and the first quarter of 2007 for leading for-profit hospitals reported by Fitch Ratings.[5] The first ratio is reported bad debt as a percentage of revenues; the second adds the estimated cost of charity care and discounts on charges to uninsured patients (see below) to bad debt. Both ratios peaked in 2006, with a subsequent reduction in the first quarter of 2007. Part of the increase during 2006 reflected one-time charges or write-offs by several companies during the fourth quarter. Part of the increase in the ratio of bad debt, charity care, and discounts to revenues is attributable to reductions in revenues associated with increased discounts during this period.

A GAO study comparing uncompensated care for non-profit and for-profit hospitals found that nonprofit hospitals' uncompensated care costs, as a percentage of patient operating costs,

[5] See Fitch's For-Profit Hospital Industry Quarterly Diagnosis, May 21, 2007, and Reserving Methodologies in the For-Profit Hospital Sector, February 8, 2007. www.fitchratings.com. The seven hospitals included in the analysis are Community Health Systems, HCA, Health Management Associates, LifePoint Hospitals, Tenet Healthcare, Triad Hospitals, and Universal Health Services. Ratios of bad debt plus charity care and discounts to revenues were not available for Health Management Associates in 2002 and for Triad in 2002 and 2003. Loomis Sayles Co., Taking the Pulse of the Nation's For-Profit Hospitals, April 2007, reports that uncompensated care as a percentage of revenues for nine of the largest for-profit hospitals rose slightly over the last few years, averaging around 18 percent in 2006.

were higher on average than for those of for-profit hospitals in four of five states studied.[6] That study also found that, in each hospital group, the burden of uncompensated care was concentrated among a small number of the largest hospitals rather than being distributed evenly across group members. Other evidence indicates significant regional differences in the amount of uncompensated care associated with differences in the size of the uninsured population.[7]

Accounting for Trends

Determining the magnitude and causes of changes in hospitals' bad debt and total uncompensated care is difficult, in part due to accounting conventions and associated discretion in the amounts that hospitals report as bad debt versus charity care. In principle, and according to accounting standards, charity care reflects amounts that a hospital does not expect to collect given the employment and financial status of the patient at the time services are provided. Again in principle, and according to traditional accounting standards, bad debt charges reflect amounts that were expected to be paid at the time services were provided, but which later proved uncollectible. In practice, hospitals often have considerable discretion in deciding whether to treat uncollectible charges as charity care or bad debt, and some hospitals may have incentives to manage the mix between the two types of uncompensated care.[8]

Accounting standards require that charges for charity care be deducted from revenues, whereas charges for services that are expected to be paid but ultimately prove uncollectible are to be included in revenues and then essentially written off as a charge (bad debt) that reduces net income. This difference in treatment might seem like a distinction without a difference: lower

[6] U.S. Government Accounting Office, Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits, Statement of David M. Walker, Testimony before the House Ways and Means Committee, May 25, 2005.
[7] See, for example, Fitch Ratings, Reserving Methodologies in the For-Profit Hospital Sector, February 8, 2007. www.fitchratings.com.
[8] Consistent with substitution between reported charity care and bad debt, there is evidence that hospitals that provide more charity care on average have lower bad debt costs. See I.W. Kwon, et al., Determinants of Hospital Bad Debt: Multivariate Statistical Analysis, *Health Services Management Research* 12 (1999): 15-24.

revenues versus higher revenues with correspondingly higher deductions from revenues – with no effect on earnings.

However, although reducing what is reported as bad debt and increasing deductions for charity care reduces a hospital's reported revenues, it also reduces the hospital's reported ratio of bad debt to revenues, and increases its reported operating margins (operating income as a percentage of revenues). Some hospitals, especially public-traded entities, might sometimes be tempted to manage bad debt percentages, operating margins, and/or revenue growth by the allocation of some doubtful accounts to charity care rather than bad debt or vice versa, e.g., by increasing charity care to increase margins or perhaps modifying the mix between bad debt and charity care to smooth volatility of reported margins. To complicate matters further, and as reflected in the bad debt, charity care, and discount ratio in Figure 2, many hospitals have recently shifted to a policy of discounting charges for uninsured patients, as opposed to the prior practice of charging amounts often much greater than the charges negotiated with third-party payers (health insurers, HMOs, self-funded health plans). Other things being equal, such shifts to discounted charges reduce a hospital's reported bad debt and increase its reported operating margin.[9]

