

Is Senator Grassley Our Savior?: The Crusade Against “Charitable” Hospitals Attacking Patients for Unpaid Bills

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ABSTRACT: This Note addresses 501(c)(3) tax-exempt hospitals’ practice of aggressively pursuing uninsured patients for outstanding medical bills. Specifically, this Note will examine whether Senator Chuck Grassley’s additions to President Obama’s Patient Protection and Affordable Care Act, which imposes stricter requirements on hospitals for keeping their tax-exemption status, is a viable way of approaching the situation. This Note requires a look at historical context, current circumstances, and a possible model for reform. This Note argues that Senator Grassley’s additions are a step in the right direction. However, the additions must orient themselves to local communities, demand clearer tax-exemption requirements, and also develop public discourse around the matter to effect long-term change, in accordance with the changing perspective of healthcare in the United States from within the industry and from society at large.

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I. INTRODUCTION

The leading cause of personal bankruptcy in the United States is medical bills.¹ At the forefront, hospital bills are “the largest single expense for half of all medically bankrupt families.”² The most perplexing question is how did hospitals, as places of healing, become such reapers of debt? The mystery deepens when one considers that a majority of hospitals in the United States are “nonprofit”³ and thus enjoy lavish tax exemptions.⁴ It is not a question with a simple answer, and the passage of the Patient Protection and Affordable Care Act (“PPACA”)⁵ is especially timely to this issue’s analysis.

In particular, Senator Chuck Grassley’s (R-IA) proposals to the America’s Healthy Future Act of 2009⁶ aimed to “improve the community service, transparency, and billing practices of non-profit hospitals.”⁷ Although Congress abandoned this legislation, it incorporated Senator Grassley’s proposals into the PPACA, passed in March 2010.⁸ The proposals’

1. See Catherine Arnst, *Study Links Medical Costs and Personal Bankruptcy*, BUS. WK., June 4, 2009, http://www.businessweek.com/bwdaily/dnflash/content/jun2009/db2009064_666715.htm (“Medical problems caused 62% of all personal bankruptcies filed in the U.S. in 2007 . . .”).

2. *Id.*

3. CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 2 (2006), available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf> (explaining that in a five-state survey of hospitals, “nonprofit hospitals accounted for a much larger share of the hospital market than [do] for-profits”).

4. Jack Burns, Note, *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level*, 29 J. CORP. L. 665, 667 (2004) (“Charitable organizations are exempt from federal income taxation. Since the initial grant of this exemption, nonprofit hospitals qualify as charitable organizations under the Internal Revenue Code.” (footnote omitted)). The *Code of Federal Regulations* articulates the requirement for hospitals to be “nonprofit” for tax exemption. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (2009). Specifically, the *Code* demands that an exempt organization “serves a public rather than a private interest.” *Id.* As such, an organization must “establish that it is not organized or operated for the benefit of private interests such as designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests.” *Id.* Hospitals that have tax-exempt status do not have to pay federal income tax. Lawrence E. Singer, *Leveraging Tax-Exempt Status of Hospitals*, 29 J. LEGAL MED. 41, 44 (2008). These hospitals can also qualify for state exemption recognition. *Id.* In addition, tax-exempt hospitals are “able to access the bond market on a tax-free basis, and able to solicit donations from individuals who, in turn, will enjoy a tax deduction for their gift.” *Id.*

5. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

6. America’s Healthy Future Act of 2009, S. 1796, 111th Cong. (2009) (as placed on the Senate Legislative Calendar, Oct. 19, 2009).

7. Press Release, Senator Chuck Grassley of Iowa, Grassley Welcomes Non-Profit Hospital Provisions in Chairman’s Health Care Reform Bill (Sept. 17, 2009), http://grassley.senate.gov/news/Article.cfm?customer_dataPageID_1502=23094.

8. Patient Protection and Affordable Care Act §§ 9001–9023 (adopting S. 1796 §§ 6000–6023).

inclusion in the healthcare-reform bill only added weight and momentum to Senator Grassley's mission. Senator Grassley's call for reform comes from a growing public need to justify nonprofit tax exemptions and is the latest development in American nonprofit hospitals' transformation over the last century and a half.

Part II of this Note gives a history of the entities at play in this medical saga. Part II.A introduces the relevant tax-exemption law in a general sense and discusses the origins of tax exemption for charitable organizations. Part II.B specifically addresses nonprofit hospitals and details the changing role of nonprofit hospitals in American history. Part II.C then examines the actual 501(c)(3) status⁹ and its oftentimes vague relationship with nonprofit hospitals. Part II.D explores how premium fees and miscommunication can quickly accumulate into mountains of unexpected and exorbitant hospital bills. Part II.E subsequently explains the resulting debt-collection activity between nonprofit hospitals and patients. Finally, Part II.F explores the increasing public discourse on the issue and evaluates Senator Grassley's contribution to the PPACA.

Part III discusses how Senator Grassley's contribution can effectively address the debt-collection problem. Part III.A expounds on the new "reasonable efforts" requirement as a method of addressing hospitals' aggressive debt collection. Part III.B discusses Senator Grassley's newly enacted fee schedule for hospitals. Since the new law stands to affect many hospitals' nonprofit status with the IRS, Part III.C explores the financial situation of hospitals without tax exemption to consider alternative ways of retaining revenue. Part III.D investigates a complicating factor: the right and need of hospitals to collect unpaid bills from patients and how this right can be reconciled with patient needs. Part III.E examines a potential justification for debt collection from the perspective of executive compensation, while Part III.F suggests a statutory redefinition to address the problem. Part III.G investigates the overall impact of the reform and Part III.H suggests how the PPACA can produce a more lasting change on the situation, using the Carilion Clinic as a model.

In Part IV, this Note concludes that Senator Grassley's reform, as seen in the PPACA, has the potential for positive and long-lasting changes if it focuses on local communities and public discourse. This Note ultimately advocates a multi-faceted approach to reform through modifying existing tax-exemption definitions, building up hospital public relations, and focusing on local communities to remedy the problem of 501(c)(3) hospitals suing patients for outstanding bills.

9. I.R.C. § 501(c)(3) (2006).

II. AN OVERVIEW OF 501(C)(3) HOSPITALS, THEIR CHANGING ROLES, AND WHAT WENT WRONG FROM SOCIETY'S PERSPECTIVE

Part II presents the background necessary to understand the concern over tax-exempt hospitals' billing practices.¹⁰ This Part starts with a general historical overview of federal tax exemption for qualified organizations and builds up to the current concern over hospitals' billing practices. This Part ends with an introduction to the passages in the PPACA that address this pressing legal issue.

A. HISTORY OF TAX-EXEMPTION LAW

Charitable organizations traditionally enjoy tax exemption from the federal government.¹¹ Broadly speaking, an organization is charitable if it aims to and does provide “[r]elief of the poor and distressed or of the underprivileged.”¹² The idea of charitable exemption is so firmly entrenched in common consciousness that “the thought of taxing charitable organizations on the same basis as profit-making enterprises seems contrary to nature.”¹³ However, the rationale behind this long-standing tradition has been lost in history, open only to speculation.¹⁴ Professor Barbara Bucholtz asserts that the Western philanthropic tradition of exempting charities from taxes stems from the Statute of Charitable Uses from the Elizabethan Era.¹⁵ Additionally, the Supreme Court reaffirms this tradition.¹⁶ The Court in *Bob Jones University v. United States* theorized that since charitable organizations already provided public resources and services that the government—and ultimately taxpayers—must otherwise finance, such organizations should not

10. This Note uses “billing practices” to refer specifically to nonprofit hospitals’ management of patients who need financial assistance.

11. Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 309–10 (1991) (“In the United States, federal tax law has relieved charitable organizations from income tax since the law’s inception, and charities have enjoyed exemption from state and local property taxes even longer.” (footnote omitted)).

12. Treas. Reg. § 1.501(c)(3)-1(d)(2) (2009).

13. Hall & Colombo, *supra* note 11, at 310.

14. Lynnore Seaton & Beth C. Koob, *Tax-Exempt Hospitals and Community Benefit*, HEALTH LAW., June 2009, at 37, 38 (“[F]rom the very beginning, there was no clear guidance in the law as to what Congress considered to be charitable, or what the motivations were for exempting charitable organizations from taxation.”).

15. Barbara K. Bucholtz, *Doing Well by Doing Good and Vice Versa: Self-Sustaining NGO/Nonprofit Organizations*, 17 J.L. & POL’Y 403, 411 (2009) (citing PRINCIPLES OF THE LAW OF NONPROFIT ORGS. § 370 (Discussion Draft 2006)).

16. *See id.* (“[T]he tax exempt status of nonprofits has, perhaps, been rationalized best by Supreme Court case law which has explained that exempt charities provide a ‘public benefit’ by conferring resources and services which the government (and, therefore, taxpayers) would otherwise have to finance.”).

have to contribute additional money to the government.¹⁷ Considering the general rationale behind charitable organizations' tax exemption, hospitals—specifically nonprofit hospitals—seem to be obvious candidates for such exemption.

B. HISTORY OF NONPROFIT HOSPITALS

Religious societies originally established nonprofit hospitals in the United States primarily to serve the poor population.¹⁸ These early counterparts were often “the only source of medical assistance available to those unable to afford private professional medical care.”¹⁹ However, from the mid-1800s through the Great Depression, the role of hospitals changed with the advent of medical technology and health insurance, which drastically increased both the price and demand of medical care.²⁰ The cumulative effect was a “substantial change in the nature of the hospital,” as well as governmental adjustments of the Internal Revenue Code (“I.R.C.”).²¹ The 501(c)(3) tax-exemption status itself, first passed in the I.R.C. of 1954, was part of the governmental response that developed in the first half of the twentieth century to these changes in hospital care.²² The resulting multi-billion-dollar healthcare industry led to the rise of for-profit hospitals and drove nonprofits to increase their earnings by implementing “cost-effective strategies to remain competitive.”²³ The presence of government facilities further complicates the modern hospital-industry landscape.²⁴

17. 461 U.S. 574, 591 (1983); Bucholtz, *supra* note 15, at 411–12 (citing Treas. Reg. § 1.501(c)(3)-1). In other words, the organization “contribute[s] to the tax base by providing goods and services that taxes would be obliged to finance.” *Id.* at 411.

18. Michele R. Goodman, Note, *Putting the Community Back in Community Benefit: Proposed State Tax Exemption Standard for Nonprofit Hospitals*, 84 IND. L.J. 713, 717 (2009).

19. *Id.*

20. *Id.* at 717–18; Seaton & Koob, *supra* note 14, at 37–38. Specifically, the advent of anesthesia and antiseptics helped to usher in the modern hospital. *Id.* at 37. In addition, Seaton and Koob date the birth of health insurance as the Great Depression, when a Texas hospital sold hospitalization plans to school teachers for a monthly fee of fifty cents. *Id.* at 38.

21. Goodman, *supra* note 18, at 718 (quoting *Utah Cnty. v. Intermountain Health Care, Inc.*, 709 P.2d 265, 271 (Utah 1985)) (internal quotation marks omitted).

22. Seaton & Koob, *supra* note 14, at 38. The authors explained that:

Throughout the first half of the 1900's, the federal income tax law was continuously refined. These revisions always included provisions for a charitable tax exemption—provisions that later became known by the section that contained them, 501(c)(3). . . . Congress [finally] passed the Internal Revenue Code of 1954 (which was when the charitable tax exemption provisions first were gathered in section 501)

Id.

23. Goodman, *supra* note 18, at 727.

24. *See id.* at 725 (“The modern hospital industry consists of three main ownership forms: nonprofit, for-profit, and government facilities.”). Government facilities complicate the picture by presenting patients with a third set of services and prices to consider and “appear to provide

While nonprofit and for-profit hospitals have similar fee schedules and sources of financial capital,²⁵ there is a significant difference between for-profit and nonprofit hospitals. Nonprofit hospitals are subject to nondistribution constraints that demand they invest all surplus revenue in operations which benefit the community (“community benefit”).²⁶ These constraints force nonprofit hospitals to provide necessary, yet unprofitable, services to their communities that for-profit hospitals do not always provide.²⁷ Thus, nonprofit hospitals and their services are crucial to the communities they serve.²⁸ However, Congress encounters difficulties in creating a general “community benefit” definition for federal tax exemption due to local communities’ unique situations.²⁹

C. 501(C)(3) STATUS AND HOSPITALS

The I.R.C. exempts an organization from federal taxation if, among other requirements, the organization has a charitable purpose that complies with those found in § 501(c)(3), such as testing for public safety, or providing charitable, literary, or educational services.³⁰ An organization is “charitable” if it aims to provide relief to the distressed or underprivileged.³¹ Although § 501(c)(3) does not expressly cover hospitals, hospital care generally qualifies as a charitable purpose as the “promotion of health,” thus

substantially greater levels of uncompensated care than either nonprofit or for-profit hospitals.” Harold L. Kaplan & Linda S. Moroney, *Intensive Care: Hospitals Face New Financial Threat of Charity Care Legislation*, AM. BANKR. INST. J., June 2006, at 28, 58. Government facilities also spar with nonprofit hospitals over the distinctions between nonprofit and for-profit facilities. Goodman, *supra* note 18, at 715.

25. Goodman, *supra* note 18, at 715.

26. *Id.*

27. *Id.* at 726–27. Goodman, citing various studies, states:

[N]onprofit hospitals were significantly more likely than for-profit hospitals to provide emergency room care as well as labor and delivery services, both identified as generally unprofitable services. . . . [F]or-profit hospitals were less likely than nonprofits to offer unprofitable services, such as psychiatric emergency care, and for-profits were slightly more likely than nonprofits to offer profitable services, for example, open heart surgery. This tendency to provide more unprofitable services, when combined with other behavioral aspects of nonprofit hospitals—such as willingness to locate in impoverished communities and ability to survive harsh economic climates—may markedly increase access to healthcare for both insured and uninsured in certain communities.

Id. at 727 (footnote omitted).

28. *See id.*

29. *Id.* at 728 (“[There is a] general concern that by tying exemptions directly to provision of charity care—excluding other community benefits—legislators may very well overlook community-valued services that nonprofit hospitals are more likely to provide.”).

30. I.R.C. § 501(a), (c)(3) (2006).

31. *See id.* § 501(c)(3) (defining “charitable”).

fulfilling the section's requirement.³² Another subsection of the I.R.C. indicates that as long as a hospital meets the organizational and operating requirements of § 501(c)(3), the "hospital . . . is an organization described in subsection (c)(3) and exempt from taxation under subsection (a)."³³

Section 501(c)(3) of the I.R.C. requires nonprofit organizations, including hospitals, to provide a vaguely defined "community benefit" to maintain their federal tax exemption.³⁴ Many hospitals claim to meet the "community benefit" requirement by emphasizing their research and educational work.³⁵ Indeed, the IRS intentionally made the requirement vague to allow nonprofit hospitals to meet the demands of a changing modern healthcare system.³⁶ The vague "community benefit" requirement allows each hospital to accommodate the needs of its specific community.³⁷ However, this wording, combined with courts' indecision on the precise boundaries of "community benefit,"³⁸ has resulted in these hospitals engaging in many more activities than just treating financially disadvantaged patients.

Tax-exempt hospitals' primary function is no longer "charity care"—serving poor and indigent populations.³⁹ Instead, they offer "unique

32. Rev. Rul. 69-545, 1969-2 C.B. 117, 118 ("In the general law of charity, the promotion of health is considered to be a charitable purpose. [And thus, a] non-profit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose.").

33. I.R.C. § 501(e)(1)(A).

34. Steven T. Miller, Comm'r, Tax Exempt & Gov't Entities, Internal Revenue Serv., *Charitable Hospitals: Modern Trends, Obligations and Challenges* 4 (Jan. 12, 2009), http://www.irs.gov/pub/irs-tege/miller_speech_011209.pdf ("In a nutshell, that is the standard—a hospital must show that it benefits the community and the public by promoting the health of that community.").

35. John Carreyrou, *Nonprofit Hospitals Flex Pricing Power*, WALL ST. J., Aug. 28, 2008, at A1.

36. Goodman, *supra* note 18, at 719 ("[T]he IRS merely redefined 'charitable purpose' to allow nonprofits to maintain exemption in a changing healthcare system . . . Revenue Ruling 83-157 . . . removed the emergency room requirement as long as other significant factors indicate that the hospital is operating exclusively to benefit the community (the 'community benefit' standard).") (footnote omitted). The emergency-room requirement refers to the fact that whether a hospital operates an emergency room that does not deny treatment on the basis of ability to pay is a substantial factor in determining whether the hospital promotes public health. *Id.*

37. *See id.* at 728 ("A community benefit analysis . . . would provide a community focus . . .").

38. *See id.* at 719-20 (describing the courts' inability to definitively interpret "community benefit"). Goodman indicates that in the past, courts' interpretations of Revenue Ruling 83-157 required that 501(c)(3) hospitals "make their services available to the entire community *plus* provide additional public benefits. . . . such as provision of free or below-cost services, conducting research, or offering free education to the public. However, courts have yet to define 'exactly which or how much of these "plus" behaviors are necessary to exemption.'" *Id.* (footnote omitted) (quoting John D. Colombo, *The Role of Tax Exemption in a Competitive Health Care Market*, 31 J. HEALTH POL. POL'Y & L. 623, 626 (2006)).

39. *See supra* notes 30-32 and accompanying text (defining "charitable" care).

benefits” such as “physician education and medical research . . . community health education . . . preventative services such as childbirth classes, meals for the elderly, and immunization clinics,” and “foster an ethos more conducive to proper medical practice than that prevailing in profit-oriented environments.”⁴⁰ As a result, it is unsurprising that as nonprofit hospitals’ tax exemption⁴¹ for the benefits they bring to their communities made healthcare an extremely lucrative business,⁴² “community benefit” activities have displaced charitable services such as caring for the poor.

D. NONPROFIT HOSPITALS V. PATIENTS

There is evidence of “nonprofit” hospitals charging uninsured patients the full, undiscounted rate, making healthcare at these nonprofit hospitals unrealistically expensive. The drastic difference between premium and insured cost of service stems from bargaining power, or rather, lack of bargaining power:

When an insurance carrier foots a hospital bill, the company “negotiates” a price with the hospital that is usually about half the original billing price. Yet when an individual without insurance is forced to pay for healthcare, they don’t have this bargaining power. So they end up paying the “full” rates, making up the slack for the deals the insurance companies have gotten (as well as the uninsured individuals who never pay their bills).⁴³

Essentially, these hospitals are “charging indigent and uninsured patients premiums [at whatever amount] they want to charge.”⁴⁴ In fact, a study of

40. Hall & Colombo, *supra* note 11, at 366; *see also supra* note 35 and accompanying text (showing other ways modern hospitals benefit their local communities aside from providing “charitable care”).