To improve financial statement transparency and comparability, the Healthcare Financial Management Association' Principles and Practices Board has recently updated its guidance on valuation of charity care and bad debt.[10] This guidance applies to all types of institutional healthcare providers, both tax-exempt and investor-owned, and is authoritative for matters not specifically covered by FASB or AICPA rules. The relevant components for this discussion are:

[9] For example, adopting discounted charges for uninsured patients reduced HCA Inc.'s reported bad debt as a percentage of revenues from 13.9 percent to 10.3 percent during the first nine months of 2006. (See U.S. Securities and Exchange Commission Form 10-Q, HCA Inc., Sept. 30, 2006).

[10] HFMA Statement 15 Valuation and Financial Statement Presentation of Charity Care and Bad Debt by Institutional Healthcare Providers. Also see Melanie Evans, Tussling Over Benefits; HFMA Accounting Rules Straddle AHA, CHA Methods, *Modern Health Care*, Dec. 4, 2006.

(1) reported charity care should be based on costs, not charges, (2) revenue should be recognized only when there is a payment agreement between provider and patient and reasonably assured collectibility, and (3) bad debt should not be reported as charity care. The guidelines address issues raised in recent congressional hearings related to the 501(c)(3) status of some hospitals, making it more difficult for hospitals to manipulate the reporting of uncompensated care.[11]

The Role of HSAs/HDHPs

While growth in HDHPs could increase hospitals' uncompensated care, the extent to which this has or will occur is uncertain in principle, and there is little hard evidence of significant effects to date. On the one hand, credit risk associated with payments from third-party payers is generally low compared with credit risk for amounts owed by individual consumers.[12] In addition, state and federal laws that require hospitals to provide emergency services before asking for payment increase credit risk. Hospitals obviously cannot repossess services that are provided, and many consumers may be aware that hospitals cannot deny them emergency services even if they have not paid previous bills.

The Emergency Medical Treatment & Active Labor Act (EMTALA), enacted by the Congress in 1986, requires hospitals that accept payment under Medicare to provide emergency services (including childbirth) regardless of citizenship, legal status, or ability to pay. Hospitals are required to provide stabilizing treatment for patients with emergency medical conditions or, if beyond the institution's capability or upon request of the patient, to arrange for an appropriate transfer of the patient to another provider.

[11] Present Law and Background Relating to the Tax Exempt Status of Charitable Hospitals, prepared for Hearing of Senate Committee on Finance by Joint Committee on Taxation, September 13, 2006. Also see note 6.
[12] For example, the hospital chain Tenet Healthcare recently reported that it collects 97 percent of every dollar billed to insurance companies, 60 percent of billings to insured individuals (i.e., those with insurance coverage requiring out-of-pocket cost sharing), and 8 percent of what it bills the uninsured. (See Tenet's Q3 2006 Earnings Call Prepared Remarks, November 7, 2006.) Note that any higher charges billed to insured individuals and the uninsured than those billed to employer-based group insurance plans would contribute to such differences.

Until 1969, not-for-profit hospitals were required to provide charity care to justify their tax-exempt status. Since that time, the Internal Revenue Service has not specifically required the provision of charity care if the hospital provides "community benefits" in other ways, such as health education, screening services to vulnerable populations, and medical research. Given increased scrutiny and congressional hearings (see, e.g., note 11 above), not-for-profit hospitals have been under increased pressure to justify their tax exemptions through provision and documentation of specific community benefits, including charity and other uncompensated care.