41. The amount of money hospitals retain from tax exemption is a nationwide sum estimated to be over \$12 billion. CONG. BUDGET OFFICE, *supra* note 3, at 2 (estimating the value of tax exemptions nonprofit hospitals received in 2002 from federal, state, and local governments at \$12.6 billion); Bill Sizemore & Nancy Young, *Do Nonprofit Hospitals Offer a Helping Hand or Heavy Hand?*, VIRGINIAN-PILOT, Sept. 16, 2007, <http://hamptonroads.com/2007/09/do-nonprofit-hospitals-offer-helping-hand-or-heavy-hand>.

42. John Carreyrou & Barbara Martinez, *Nonprofit Hospitals, Once For the Poor, Strike It Rich*, WALL ST. J., Apr. 4, 2008, at A1 (“[M]any nonprofit hospitals have seen earnings soar in recent years. The combined net income of the 50 largest nonprofit hospitals jumped nearly eight-fold to \$4.27 billion between 2001 and 2006 . . .”).

43. Kari Lydersen, *Why Hospitals Overcharge the Uninsured Patients*, BUSINESSREPORTER.ORG, <http://www.businessreporter.org/hospitals-overcharge-uninsured-patients.htm> (last visited Oct. 21, 2010).

44. Interview with Sheldon F. Kurtz, Percy Bordwell Professor of Law, Univ. of Iowa Coll. of Law, in Iowa City, Iowa (Nov. 3, 2009). Gerard Anderson also illustrates the huge difference between what hospitals charge insured patients and what they charge uninsured patients. Gerard F. Anderson, *From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 781 (2007). Anderson uses two commonly used ratios to emphasize the point: charge-to-cost ratios and gross-to-net revenues. *Id.* Charge-to-cost ratios show that the

hospitals in the Chicago area found that “each hospital charged uninsured patients up to twice the payments the hospitals accepted from insurance plans.”⁴⁵ For example, the Carilion Health System in Virginia charges \$4727 for a colonoscopy, which is four to ten times more than what a local endoscopy center charges.⁴⁶ On a national scale, medically bankrupt families with private insurance averaged \$17,749 in medical bills, while the uninsured’s bills averaged a much higher \$26,971.⁴⁷

Equally, if not more problematic, is hospitals’ inconsistent disclosure to patients of the availability of Medicaid or “free bed” programs.⁴⁸ In an interview with twenty of Yale-New Haven Hospital’s patients-turned-debtors, most said they did not know and did not remember being informed that the hospital had a “free care” or “charity care” program.⁴⁹ The hospital even told one patient that charity care did not exist when she asked.⁵⁰ This situation affects both new and existing patients. Many people who regularly receive treatment from these hospitals find themselves suddenly stuck with huge figures in “bad debt.”⁵¹ This debt can be attributed to either a gap in Medicaid coverage that the person was unaware of until after treatment or the hospital’s misdirection.⁵²

E. BAD DEBT AND DEBT COLLECTION

Equally important is how the hospitals collect “bad debt” from patients. Many describe these hospitals’ collection tactics as “predatory”⁵³ and

“ratio of charges to costs measures the relationship between actual hospital charges for services (what self-pay patients are generally asked to pay) and Medicare-allowable costs (what the [Centers for Medicare & Medicaid Services] has determined to be the costs associated with care for all patients, not just Medicare patients).” *Id.* In 2004, this ratio was 3.07. *Id.* In layman’s terms, every \$100 in Medicare-allowable costs is equivalent to \$307 for everyone else who walks in the door. Looking next at the gross-to-net revenues, Anderson demonstrates that if a hospital actually collected these charges from every patient in 2004, its profit margin would average over 200%. *Id.* However, in reality, hospitals only averaged a profit margin of 5.2%. *Id.* at 782.

45. Beverly Cohen, *The Controversy over Hospital Charges to the Uninsured—No Villains, No Heroes*, 51 VILL. L. REV. 95, 104 (2006).

46. Carreyrou, *supra* note 35.

47. Arnst, *supra* note 1.

48. *See infra* notes 56–57 and accompanying text (describing patients’ lack of knowledge concerning hospital financial aid).

49. CONN. CTR. FOR A NEW ECON., UNCHARITABLE CARE: YALE-NEW HAVEN HOSPITAL’S CHARITY CARE AND COLLECTIONS PRACTICES 19 (2003), available at http://www.ctneweconomy.org/Resources/uncharitable_care.pdf.

50. *Id.*

51. *Uncharitable Care* indicates that the Yale-New Haven Hospital “classifies most of its uncompensated service to the uninsured and underinsured as ‘bad debt.’” *Id.* at i.

52. *See id.* at 3–9 (detailing personal accounts of patients who inadvertently became indebted to Yale-New Haven Hospital).

53. Laurence Hammack, *Critics Question if Hospitals’ Charity Care Is Enough*, ROANOKE TIMES, Sept. 14, 2008, 2008 WLNR 17564089 (internal quotation marks omitted).

“aggressive.”⁵⁴ Some tactics include weekly letters and phone calls, filing lawsuits, garnishing wages and bank accounts, and obtaining liens on homes.⁵⁵ Often, patients do not know they owe the hospital money until they are sued. Because they fill out paperwork for financial aid prior to treatment and receive no notification post treatment, they assume that the bill has been sorted out.⁵⁶ These tactics can devastate patients, both financially and personally, leading to ruined credit ratings, moves to run-down housing, and even bankruptcy.⁵⁷

Although it is surprising that “charitable” organizations utilize such practices, lawsuits against patients for “bad debt” are not uncommon. In 2002, Yale-New Haven Hospital, the largest charitable healthcare provider in New Haven, Connecticut,⁵⁸ filed 426 lawsuits against patients.⁵⁹ Up until very recently, forty percent of the total judgments in Roanoke City General District Court—roughly 33,000 judgments since 2003—resulted from claims by Southwest-Virginian 501(c)(3) Carilion Clinic.⁶⁰ In one year, Carilion sued 9888 patients, garnished the wages of 5478 people, and placed liens on 3920 homes.⁶¹

This activity did not go unnoticed. Within the past decade, increasing numbers of reports, articles, and studies have emerged throughout the country, notably including the *Wall Street Journal's* series of articles beginning in 2003.⁶² The issue exploded in 2004 as patients began to countersue

54. Sizemore & Young, *supra* note 41.

55. CONN. CTR. FOR A NEW ECON., *supra* note 49, at 3–9; *see also* Sizemore & Young, *supra* note 41 (describing aggressive tactics hospitals use to collect unpaid bills).

56. CONN. CTR. FOR A NEW ECON., *supra* note 49, at 3–9. The hospital even told one patient “[d]on’t worry” before his operation, and the patient heard nothing else on the matter until he was sued afterwards. *Id.* at 3 (internal quotation marks omitted).

57. Bill Sizemore & Nancy Young, *Hospital Day in Court*, VIRGINIAN-PILOT, Sept. 16, 2007, <http://www.roanoke.com/news/wb/176617>.

58. CONN. CTR. FOR A NEW ECON., *supra* note 49, at 1.

59. *Id.* at 12.

60. Laurence Hammack, *Carilion Cases Dominate General District Docket*, ROANOKE TIMES, Sept. 14, 2008, 2008 WLNR 17459029. Carilion is such a regular at the courthouse that the Roanoke City General District Court devotes one morning a week to its cases. Carreyrou, *supra* note 35. The assessment was taken in late 2008. Hammack, *supra*.

61. Carreyrou, *supra* note 35. The figures specifically refer to Carilion’s fiscal year ending on September 30, 2007. *Id.*

62. *See generally* Carreyrou & Martinez, *supra* note 42 (showing the criticism behind nonprofit hospitals’ tax exemption; despite making significant profits in recent years, nonprofit hospitals still sue their uninsured patients for unpaid bills); Lucette Lagnado, *Anatomy of a Hospital Bill*, WALL ST. J., Sept. 21, 2004, at B1 (relays the story of a man who found himself \$40,000 in debt after a twenty-one-hour stay at the hospital); Lucette Lagnado, *Full Price: A Young Woman, an Appendectomy, and a \$19,000 Debt*, WALL ST. J., Mar. 17, 2003, at A1 (writing about a young woman who incurred \$19,200 in medical bills after two days in the hospital); Lucette Lagnado, *Twenty Years and Still Paying*, WALL ST. J., Mar. 13, 2003, at B1 (documenting a widower’s growing debt from interest on his wife’s hospital bills); Barbara Martinez, *Pursuing*

hospitals in class-action suits for unfair and improper collection tactics.⁶³ Recently, a Chicago filmmaker documented this hospital practice in a documentary, *Do No Harm*.⁶⁴ The film aims to “draw national attention to hospital corruption and the plight of the uninsured.”⁶⁵ Illinois Attorney General Lisa Madigan, who attended *Do No Harm*’s Chicago premiere, stated: “In the absence of laws to protect health care consumers from overly aggressive billing and collection practices, many Illinois hospitals employed strategies similar to those [found in the documentary]’”⁶⁶

F. SENATOR GRASSLEY AND THE PPACA

Growing national concern over the lack of such laws sparked much governmental debate and activism, culminating in President Obama’s controversial healthcare reform. On March 23, 2010, President Obama signed the PPACA into law.⁶⁷ The PPACA incorporated Iowa Senator Chuck Grassley’s proposals for additional requirements for 501(c)(3) hospitals.⁶⁸ As they followed the shifting discussion on Capitol Hill, anxious healthcare providers at nonprofit hospitals feared the removal of their tax exemption.⁶⁹ However, Senator Grassley’s contributions to the PPACA do not go this far. His contributions include a subsection specifically addressing the collection practices of hospitals.⁷⁰ The subsection explicitly states that a hospital is charitable “only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance.”⁷¹

Charitable Mission Leaves a Hospital Struggling, WALL ST. J., Dec. 12, 2008, at A1 (describing the difficulties of a nonprofit hospital that declined to sue its patients).