On the other hand, under HSAs, high deductibles are at least partially if not fully collateralized (de facto if not de jure) by assets in the HSAs. As elaborated below, this should reduce any effects of higher deductibles on nonpayment under HSA/HDHPs, although it might in some instances still be difficult or costly to collect cost-sharing obligations after services have been rendered. Perhaps more important, and as noted above, the objectives of HSA/HDHPs include increasing the number of persons with some level of catastrophic coverage for medical expenses and ultimately helping to reduce health care costs. Other things being equal, success on these dimensions would reduce the cost of uncompensated care. Even if high deductibles increase credit risk for persons with such plans compared with persons with "traditional" low deductible coverage, the costs of bad debt could decline, at least eventually, if the overall number of persons that have some health insurance increases, especially if health care costs grow a slower rate. Intuitively, more people are likely to insure if the cost of health care and thus health insurance grow as a slower rate. Thus, absent evidence that growth in HSA/HDHPs has *not* led to fewer people being uninsured *compared with what would likely have occurred without such growth*, any evidence of greater credit risk for persons with high deductible plans than for persons with low

deductible plans will tend to overstate any increase attributable to uncollectibility from the growth of such plans.[13]

More generally, any adverse effects of consumer-directed plans on the total magnitude of hospitals' uncompensated care are necessarily uncertain for a number of reasons (beyond the previously discussed difficulty of sorting out possible changes in accounting for charity care vis-à-vis bad debt). HSA/HDHPs are relatively new, and there has been no systematic analysis of their possible effects on uncompensated care. Making inferences about the relationship between such plans and uncompensated care would require disentangling their effects from potentially confounding influences, including:

- The contemporaneous increase in the total number of persons without health insurance. Other things being equal, increases in the number of uninsured will put upward pressure on charity care and bad debt costs. Revised figures from the U.S. Census Bureau report that the number of people without health insurance increased from 43.4 million to 47.0 million from 2004 to 2006, representing an increase from 14.9 percent of the population to 15.8 percent.[14] Sponsorship of employment based-health insurance has eroded, and such plans are likely to provide less comprehensive benefits and to require greater cost sharing by employees than in the past.[15]

- Increases in the costs of hospitalization and on-going increases in sizes of deductibles and other forms of cost sharing in "traditional" health plans, which reduces the gap between such plans and HDHPs and by itself could produce some increase in bad debt expense.

- A possible temporary increase in bad debt associated with a spike in personal bankruptcy filings prior to changes in bankruptcy law that took effect in October 2005.[16]

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[13] An August 2005 study by the Commonwealth Foundation reported that more than half of consumers surveyed with a deductible of at least $1,000 reported having trouble paying medical bills, or were paying off medical debt, compared with about a quarter of consumers with no deductible. This type of finding does not consider whether high deductible plans may increase the number of people with insurance, and relatively few consumers have zero deductible policies. Also see note 16 below.

[14] See http://www.census.gov/prod/2007pubs/p60-233.pdf Accessed February 25, 2008; http://www.census.gov/hhes/www/hlthins/usernote/usernote3-21rev.html Accessed May 28, 2007.

[15] These factors may partially explain the slight declines in employee participation over that time. Paul Fronstein, Can Consumerism Slow the Rate of Health Benefit Cost Increases? *EBRI Issue Brief*, Number 247, July 2002.

[16] See Cinda Becker, Adjusting to the New Bankruptcy Law, *Modern Healthcare*, Nov. 21, 2005. Evidence suggests that medical expenses contribute significantly to bankruptcy filings, but the estimated magnitude of the effect varies widely across studies. See David Himmelstein, et al., Illness and Injury as Contributors to Bankruptcy, *Health Affairs – Web Exclusive* 24 (2005): W5-63 and the exchange between those authors and David Dranove and Michael Millenson, *Health Affairs – Web Exclusive* 25 (2006): W74-93. Also see Aparna Mathur, Medical Bills and Bankruptcy Filings, American Enterprise Institute, 2006.

- The possibility that some hospitals reduced collection efforts following a spate of adverse publicity and litigation associated with billing and collection practices for uninsured patients.