63. See Neville M. Bilimoria, *Patients Challenge Nonprofit Hospitals’ Charitable-Care Practices*, 93 ILL. B.J. 134, 134 (2005) (examining “class action lawsuits brought by plaintiffs, patients of the hospitals, who claim that these hospitals violated their obligations as charities by overcharging uninsured patients”).

64. DO NO HARM (The Kindling Group 2009).

65. *About the Film*, DO NO HARM, <http://www.donoharmdoc.com/about.asp> (last visited Oct. 21, 2010).

66. Alex Parker, *Health Care Billing Abuses “Stranger than Fiction,”* CHI-TOWN DAILY NEWS (May 22, 2009, 2:45 PM), http://www.chitowndailynews.org/Chicago_news/Health_care_billing_abuses_stranger_than_fiction_.27308.

67. Patent Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

68. Senator Grassley originally laid out his proposals for 501(c)(3) hospitals in a healthcare bill that Senate Finance Chairman Max Baucus introduced, titled “America’s Healthy Future Act.” However, that bill was abandoned after the enactment of the PPACA, and Senator Grassley’s proposals were incorporated in the newly enacted PPACA.

69. Barbara Martinez, *Nonprofit Hospitals Dodge Excise-Tax Bullet in Baucus Bill*, WALL ST. J. HEALTH BLOG (Sept. 16, 2009, 1:26 PM), <http://blogs.wsj.com/health/2009/09/16/nonprofit-hospitals-dodge-excise-tax-bullet-in-baucus-bill/>.

70. Patient Protection and Affordable Care Act § 9007 (to be codified at I.R.C. § 501(r)).

71. *Id.* § 9007(a) (to be codified at I.R.C. § 501(r)(6)). This section was initially proposed as America’s Healthy Future Act of 2009, S. 1796, 111th Cong. § 6007(a) (2009) (as placed on the Senate Legislative Calendar, Oct. 19, 2009). The PPACA does not include an explicit

The fact that this is the most drastic amendment to 501(c)(3) requirements in thirty-five years⁷² indicates the growing consideration the country is giving to this subject. The PPACA will undoubtedly alter the practices of these hospitals in ways this nation has not seen for decades. However, determining whether the changes will be for better or for worse requires a careful examination of Senator Grassley's contributions to the PPACA in relation to existing hospital practices.

III. BATTLING 501(C)(3) HOSPITALS' DEBT-COLLECTION HABITS WITH SENATOR GRASSLEY'S CONTRIBUTION

Part III will apply the PPACA to 501(c)(3) hospital billing practices and speculate on the PPACA's effectiveness in addressing the issue. Specifically, this Part first examines Senator Grassley's additional requirements for charitable hospitals and the significance of tax exemption to the hospitals themselves. This Part then acknowledges hospitals' rights to such collection practices but also suggests reasons why hospitals should avoid them. Finally, this Part will explain how to maximize the effectiveness of Senator Grassley's contributions to the PPACA by integrating them into a larger reform eliminating harmful 501(c)(3) collection practices.

A. "REASONABLE EFFORTS": A PROPOSED ATTEMPT AT CIVILITY

The PPACA's reform prohibits nonprofit hospitals from undertaking extraordinary collection actions without first making "reasonable efforts" to inform patients of financial-aid policies.⁷³ However, what constitutes "reasonable efforts" is unclear. The passages give little instruction on what constitutes a reasonable effort. Instead, it is up to the Secretary of Health and Human Services ("the Secretary") to "issue such regulations and guidance as . . . to what constitutes reasonable efforts."⁷⁴ This addition to

definition of "extraordinary collections." However, Senator Grassley's proposal in the first draft of America's Healthy Future Act of 2009 did define "extraordinary collections" to include lawsuits, property liens, arrest, mandated court attendance, and other similar collection tactics. S. REP. NO. 111-89, at 339 (2009).

72. Martinez, *supra* note 69.

73. Patient Protection and Affordable Care Act § 9007(a) (to be codified at I.R.C. § 501(r)(6)).

74. *Id.* The first draft of America's Healthy Future Act of 2009 went further and elaborated on what the legislature considered "reasonable." S. REP. NO. 111-89, at 340. "Reasonable efforts" according to the first draft included notification "upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls, before collection action or reporting to credit rating agencies is initiated." *Id.* To gain a better understanding of who should qualify for financial assistance, prior to the PPACA's passage, "hospital care [was] free for anyone with income below the poverty level, \$18,850 for a family of four. At some local hospitals, [it was] up to twice the poverty level." Misti Crane & Geoff Dutton, *Nonprofit Hospitals' Collection and Charity Policies Under Fire*, COLUMBUS DISPATCH, Mar. 7, 2005, 2005 WLNR 24964685. The PPACA requires tax-exempt hospitals to establish a written financial-assistance policy that includes eligibility

nonprofit-hospital protocol addresses the inconsistencies that many patients currently experience when attempting to obtain financial-aid information from hospitals.⁷⁵ The addition seems to at least require some form of communication between the hospital and patients about the cost of treatment.

A standard that relies on the Secretary's discretion does raise the question of the protocol's appropriateness in a hospital context. Whenever one party, at an obvious advantage over another, is given unspecified instructions to "notify" the weaker party of its price for much-needed treatment in any "reasonable" way, there is danger that the advantaged party will abuse its pricing and notification powers. However, this is preferable to the situation that existed prior to the PPACA's enactment.

Before the PPACA, even an adhesion contract that typically did not allow a "realistic opportunity to bargain and [denied] . . . the desired product or services except by acquiescing in the form contract"⁷⁶ put patients in a better legal position when litigating with a hospital over medical bills. With an adhesion contract, the patient at least had the opportunity to argue that the contract was unenforceable.⁷⁷ Nonetheless, it seemed to patients that only an act of God could provide any relief in court.

In 2008, Franklin Square Hospital sued uninsured Renee Alisea for a \$10,800 hysterectomy after her surgeon promised that "his services would be free because of her 'poverty' and said he had 'made arrangements' for the hospital to waive its charges."⁷⁸ Commenting on her upcoming trial, Alisea doubted she had any chance to win. However, she remained optimistic, stating: "I'm hoping that I get a judge that really has a heart and can really understand and acknowledge what is going on here."⁷⁹ Prior to the PPACA, hospitals had the upper hand in a battle over unpaid debt, as part of a standard debtor-creditor relationship. The PPACA, even with its

criteria for financial assistance, but does not define such eligibility criteria. Patient Protection and Affordable Care Act § 9007(a) (to be codified at I.R.C. § 501(r)(4)(A)).

75. An example is Willie Mae White's circumstance. Fred Schulte & James Drew, *In Their Debt: Sun Special Investigation*, BALT. SUN, Dec. 21, 2008, 2008 WLNR 24530360. When Ms. White had an emergency surgery for a brain aneurism, she asked about financial aid and was told that her balance was "zero." *Id.* Maryland nonprofit hospital Johns Hopkins Bayview Medical Center later sued her for over \$36,000. *Id.*

76. *Wheeler v. St. Joseph Hosp.*, 133 Cal. Rptr. 775, 783 (Ct. App. 1976).

77. With standard adhesion contracts, patients can argue the contract is unenforceable either because it "does not fall within the reasonable expectations of the weaker or 'adhering' party . . . [or that the contract] is unduly oppressive or 'unconscionable.'" *Graham v. Scissor-Tail, Inc.*, 623 P.2d 165, 172-73 (Cal. 1981) (per curiam).

78. Schulte & Drew, *supra* note 75.

79. Lloyd Fox, *Renee Alisea Talks About Ovarian Cancer, Her Hysterectomy and Unexpected Hospital Bills*, BALT. SUN, <http://www.baltimoresun.com/videobeta/fbcd882-d774-404d-a398-23bbo3475d5f/News/Renee-Alisea-talks-about-ovarian-cancer-her-hysterectomy-and-unexpected-hospital-bills> (last visited Oct. 21, 2010).

gift of discretion to the Secretary, at least offers patients a leg to stand on in the courtroom.

B. SENATOR GRASSLEY'S INNOVATION: PRICES NOT MEANT FOR THE POOR

The PPACA, through Senator Grassley's contributions, also attempts to tackle the heart of the problem: nonprofit hospitals charging uninsured patients premium prices for treatment. Senator Grassley's specific additions include limiting "amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy . . . to not more than the lowest amounts charged to individuals who have insurance . . . [and] prohibits the use of gross charges."⁸⁰ To patients like Renee Alisea, whose experience led her to believe that if "you got somebody who doesn't have any insurance . . . the only way you can get help is if you're dying,"⁸¹ this section is key to a humane healthcare system.