Private Sector Reponses to Rising Credit Risk

Hospitals, HSA custodians, and health insurers are taking a number of actions to address possible increased credit risk associated with HDHPs. More hospitals are beginning to seek upfront payment for non-emergency services and are adopting new technology and automated tools to screen for credit risk and obtain credit data before non-emergency services are provided. Other actions that hospitals can take at the time of service to increase payment rates include:[17]

- Requiring deposits to cover deductibles and other co-payments until payments are received from insurers
- Offering discounts for prompt payment for services
- Imposing tighter screens for emergency versus non-emergency cases and deferring non-emergency / elective services until patients have the funds or credit to pay their charges
- Monitoring patient flow to deny additional non-emergency services to persons who have not paid previous bills

Hospitals also are taking actions to improve collection following the provision of services, including adopting better systems for and prioritization of patient follow-up and making more efficient use of collection agencies and sales of their bad debt. The market for hospital bad debt has grown significantly, increasing hospitals' options and creating substantial competition between bad debt buyers (that pay hospitals upfront for the rights to all amounts collected) and traditional collection agencies (that receive a stipulated percentage of amounts collected). According to the firm Kaulin Ginsberg, about one-third of hospital bad debt is now being sold to debt buyers.[18] Growth in the market for hospital bad debt and competition among debt buyers and collection agencies should ultimately improve collections and hospitals' net recovery rates.

[17] See, for example, Bruce Nelson and Jordan Levitt, Battling Bad Debt, *Healthcare Financial Management*, Sept. 1, 2006.
[18] See Debt Buying: The Health Care Market, *Collections & Credit Risk*, October 1, 2006.

As noted above, credit risk is reduced under HSA/HDHPs compared with comparable insurance coverage without an HSA because funds in HSA accounts essentially collateralize part or all of plan deductibles. HSA enrollees who choose to pay medical expenses from their HSAs generally may access the funds by check or credit card, and they can authorize health care providers to access their accounts. Moreover health insurers that market HSA/HDHPs, banks, and other HSA custodians have strong financial incentives to help ensure that the plans succeed and grow, including incentives to make the plans user-friendly for consumers and providers, which in part involves designing and implementing procedures to reduce credit risk (and to improve transparencies of charges to consumers).

Consistent with those incentives, there is a growing market for medical credit cards and related instruments in conjunction with the growth in consumer-directed health plans. Some credit card programs are linked to HSAs. Others simply establish credit lines for uninsured medical expenses that shift patients' obligations to repay from providers to the lender, thus enhancing security to health care providers.

In the former category, for example, American Express has introduced the HealthPay Plus Card, which allows HSA enrollees direct access to their funds and access to a credit line for gaps between the cardholder's expenses and his or her HSA account balance. The card can be used at any health care provider that accepts American Express cards.[19] WellPoint Inc., the largest health insurer by membership, is offering a similar program for HSA holders through American Express. CIGNA HealthCare has introduced the HealthePass, which will access HSA funds or a line of credit and release payment at the time an insurance claim is settled. CIGNA's product is

[19] http://www152.americanexperess.com/entcamp/Web/HealthPayBasics.jsp , accessed Jan. 12, 2007.

"designed to simplify and improve payment processes to help patients anticipate and manage their health care costs, shorten provider revenue cycles and help address patient bad debt."[20]

In the second category, credit enhancement not necessarily linked to HSAs, Citibank has introduced a medical credit card, the Citi Health Card, with a variety of repayment options to fund medical expenses not covered by insurance.[21] The Exante division of UnitedHealth Group, Inc., the largest health insurer by market capitalization, has introduced a pilot program in Texas with Tenet Healthcare under which patients receive discounts on some medical services and Exante pays on the patient's behalf, with the patient's payment obligation transferred to Exante. Exante collects from the patient's FSA or HRA if enrolled with available funds. If not, enrollees can pay the balance directly, or from any HSA. If necessary and following a grace period, unpaid amounts are repaid over time through payroll deduction, with interest charged on the unpaid balance.[22]

Like HSA/HDHPs, the development of medical credit cards and related instruments is in its relative infancy. It is very likely that growth in HSA/HDHPs will be accompanied by the spread of instruments that reduce providers' credit risk, whether by giving the provider de facto access to HSA account balances in the event of non-payment, or by a third-party paying the provider, with the patient obligated to repay that third-party. Thus, given what is presently known, any increased credit risk associated with consumer-directed plans in general, and with HSA/HDHPs in particular would appear to be manageable through the development of such instruments and through better management of credit risk by providers. It also seems likely that the market for hospital services will evolve towards greater transparency and access to hospital charges before or at the point services are rendered.

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[20] See Healthcare Costs; CIGNA HealthCare to launch HealthePass to Assist Patients in Paying for Health Care, *Life Science Weekly*, November 21, 2006.
[21] http://www.citibank.com/us/cards/cardserv/healthcard/ , accessed Jan. 12, 2007.
[22] Kim Dixon, Analysis – US Hospitals Hope Credit Card Plans Ease Bad Debt, *Reuters News*, Jan. 8, 2007. Fitch Ratings, Bad Debt and Reserving Methodologies in the For-Profit Hospital Sector. February 8, 2007.

Legislation to Reduce HSA/HDHP Credit Risk

Providers do not have direct access to HSA account balances under current law. Allowing such access would likely reduce credit risk associated with HSA/HDHPs. However, as described above, some HSA insurers/custodians are offering instruments that allow patients to pay providers directly from their HSA balances. In addition, HSA enrollees' ability to choose whether to use HSA funds to pay for uninsured medical expenses or pay such expenses "out of pocket" without drawing down their tax deferred accounts is a valuable source of flexibility for enrollees. It enhances enrollees' "ownership" and the ability to fund future medical expenses and thus non-medical expenses during retirement.[23]

Given what is presently known (or not known) about the effects of HSA/HDHPs on the total cost of uncompensated care, and the incentives in the marketplace to maintain such flexibility while also managing providers' credit risk, any legislation to allow providers direct access to HSA balances would appear premature. If such legislation were to be considered, the preferred approach would be to allow providers' access only after bills remain unpaid after some specified time period (e.g., 60-90 days).[24] Another issue that could be addressed is possible clarification of rules concerning what HSA custodians and other financial institutions are legally permitted to do under complex Truth-in-Lending laws and regulations when designing new products and systems for administering HSAs.

Conclusion

The evolving shift from pre-paid health care through comprehensive, first-dollar insurance coverage toward greater reliance on "catastrophic" health insurance coverage necessarily raises issues concerning the ability of medical care providers to collect for services rendered. But there

[23] Tax rules for HSAs allow an account holder to delay their reimbursement of past medical claims into future years, thus providing additional flexibility.
[24] See Martin Feldstein, Balancing the Goals of Health Care Provision and Financing, *Health Affairs* 25 (2006): 1603-1611.

is no clear-cut evidence that HSA/HDHPs and other consumer-directed health plans have significantly increased hospital bad debt. The plans are relatively new and thus far represent a small percentage of health plans.

Going forward, the relevant policy question regarding collections is not whether the probability of non-payment increases for a given consumer with an HSA/HDHP (or other consumer-directed plan) compared with what would be the case if the consumer had a health plan with significantly lower cost sharing. Instead, the key questions concerning HSA/HDHPs are: (1) the extent to which collectibility worsens overall after consideration of the possible favorable effects on the number of persons that have any health insurance, and (2) whether any net increase in provider bad debts from the expansion of HSA/HDHPs is large enough to make it relevant to future policy decisions regarding such plans or other health care reform initiatives.

Given time and accumulation of data, more evidence will become available concerning the approximate magnitude of the effects of HSA/HDHPs and other consumer-directed plans on provider collections. More experience and empirical evidence are needed before reaching any conclusions about whether the collection issue is significant enough to affect broad policy regarding HSA/HDHPs. Private sector responses and initiatives to date for improving collections and managing credit risk favor at least cautious optimism concerning the evolution of systems to facilitate provider collections from persons with HDHPs in general and HSAs in particular.