This requirement transforms current billing practices into opportunities for revoking hospitals' 501(c)(3) status. Presently, many 501(c)(3) hospitals that charge premium or higher prices to uninsured patients for their services can do so because of the ill-defined "community benefit" standard. In one instance, plaintiffs alleged that a nonprofit health group, Sutter Health, charged them four to five times more than what it charged insured patients.⁸² Already accused of falsely advertising itself as a community-based and not-for-profit organization, Sutter counter-sued the patients who brought the original suit⁸³ before finally settling.⁸⁴ To date, the members of Sutter Health maintain their 501(c)(3) tax exemption.⁸⁵ Despite many attempts, a successful court action against such prices has yet to occur.⁸⁶ Courts have dismissed other claims of contractual duty violation

80. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 857 (2010) (to be codified at I.R.C. § 501(r)(5)).

81. Fox, *supra* note 79.

82. Rachel Osterman, *Sutter Health Takes Gloves Off in Lawsuit: Counterclaim Is Filed Against Uninsured Who Didn't Pay Bills*, SACRAMENTO BEE, Aug. 19, 2005, at D1, 2005 WLNR 13101546.

83. *Id.*

84. Press Release, Sutter Health, Sutter Health Settles Lawsuit over Prices Charged to Uninsured; Reaffirms Its Charity Care and Discount Policies (Aug. 3, 2006), http://www.sutterhealth.org/about/news/newso6_settlement.html.

85. See, e.g., *Form 990: Return of Organization Exempt from Income Tax*, SUTTER HEALTH (2004), http://www.sutterhealth.org/about/sh_2004_990.pdf (providing the filled out 501(c)(3) nonprofit corporation form for Sutter Health); *Sutter Amador Hospital Foundation*, SUTTER AMADOR HOSP., http://www.sutteramadorhospital.org/communityrelations/foundation_board.html (last visited Oct. 21, 2010) (stating that Sutter Amador Hospital "is a not-for-profit, 501(c)3 [sic] community hospital affiliate of Sutter Health").

86. One attempt at consolidating actions against unreasonable treatment prices lists twenty-eight actions across twenty-one districts: three actions each in the Middle District of Georgia and the Northern District of Illinois; two actions each in the Middle District of Florida, the District of Minnesota, and the Northern District of Ohio; and one action each in the

based on a party's 501(c)(3) tax-exempt status due to lack of standing.⁸⁷ However, appellate courts have occasionally supported actions against such prices by upholding tax-exemption denials after healthcare providers appealed these denials.⁸⁸

Subsequently, it is difficult to distinguish between nonprofit and for-profit hospitals when examining their actual practices.⁸⁹ The PPACA forges a method for distinguishing them, differentiating between hospitals that

Northern District of Alabama, the District of Arizona, the Northern District of California, the District of Colorado, the Southern District of Florida, the Northern and Southern Districts of Georgia, the Southern District of Mississippi, the Eastern District of Missouri, the District of New Jersey, the District of New Mexico, the Southern District of New York, the Western District of Pennsylvania, the Middle District of Tennessee, and the Eastern and Northern Districts of Texas. *In re Not-for-Profit Hosps./Uninsured Patients Litig.*, 341 F. Supp. 2d 1354, 1355 (J.P.M.L. 2004).

87. See *Lorens v. Catholic Health Care Partners*, 356 F. Supp. 2d 827, 831 (N.D. Ohio 2005) (noting that although "this lawsuit is one of dozens of similar lawsuits filed in district courts across the country on behalf of uninsured and indigent patients," no court has yet found for the plaintiffs on any substantive legal issue in these cases). The opinion states that "[p]laintiff maintains that CHP owes her, and other similarly-situated uninsured Americans, a contractual duty based on CHP's tax-exempt status under [I.R.C.] § 501(c)(3). . . . Permitting this claim to continue would require the court to make numerous jumps in logic that run counter to legal authority." *Id.*

88. See *IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188, 1199–200 (10th Cir. 2003) (using petitioners' requirement that all enrollees pay a premium to receive benefits and their unwillingness to subsidize dues for those who cannot afford subscribership as evidence that petitioners lack a charitable purpose); *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1219–20 (3d Cir. 1993) (holding that healthcare provider was not entitled to tax exemption in part because it did not provide free or low-cost services); cf. *St. David's Health Care Sys. v. United States*, 349 F.3d 232 (5th Cir. 2003) (discussing free or low-cost care as one factor in the determination of whether a nonprofit hospital is charitable under the community-benefit standard of § 501(c)(3)).

89. The Congressional Budget Office's study of nonprofit hospitals in five states shows:

When regression techniques were used to adjust for the hospitals' size and location and for the characteristics of the local populations, nonprofit hospitals were estimated to have an average uncompensated-care share that was 0.6 percentage points higher than that for otherwise similar for-profit hospitals. That estimated difference corresponds to nonprofit hospitals in the five selected states providing between \$100 million and \$700 million more in uncompensated care than would have been provided if they had been for-profits.

CONG. BUDGET OFFICE, *supra* note 3, at 2. In addition, former IRS Commissioner Mark W. Everson in a hearing stated:

[S]ince 1969 [there] has been a convergence of practices between the for-profit and nonprofit hospital sectors, rendering it increasingly difficult to differentiate for-profit from not-for-profit health care providers. In our review of tax-exempt hospitals, some of the issues we are finding include complex joint ventures with profit-making companies, excessive executive compensation, operating for the benefit of private interest rather than the public good, unrelated business income and employment taxes.

The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means, 109th Cong. 9 (2005) (statement of Mark Everson, Comm'r, Internal Revenue Service).

charge patients qualifying for financial assistance more than what they charge insured patients from those that charge financially disadvantaged patients the same amount as insured patients.⁹⁰ This criterion is more straightforward than the existing “community benefit” standard and, in the eyes of community members, seems to redraw the fading distinction between charitable, nonprofit hospitals worthy of federal tax exemption and for-profit hospitals.⁹¹ Senator Grassley’s proposed reform does not disqualify hospitals that charge all patients the same price (regardless of their financial status) from tax exemption. Nor does it bring back the dual-healthcare systems evident in the past, where it would have been easier to dole out a federal tax exemption to one class of hospitals but not the other. However, Senator Grassley’s reform promises a clearer and modern distinction by offering a crisp method of determining which hospitals are more deserving of a tax exemption.⁹²

Although the PPACA advocates transparency and organizational responsibility, other reform measures do as well. Scandals in the nonprofit world similar to the Enron fiasco put nonprofits under the microscope.⁹³ As the resulting cry for corporate transparency grew louder, the IRS finally

90. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 855–57 (2010) (to be codified at I.R.C. § 501(r)).

91. Cf. Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 10 (1995) (indicating that in the nineteenth century, “[t]wo separate health care provider systems were established: hospitals for the poor, largely supported by government subsidies and religious organizations, and physician-provided care, supported by patient fees”); Shelley A. Sackett, *Conversion of Not-for-Profit Health Care Providers: A Proposal for Federal Guidelines on Mandated Charitable Foundations*, 10 STAN. L. & POLY REV. 247, 248 (1999) (“A two-tiered system of medical care developed, including private, ‘fee-for-service’ care for those who could afford it, and a voluntary public system funded by taxes and private contributions for those less well-off.”).

92. Patient Protection and Affordable Care Act § 9007(a) (to be codified at I.R.C. § 501(r)). Rather than leaving hospital-service pricing to the mercy of future legislatures, the PPACA specifically suggests a few methods to assure that financially disadvantaged patients are charged fairly: “amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy . . . [cannot be] more than the lowest amounts charged to individuals who have insurance covering such care.” *Id.*

93. Joseph Goldstein, *Exerting Their Patients*, A.B.A. J., May 2009, at 19, 19. Transparency of nonprofits’ corporate operations especially became a focal point for investigation. See Lisa W. Clark, Katherine M. Kelton & David Flynn, *What May Arrive in Tomorrow’s Mail?: An Analysis of Class Action Lawsuits Concerning Hospital Billing of Uninsured Patients*, 13 Health L. Rep. (BNA) 1134, 1134–35 (July 29, 2004) (indicating that in 2004, the Subcommittee on Oversight of the House Committee on Ways and Means began a series of hearings on hospital pricing to “examine the current hospital pricing system and focus on the lack of transparency in hospital charges, which hinders consumers from making informed choices about where they get care and the options for increasing information about hospital pricing” (internal quotation marks omitted)); Carol Pryor, *The Hospital Billing and Collections Flap: It’s Not Over Yet*, J. HEALTH CARE COMPLIANCE, May–June 2005, at 25, 29 (“Hospitals need to focus serious attention on revising, clarifying, and publicizing their financial assistance policies and, just as importantly, on effectively monitoring their implementation.”).

responded by significantly amending its Form 990 beginning in 2009.⁹⁴ Form 990 is the traditional IRS annual tax return for most nonprofits—not just 501(c)(3) organizations.⁹⁵ The form's freshly amended sections include a schedule directly aimed at hospitals.⁹⁶ Schedule H clearly defines the troublesomely vague "charitable care" as "free or discounted health services provided to persons who meet the organization's criteria for financial assistance."⁹⁷ The form takes a more assertive position than Senator Grassley's contributions to the PPACA and aims to change the inner workings of nonprofit hospitals, rather than hospitals' patient policies.

For Senator Grassley's contributions to truly alter the healthcare situation, they must reinforce the points that Form 990 purports to make: internal corporate change with an eye toward public service, and re-evaluation of how tax-exempt hospitals should actively fulfill their charitable missions of "community benefit."⁹⁸ Form 990 may indicate a shifting perspective on how hospitals, and nonprofits generally, should take their public image and the public's role in their internal operations seriously. For hospitals, that includes the price they charge poor and disadvantaged patients. Such a shift is an optimistic sign that the PPACA will be able to positively affect changes to the billing practices of hospitals. Future health-reform advocates must capitalize on this momentum.

C. A HOSPITAL'S WORLD WITHOUT TAX EXEMPTION

Senator Grassley's reform measures flesh out a more truthful representation of what should qualify as a nonprofit hospital. As such, they will aid in revoking the tax-exemption status of some organizations that currently enjoy it. Without such an exemption, the question remains whether a hospital can stay viable in today's healthcare market.⁹⁹

94. Lisa A. Runquist & Michael E. Malamut, *The IRS's New Regulation of Nonprofit Governance*, BUS. L. TODAY, July/Aug. 2009, at 29, 29.

95. *Id.*

96. IRS, DEP'T. OF TREASURY, SCHEDULE H (FORM 990) (2009).

97. IRS, DEP'T OF TREASURY, INSTRUCTIONS FOR SCHEDULE H (FORM 990) 2 (2009).

98. For a detailed analysis of Form 990's attempt to hold hospitals more responsible for their need to provide "community benefit," see generally Fred Joseph Hellinger, *Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements*, 34 J. HEALTH POL. POL'Y & L. 37 (2009), which describes changes to Form 990 and how they affect tax-exempt hospitals' "community benefits" requirement.

99. The PPACA spells out exactly how much tax a hospital must pay if it fails to meet its § 501 requirements: "If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to \$50,000." Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(b)(1), 124 Stat. 119, 857 (2010) (to be codified at I.R.C. § 4959).

Prior to World War II, hospitals relied on philanthropic support for a large portion of their income¹⁰⁰ and in return, reflected the local culture they served.¹⁰¹ It was only after the war, and the rise of third-party reimbursement structures, that hospitals began to rely heavily on private insurance and government funding.¹⁰² By the mid 1960s, “the character of nonprofit hospitals ha[d] become remarkably homogenous . . . [to the point that] ‘the notion of an institution closely connected to its community seemed like a romantic remnant of a “pre-scientific” era.’”¹⁰³ The “donative” theory realizes this increasing similarity amongst hospitals. The theory indicates that hospitals must find ways of distinguishing themselves from each other—otherwise, they will lack the appeal to motivate enough philanthropic interest to keep up with the increasing costs of running a healthcare institution without a governmental crutch.¹⁰⁴

D. DEBT COLLECTION: A HOSPITAL RIGHT OR EXCUSE?

The PPACA forbids hospitals from using certain extraordinary collection actions against patients without “reasonable efforts” to inform the patient of the hospital’s financial aid policies.¹⁰⁵ So far, this is a positive step toward fairer treatment of patients. Nevertheless, improvements must not come at the expense of other rights—namely those that even nonprofit

100. Specifically, “hospitals depended on philanthropy for roughly one-quarter to one-third of their operating budget and for the bulk of their capital funds.” Hall & Colombo, *supra* note 11, at 407.

101. “The early growth of voluntary hospitals after the turn of the century ‘reflected the idiosyncratic qualities of the community they served.’” *Id.* (quoting David Rosner, *Heterogeneity and Uniformity: Historical Perspectives on the Voluntary Hospital*, in *IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS* 87, 93 (1988)).

102. *Id.* The government’s role in funding healthcare rapidly expanded in the 1960s with the creation of Medicare and Medicaid. *Id.*

103. *Id.* at 408 (quoting Rosner, *supra* note 101, at 122).

104. *Id.* “At present, the lack of donative support is evidence either that nonprofit hospitals do not provide a service materially different than that otherwise available, or that if they do, they are sufficiently supported in more direct ways.” *Id.* To detail how deeply entrenched the government is in healthcare funding in the United States, James McGrath explains:

The federal government is the largest funding source for health care in the United States as a direct third-party payer. Of the approximately 84.4% of the American population (243.3 million people) who had health insurance in 2003, 31% were insured by the federal government. Approximately 76.8 million people were covered directly by government-paid health insurance programs. Medicare is the federal program which helps pay health care costs for people age sixty-five and older and for certain people under the age of sixty-five with disabilities. Medicare alone . . . covered about 35.6 million Americans in 2003.

James McGrath, *Overcharging the Uninsured in Hospitals: Shifting a Greater Share of Uncompensated Medical Care Costs to the Federal Government*, 26 QUINNIPIAC L. REV. 173, 185–86 (2007) (footnotes omitted).

105. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 857 (2010) (to be codified at I.R.C. § 501(r)).

hospitals are entitled to as part of a debtor–creditor relationship. To anyone who suffered through an unexpectedly pricey visit to the hospital, this right seems contradictory to a selfless, tax-exempt organization. Regardless, it is one that courts uphold.¹⁰⁶ The mere fact that an organization is a nonprofit does not create any sort of auxiliary fiduciary duty between it and an individual once they are engaged in a contractual relationship involving the exchange of money for services.¹⁰⁷

Furthermore, even the most community-minded 501(c)(3) hospital must profit to keep functioning. After all, hospitals are dealing with rising out-of-pocket health costs,¹⁰⁸ lowered rates of patient admissions, a growing amount of unpaid care,¹⁰⁹ and competition with both for-profit hospitals¹¹⁰ and healthcare providers.¹¹¹ Tactics such as suing, failing to explain financial assistance options, and even offering credit to patients to later collect on are all legal, “as long as hospitals comply with a federal law that requires them to treat anyone who comes in with an emergency—regardless of their ability to pay.”¹¹² Setting aside the fact that hospitals and patients disagree over what should be considered an “emergency,”¹¹³ hospitals claim that post-emergency, they only sue those able to pay.¹¹⁴ In reality, evidence

106. See *Morrell v. Wellstar Health Sys., Inc.*, 633 S.E.2d 68, 74 (Ga. Ct. App. 2006) (“When nonprofit hospitals and their patients enter into agreements on the price to be charged for medical care, they are ordinarily engaged in business transactions indistinguishable from those engaged in by for-profit corporations with no confidential or fiduciary relationship between the parties.”).

107. *Id.*

108. “[T]he \$250 billion price tag in 2005 is expected to exceed \$420 billion by 2015.” Jessica Bennett, *The Other Credit Crunch*, NEWSWEEK, Nov. 24, 2008, <http://www.newsweek.com/id/170701>. Additionally, “[h]ospital executives say they are in a bind. If patients don’t pay, the hospital can’t provide expensive and advanced medical care.” Liz Kowalczyk, *Hospital Using Liens To Collect from Patients*, BOS. GLOBE, Oct. 17, 2004, 2004 WLNR 3617319.

109. Bennett, *supra* note 108 (“[A]dmissions are down 9 percent. Unpaid care is up by 8 percent.”).

110. See Jonathan Cohn, *Uncharitable?*, N.Y. TIMES, Dec. 19, 2004, § 6 (Magazine), at 51 (describing the contradictory demands on modern hospitals). Cohn describes the dilemma:

[T]he mandate to be competitive and the mandate to be compassionate are in some ways simply incompatible: “We can’t ask nonprofits to be more like for-profits in the ways that we like—efficient, responsive, aggressive—without expecting that they will also become more like for-profits in the ways that we don’t: rapacious, hardheaded and, yes, sometimes selfish.”

Id.

111. See *id.* (“The competitive pressure on hospitals may be increasing, too, particularly given the recent explosion of physician ownership of specialty facilities that draw lucrative lines of business, like orthopedics and cardiovascular surgery, away from hospitals.”).

112. Bennett, *supra* note 108.

113. *Id.*

114. See Hammack, *supra* note 60 (“The only people it sues for unpaid medical bills, Carilion says, are the ones it believes have the means to pay them.”); Schulte & Drew, *supra* note 75 (“[Johns Hopkins Hospital] said it sues only those patients who have the ability to pay.”).

shows that while uninsured patients may start out as being potentially able to pay, hospitals' fee structures and billing practices lead directly to patients quickly getting in over their heads.¹¹⁵

Nonprofit hospitals may believe that they are complying with federal law by treating anyone with an emergency who enters their institution, but studies show that over forty-six percent of surveyed, uninsured patients claim they owed money to the facility in which they received emergency-room care.¹¹⁶ Sixty percent of uninsured patients also claim problems related to medical debt.¹¹⁷ For a number of these people unfortunate enough to go through a medical emergency without insurance, medical debt is more than just an innocuous, monthly bill in the mail. Forty percent said they could not pay for basic necessities such as food, heat, or rent; over fifty percent used most or all of their savings to pay medical bills; and over twenty percent indicated that they took large credit-card debt or mortgages to pay medical bills.¹¹⁸ With downward spirals like these, it is arguable as to whether these community members truly "benefited" in the long term from these hospitals' involvement in their lives.

In their defense, hospitals see it as their "obligation to collect from nonpaying patients to avoid higher costs for those who do pay."¹¹⁹ However, the rationalization for this "obligation" falls apart when considering the existing price of treatment. Uninsured patients who are not signed up with hospitals' indigent programs pay the most for hospital treatment—more than any insured patient or indigent patient.¹²⁰ As discussed earlier,

115. See *A Review of Hospital Billing and Collection Practices: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 108th Cong. 34 (2004) (statement of Mark Rukavina, Executive Director, The Access Project) ("Our interviews with low-income people with medical debt found that many respondents . . . found that the terms of the plans hospitals offered were difficult to maintain, given inflexible hospital collection practices and their own tenuous financial circumstances." (emphasis omitted)).

116. *Id.*

117. *Id.* at 33 (citing SARA R. COLLINS ET AL., COMMONWEALTH FUND, THE AFFORDABILITY CRISIS IN U.S. HEALTH CARE: FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY (2004)).