Figure 1
National Uncompensated Care Cost for Registered Community Hospitals: 1980-2005

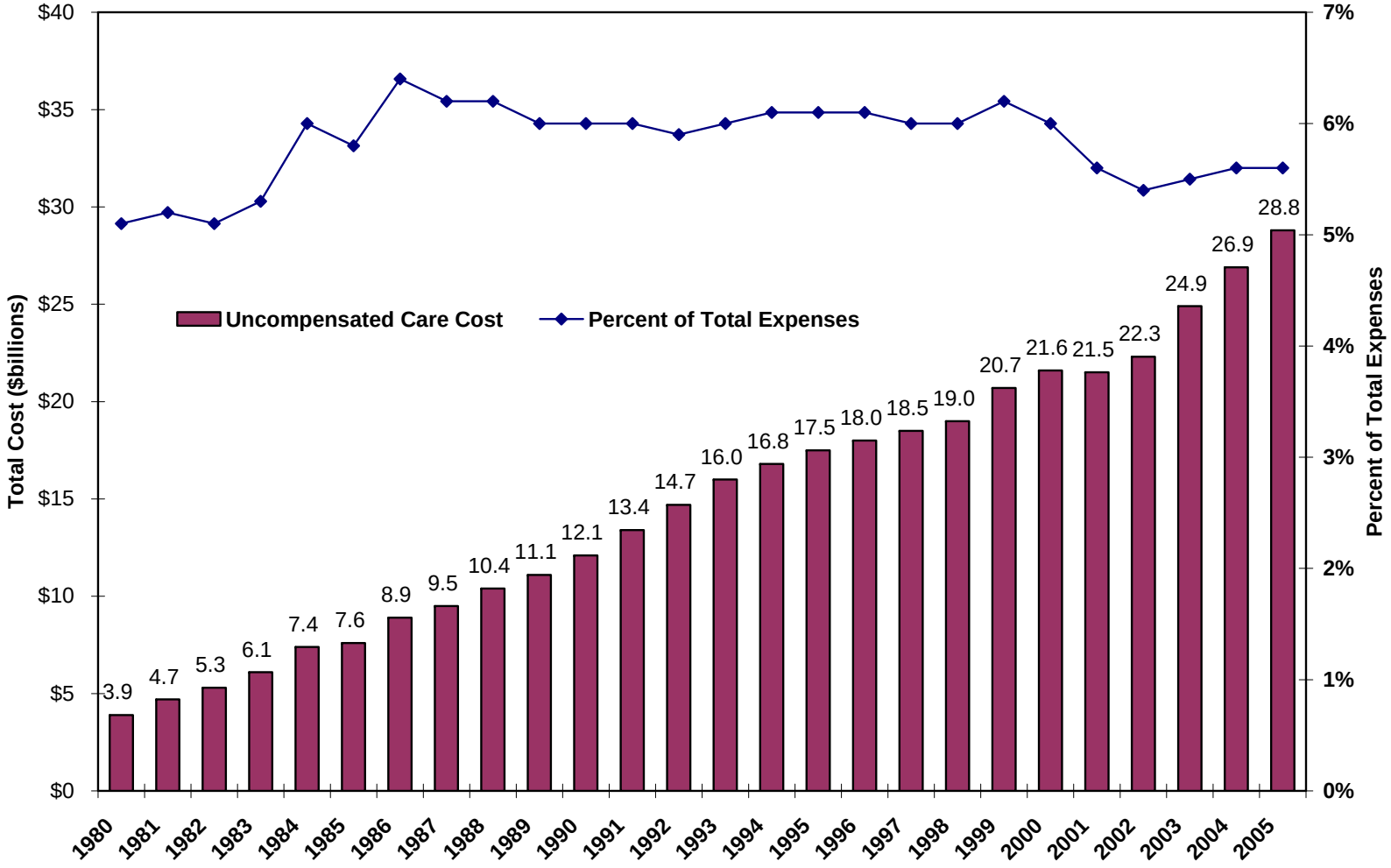

Figure 2
Average Ratios of Bad Debt and Bad Debt plus Charity Care and Discounts to Revenues for Leading For-Profit Hospitals: 2002 - 2007Q1