118. *Id.* at 33–34.

119. Hammack, *supra* note 60.

120. *The Uninsured: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 108th Cong. 50 (2004) (statement of Glenn Melnick, Director, Center for Health Financing, Policy and Management). Hospitals have two sets of prices: list prices and net prices. *Id.* List prices are the rack rates that hospitals display for their rooms and are the same for anyone passing through their doors. *Id.* Net prices are the prices patients actually pay, depending on their insurance status and whether they qualify for hospital indigent programs. *Id.* To demonstrate the point, Melnick presents the price for an appendectomy in California in 2002. *Id.* The list price for all patients was \$18,229, but the net price ranged drastically. *Id.* Managed-care plans paid about \$6000 and Medicare paid about \$4800. *Id.* Indigent self-pay patients paid about \$1700, but nonindigent self-pay patients paid a whopping \$8000. *Id.*

hospitals often do not tell qualified patients about indigent programs,¹²¹ leaving already financially disadvantaged patients and their families to foot the largest hospital bills of any of the patients. It is unsurprising that these patients end up not paying, since they started with an already higher sticker price.

E. EXECUTIVE JUSTIFICATION FOR DEBT COLLECTION

The important question is whether suing the very people these hospitals are designed to help can really be considered to be within the spirit of a “charitable purpose.” If not, these hospitals are directly violating the reason for their tax exemption. Without such exemptions, nonprofits’ financial world is a much crueler place.¹²² To evaluate such debt-collection practices from a “charitable purpose” standpoint, it is helpful to look at how hospitals justify other controversial spending: executive compensation.

A recent study of fourteen tax-exempt hospitals in Florida’s Tampa Bay area revealed that the average compensation for chief executives at those hospitals was about \$876,000—drastically higher than the national average of \$490,000.¹²³ Even with the economic downturn, nonprofit hospitals still offer their top executives lavish awards.¹²⁴ Hospitals seemingly justify these large figures by the even larger revenue that these executives generate, which is theoretically put back into the community through provided services.¹²⁵ However, rewarding CEOs for the revenue they bring to nonprofits does not address whether those nonprofits are truly benefiting their communities the way they should for tax exemption. Rather, advocates for paying CEOs the big bucks justify their high salaries with the healthcare savings that these executives generate and their ability to eliminate

121. See *supra* note 56 and accompanying text (describing patients’ lack of knowledge on hospital financial assistance).

122. See *supra* Part III.C (discussing hospital alternatives to revenue without tax exemption).

123. Kris Hundley, *Economic Downturn? Not for These Tampa Bay Nonprofit Hospital Chiefs*, ST. PETERSBURG TIMES, Jan. 31, 2010, 2010 WLNR 2112618.

124. Ben Sutherly, *Hospital CEOs Face Pay Freezes amid Recession*, DAYTON DAILY NEWS, Jan. 2, 2010, 2010 WLNR 149278 (“The smallest increase in pay for local hospital CEOs from 2007–08—including base salary, bonus and incentives—was 6.4 percent. Most got increases of 14 percent or more.”).

125. When questioned, Steve Mason, head of BayCare Health System who earned more than \$1.7 million in 2008, said that he would not apologize for his pay. Hundley, *supra* note 123. He felt entitled to his earnings because he has “significant responsibility over a lot of resources, providing a service that improves the health of the community.” *Id.* (internal quotation marks omitted). Revenue for the seven-hospital system he leads seems to back up his statement, which was over \$2 billion in 2008. *Id.* Similarly, the president and CEO of an Ohio-based nonprofit hospital group argues that “[t]he return on investment to our community is very positive when you look at their compensation versus quality and access to care.” Ben Sutherly, *Critics Question Benchmarks Used To Set Hospital CEO Pay*, DAYTON DAILY NEWS, Jan. 3, 2010, 2010 WLNR 149282 (quoting Bryan Bucklew, President and CEO, Greater Dayton Area Hospital Association) (internal quotation marks omitted).

duplication of services.¹²⁶ If hospitals instead link CEO pay to these executives' ability to meet community needs, nonprofit hospitals will be more likely to meet the actual needs of their communities rather than the mere needs of a nonprofit for profit.¹²⁷

Furthermore, if nonprofit hospitals justify lavish CEO salaries through resulting revenue, the same balancing act should apply to their litigation efforts: Does the money earned by suing community members justify the destruction and grief brought to these defendants? This unconscionable seesaw casts doubt on whether hospitals can apply this reasoning to the money they pay their attorneys to sue patients. A growing societal consensus begs to differ.¹²⁸

F. DEBT BY ANY OTHER NAME . . . MIGHT NOT BE DEBT

Examining a current policy split between the Catholic Health Association of the United States ("CHA") and the American Hospital Association ("AHA") on how to address the debt itself presents a potential solution.¹²⁹ Specifically, the CHA and AHA disagree on whether Medicare shortfalls and bad debt should count toward 501(c)(3) hospitals' uncompensated care, and thus, charitable care.¹³⁰ CHA says "no," while AHA says "yes."¹³¹ Senator Grassley's contribution to the PPACA seems to lean toward the CHA's position of excluding debt from charitable care by separately listing "levels of charity care provided" and "bad debt expenses" in its demands for disclosure.¹³² The complicating factor is that the IRS has not

126. Sutherly, *supra* note 125.

127. Sutherly, *supra* note 124 ("CEO compensation needs to be tied to outcomes based on what's good for the community, as well as what's good for the institution . . . I think the CEO compensation packages reflect corporate America, and we need more than that from health care." (quoting Cathy Levine of the Universal Health Care Action Network of Ohio)).

128. Recent laws directly address concerns about overcharging uninsured patients and hospital-collection practices:

A 2006 California law, for instance, caps what hospitals may charge many uninsured patients at what the hospital would receive were a government program such as Medicare footing the bill.

And a 2008 Illinois law puts the cap at 135 percent of the cost of the medical care. The Illinois law also has a provision that will change hospital collection practices: Hospitals can't in any one year collect from uninsured patients an amount more than a quarter of the patient's family's income.

Goldstein, *supra* note 93, at 19.

129. Seaton & Koob, *supra* note 14, at 39-40.

130. *Id.* at 40.

131. *Id.*

132. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 855 (2010) (to be codified at I.R.C. § 501(r)).

presented an official definition of “uncompensated care”¹³³ as a type of community benefit. Hospitals feel pressured to sue because of the perceptions accompanying the accumulation of unpaid shortfalls and bad debt. Since these bills and debts do not fit within any IRS-sanctioned “charitable care” definition, this debt is considered a loss for the hospital: pure expense with no resulting benefit. Although some hospitals try to alleviate the strain by declaring such losses as uncompensated care, they do so inconsistently¹³⁴ and therefore ineffectively, leading others to sue under debtor–creditor contractual rights.¹³⁵

The PPACA only states that “[t]he Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit . . . [i]nformation with respect to private tax-exempt, taxable, and government-owned hospitals regarding—(i) levels of charity care provided [and] (ii) bad debt expenses”¹³⁶ The language in the PPACA separates bad debt “expenses” from “charity care.” To put a more assertive end to unfair hospital litigation, Senator Grassley’s contributions to the PPACA should be coupled with an assertion that bad debt, valued at its net price,¹³⁷ must also be considered “charity care” and not just an “expense.” This is vital because only at that point can nonprofit hospitals count shortfalls and bad debt as more than mere expenses and instead count them as ways nonprofit hospitals can truthfully meet their tax-exemption requirements. Explicitly connecting the concept of “bad debt” and “charity care” will further the call for transparency and responsibility from nonprofit hospitals and bolster public trust. Clarifying the PPACA to include such a proposition can help the public regain trust in charitable hospitals by protecting patients from aggressive debt collection and nonprofit hospitals that benefit their communities from losing their much-needed tax exemption.

133. IRS, EXECUTIVE SUMMARY HOSPITAL COMPLIANCE PROJECT: INTERIM REPORT 1 (2007), http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_execsummary_072007.pdf.

134. See IRS EXEMPT ORG. (TE/GE), HOSPITAL COMPLIANCE PROJECT: FINAL REPORT 98–105 (2009), <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf> (reporting findings on hospital practices of reporting bad debt and shortfalls as uncompensated care).

135. See *supra* notes 105–07 and accompanying text (describing the debtor–creditor relationship that exists between hospitals and patients).

136. Patient Protection and Affordable Care Act § 9007(e)(1) (to be codified at I.R.C. § 501 note).

137. Uncompensated care counting towards “charity care” should be valued at its net price—the price that patients are billed—rather than the list price—the inflated sticker price that hospitals put on their rooms. That more accurately reflects the cost of charity care from the community’s standpoint.

G. *A LESSON FROM CARILION: SENATOR GRASSLEY'S CONTRIBUTION NEEDS
ADDITIONAL REGULATORY MEASURES TO BE EFFECTIVE AGAINST
VIRAL 501(C)(3) HOSPITAL DEBT COLLECTION*

Carilion Clinic serves as a prime example of a nonprofit hospital overcharging and then suing patients. The health group brought so many suits to court that the district court reserved a whole morning for Carilion's cases.¹³⁸ On top of that, Carilion's prices were astronomically high.¹³⁹

Shockingly, in 2009, Carilion managed to scale back on its collection process.¹⁴⁰ In the nine-month span of January to September, Carilion filed 2525 collections cases, a seventy-six percent decrease from the same period one year earlier.¹⁴¹ Simultaneously, it was able to raise the amount it spent on charitable care by twenty-six percent, totaling more than \$51 million last fiscal year.¹⁴²

When asked how they were able to accomplish this, Carilion spokesman Eric Earnhart credited both an expanded charity-care policy that qualified more people for free or discounted care and also the implementation of a new credit database that allows Carilion to research patients' financial backgrounds before determining whether to take them to court.¹⁴³ When asked why Carilion changed their tactics when they earlier stated that suing was obligatory,¹⁴⁴ Earnhart gave two reasons: First, a "bleak economy" reacquainted them with their role as a "safety net" in the community; and second, fifteen months of bad press.¹⁴⁵ According to Carilion's statements, the "public outcry over its debt collection practices was also a factor."¹⁴⁶

Skeptics wonder whether this change of colors is temporary.¹⁴⁷ Regardless, the fact that Carilion's new approach is financially viable for the clinic illustrates a promising model to other nonprofit hospitals attempting to break the ruthless cycle of overcharging and then suing. If Earnhart's statements are true, then Carilion also presents a way that Senator Grassley's contributions to the PPACA can affect change.

Carilion's transformation proves the donative theory. Once the economy began to fail, Carilion turned back to the local community, offering more charity care than before and qualifying more patients for free

138. Carreyrou, *supra* note 35.

139. See *supra* text accompanying note 46 (describing the high prices that Carilion charged for its services).

140. Laurence Hammack, *Carilion Scales Back on Collecting Unpaid Bills*, ROANOKE TIMES, Nov. 1, 2009, 2009 WLNR 21875499.

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

or discounted care.¹⁴⁸ In this way, the clinic distinguishes itself from other competitors, both nonprofit and for-profit, and creates a niche market for itself.¹⁴⁹ To further develop its place in this market (and to dispel its bad reputation), Carilion not only dedicated 5.1% of its total revenues to charity care but additionally spent several million dollars for medical education and community-group grants.¹⁵⁰

Carilion's motivation to change, derived in part from bad press, also emphasizes the changing perspective of nonprofit healthcare that Schedule H of Form 990 suggests: from within the industry and from the public standpoint. Possibly as a backlash to costly personal insurance plans and big-government plans of the 1960s, healthcare is once again becoming personal. Public relations are crucial for healthcare providers as people push for more transparency and heightened responsibility in board governance. This is especially the case for nonprofit hospitals and their hotly contested tax exemptions.

Carilion's case provides a valuable example for proposals addressing the debt-collection catastrophe. As Senator Grassley's contributions to the PPACA will inevitably upset the 501(c)(3) status of some hospitals, it is important to provide these hospitals with ways of sustaining themselves without federal funding. Carilion teaches these organizations to distinguish themselves and aim locally. Additionally, Carilion shows that nothing is better for Senator Grassley's contributions to the PPACA than public outcry.¹⁵¹ The more people who become dissatisfied with how hospitals are treating them, their friends, and their families, the more likely these errant 501(c)(3) hospitals will reinvent themselves in hopes of bringing back paying customers.

H. MAXIMIZING SENATOR GRASSLEY'S IMPACT

The new requirements for nonprofit hospitals in the PPACA seem to address all the major pieces of the debt-collection problem. The PPACA requires more financial-assistance disclosure to patients prior to medical treatment, protecting patients from receiving a surprise bill of thousands of dollars two weeks later. To nip the problem in the bud, the PPACA prohibits 501(c)(3) hospitals from charging financially disadvantaged patients

148. *Id.*

149. Hammack further notes that Carilion is "the 'safety net' health care provider in [its] region," and that the *Wall Street Journal* blamed a monopoly by Carilion in the Roanoke Valley as the cause of higher health care costs. *Id.* (emphasis added) (internal quotation marks omitted).

150. *Id.*

151. See Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 563-64 (2006) ("The media stories and follow-up legal interventions have involved unprecedented scrutiny of hospitals' efforts to collect their bills.").

anything above the rate that insured patients receive.¹⁵² The law even demands a higher sense of accountability from the government by requiring “[t]he Secretary of the Treasury or the Secretary’s delegate [to] review at least once every 3 years the community benefit activities of each hospital organization”¹⁵³ as currently featured on the new Schedule H of Form 990.¹⁵⁴

Nonetheless, what will make or break this is the PPACA’s ability to combat predatory billing practices of nonprofit hospitals. Litigious hospitals already have guidelines quite similar to the law in place.¹⁵⁵ With the PPACA’s ambiguous “reasonable efforts” requirement, it is quite possible that the PPACA will be nothing more than another inconvenience to tax-exemption status. Indeed, “[i]t is one thing to have financial aid and charity care policies in place; it is quite another to make them accessible to the public’ ‘It is in this latter area that a majority of hospitals have failed.’”¹⁵⁶ Even with the reform, hospitals can still sue patients claiming a breakdown in communication, as long as the hospital’s efforts were “reasonable.” Carilion Clinic offers a helpful model for preventing such actions and presents ways that Senator Grassley’s contributions to the PPACA can maximize the PPACA’s effectiveness.

152. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 857 (2010) (to be codified at I.R.C. § 501(r)(5)).

153. *Id.* § 9007(c).

154. IRS, *supra* note 96.

155. Schulte & Drew, *supra* note 75 (“Maryland Hospital Association guidelines dating to September 2003 require each hospital to ‘clearly communicate’ their policies and to ‘re-evaluate the patient’s financial condition’ prior to suing over an unpaid bill.”).

156. Hammack, *supra* note 60. In response to the *Baltimore Sun*’s exposé on its aggressive debt-collection practice, Schulte & Drew, *supra* note 75, the University of Maryland Medical Center (“UMMC”) issued a responding statement. In the statement, UMMC’s tone echoes that of Carilion when defending its billing methods. Hammack, *supra* note 53. “We and all Maryland hospitals are expected to do everything we can to bill and collect payment for our services. Uncompensated care creates a burden for everyone else who pays for medical insurance—taxpayers, individuals who buy their own health insurance and companies that provide insurance for their workers.” Univ. of Md. Med. Sys., *University of Maryland Medical System’s Statement*, BALT. SUN, Dec. 14, 2008, <http://www.baltimoresun.com/news/nation-world/bal-hospitaldebtumstatement1214.0,4685717.story>. In a similar statement, Johns Hopkins Medicine reiterates:

If these debts are not recovered by hospitals, all of these unpaid bills are spread around to those who do pay their bills. Collecting this debt helps patients by keeping costs down and no hospital is tempted to refuse care because someone cannot pay.

In states without such a system, uninsured people may be charged 200 to 500 percent more than the actual cost of care in order to make up . . . for the bad debt

Questions & Answers, JOHNS HOPKINS MED., http://www.hopkinsmedicine.org/news/stories/uncompensated_care_info/questions.html (last visited Oct. 21, 2010).

Finally, the “right moment” is critical. The PPACA must be accompanied by acknowledgment from the hospitals themselves of this changing social perception of hospital practices; it is imperative for hospitals to be sensitive to the role they play in their communities beyond providing healthcare. The first step is to improve public relations and communication with patients. This goal can be better reached even by simply learning to effectively use social media.¹⁵⁷

To cement the effectiveness of the PPACA’s implementation, “charitable care” must also include bad debt. In an ideal world, hospitals adequately inform patients how much they will charge prior to expensive medical procedures. Alas, this might not always be the case.¹⁵⁸ The ability to label bad debt and Medicare shortfalls as “charitable care” for tax-exemption purposes will ease hospitals’ urges to aggressively hound those patients who slip through the communication cracks after both parties incur treatment expenses. The PPACA further requires a report on information about “private tax-exempt hospitals regarding costs incurred for community benefit activities,”¹⁵⁹ but the vagueness of this language leaves much to the imagination regarding what is considered a community-benefit activity. Allowing bad debt to count towards “charitable care” enables hospitals to concentrate their energy on meeting the “community benefits” standard in tangible, modern ways—through unprofitable but necessary services and advancing medical technology. These factors must be integrated before the PPACA can fully help hospitals address the needs of their communities and stay viable in a changing healthcare climate.

IV. CONCLUSION

The PPACA will affect the debt-collection and litigation practices of nonprofit hospitals. These practices, especially by nonprofit hospitals with tax exemptions, require regulation, but the PPACA may not be enough to provide it. The problem of hospital debt collection is one that stems from a larger, more complex picture of the shifting nature of healthcare in this country. It is entirely possible that complete reform of the system is the only way of solving the issue. Realistically, however, a multi-tiered legislative approach with an eye to local communities may be the most feasible way to

157. It seems that “many hospitals are simply setting up Twitter accounts, posting videos on YouTube and creating Facebook pages without thinking how they can use these tools to support their service lines and improve communications with the community they serve.” Dan Bowman, *Most Hospitals Don’t Budget, Plan for Social Media*, FIERCEHEALTHCARE, Feb. 3, 2010, <http://www.fiercehealthcare.com/story/most-hospitals-dont-budget-plan-social-media/2010-02-03#ixzz0ex917DFx> (quoting blogger Jennifer Riggle, Associate Vice President at PR firm CRT/tanaka) (internal quotation marks omitted).

158. See *supra* notes 48–50, 56 and accompanying text (examining the inadequacies of hospital communication to patients regarding financial assistance).

159. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(e)(1)(B), 124 Stat. 119, 858 (2010) (to be codified at I.R.C. § 501 note).

presently approach the situation. Senator Grassley's contribution to the PPACA is a start in the right direction, but it will require more help from Congress and the public to effect any lasting damage to the nonprofit debt-collection monster.