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PPACA: Leveling the Payment Field

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I. INTRODUCTION

In the last ten years, the American media has been replete with stories about nonprofit tax-exempt hospitals overcharging, aggressively billing, and even suing patients who are underinsured members of the working poor unable to pay their medical bills.[1] Alternatively, hospital executives report that their institutions have been victims of bad press and misinformation, suffering damage to their reputations despite the fact that they provide billions of dollars of unreimbursed care to patients every year.[2]

Section 9007 of the Patient Protection and Affordable Care Act (PPACA) entitled "Additional Requirements for Charitable Hospitals" may help balance the financial burdens perceived by tax-exempt hospitals that extend unreimbursed care every day with those felt by patients who receive and are billed for care they cannot live without, yet cannot afford.[3] By implementing nationally uniform charity care reporting requirements and limiting the rates charged to uninsured patients, PPACA may shed light on the levels of and types of charity care the tax-exempt hospitals provide to their communities and catalyze an increase in access to care.

Part One of this article discusses past litigation involving tax-exempt hospitals and both state tax exemptions and the Internal Revenue Code's Section 501(c)(3), which

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1. *See* Beverly Cohen, *The Controversy over Hospital Charges to the Uninsured—No Villains, No Heroes*, 51 VILL. L. REV. 95, 104 (2006); Jonathan Cohn, *Uncharitable?*, N.Y. TIMES MAGAZINE DESK, Dec. 12, 2004 at 51; Transcript from CBS Broadcast of 60 Minutes: Hospitals: Is the Price Right?, CBS NEWS, http:// www.cbsnews.com/stories/2006/03/02/60minutes/main1362808.shtml (last visited May 8, 2011) (detailing two uninsured families struggles to pay exorbitant bills incurred at nonprofit hospitals).

2. Cohn, *supra* note 1.

3. Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010).

exempts an organization from federal taxation if the organization has a "charitable purpose."[4] Part Two of this article describes the requirements set by the PPACA for nonprofit hospitals, explaining what hospitals have to do in order to comply with the new law, as well as some background on what led the provisions to come into effect. Part Three examines whether § 9007's requirements provide enough incentive to hospitals in order to increase access to affordable care for low-income patients.

II. 501(C)(3)'S FAILURE TO HOLD HOSPITALS ACCOUNTABLE FOR CHARITY CARE

Since 1969, the Internal Revenue Service has not required hospitals to provide charity care to receive a federal tax exemption rather, the IRS only requires that hospitals engage in "community benefit activities" in order to qualify for exemption.[5] Receipt of tax deductible contributions, the ability to issue tax-free bonds, and, most importantly, federal income tax exemption are among the financial advantages nonprofit hospitals enjoy as tax-exempt entities under the Federal Revenue Code.[6] In 2005, the House Tax Panel Chairman estimated that these federal benefits amounted to $50 billion annually.[7]

In 2005, the U.S. Government Accountability Office (GAO) reported that government hospitals provided significantly higher uncompensated care (bad debt and free care combined) than private nonprofit and investor-owned hospitals.[8] Beyond the comparison of hospitals across the profit spectrum, the report also brought to light the fact that only a small percentage of hospitals provided the majority of the private not-for-profit uncompensated care burden.[9] Ultimately, the GAO concluded that the 501(c)(3) tax exemption policy simply fails to hold tax-exempt nonprofit hospitals accountable for providing services of benefit to the public.[10]

Notably, some studies have found that most hospitals would not earn their tax exemption on the value of charity care alone—especially if the charity care is expressed

4. I.R.C. § 501(c)(3) (2006).

5. U.S. GAO, NONPROFIT HOSPITALS: VARIATIONS IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFITS REQUIREMENTS (2008). [hereinafter "GAO Report 2"].

6. Cecilia M. Jardon McGregor, *The Community Benefit Standard For Nonprofit Hospitals: Which Community, and For Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 310-11. (2007).

7. *Id.* at 310.

8. DAVID M. WALKER, U.S. GAO, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS: UNCOMPENSATED CARE AND OTHER COMMUNITY BENEFITS, 19 (2005).

9. *Id.*

10. *Id.*

in terms of costs, rather than charges.[11] One 2007 survey found a broad range of charity-care practices among hospitals, while one in five spent ten percent of revenue on uncompensated care, the remaining nonprofit hospitals surveyed spent three percent or less.[12] The community benefit standard became subject to intense scrutiny in 2003, when the *Wall Street Journal* began a series of articles documenting abusive billings practices pursued by not-for-profit hospitals against indigent patients.[13] The articles reported that nonprofit hospitals fare better financially than their for-profit counterparts, with seventy-seven percent of nonprofit hospitals, as opposed to sixty-one percent of for-profit hospitals, earning profits.[14]

These studies emphasize the need for Section 9007 of PPACA as an attempt to balance the amount that hospitals are saving in tax exemptions versus the monetary value of the charity care they provide to their communities. Yet, the PPACA does not go so far as to mandate a minimum level of charity care for nonprofit hospitals, instead it requires them to implement new community needs assessments and reporting systems for their community benefits.

a. State Tax exemptions and Reporting Requirements Vary

The term "nonprofit" refers to the way that an organization is structured under state law, with the chief requirement being that such organizations are constrained with what they may do with their profits, particularly they cannot have equity owners entitled to receive distributions of revenue generated.[15] While nonprofit status is a requirement for state and federal tax exemption, it does not automatically confer tax-exempt status.[16] Nonprofit entities may apply for tax exemptions under the federal income tax, the state income tax, the state property tax, and the state sales/use tax.[17] Hospitals typically

11. Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility And How Should It Be Defined And Reported?*, 51 ST. LOUIS U. L.J. 459, 465 (2007)(citing studies by the Cong. Budget Off., the Gen. Acct. Off, and the Ctr. For Tax and Budget Accountability).

12. Theo Francis, *Politics & Economics: Lawmakers Question if Nonprofit Hospitals Help the Poor Enough*, WALL ST. J., July 20, 2007, at A5 (487 hospitals surveyed).

13. *See* Amanda W. Thai, *Is Senator Grassley Our Savior?: The Crusade Against "Charitable" Hospitals Attacking Patients For Unpaid Bills*, 96 IOWA L. REV. 761, 771-72 n.62 (2011).

14. John Carreyrou & Barbara Martinez, *Nonprofit Hospitals, Once For the Poor, Strike It Rich*, WALL ST. J., Apr. 4, 2008, at A1.

15. John D. Colombo, *Federal and State Tax exemption Policy, Medical Debt and Healthcare For the Poor* 51 St. Louis L.J. 433, 435-56 (2007).

16. *Id*. at 435.

17. *Id*. at 436.

organize themselves as nonprofit organizations under state law, and apply for federal income tax exemption as charitable organizations.[18]

Rather than waiting for federal laws to require hospitals to provide more charity care in return for federal income tax breaks, a number of states have either proposed legislation, pressured hospitals through their political branches, or passed laws that require a minimum charity benefit in return for state tax exemptions.[19] In 2008, the GAO reported that fifteen states have community benefits requirements, five of which (Alabama, Mississippi, Pennsylvania, Texas, and West Virginia) require a minimum amount of community benefits, while four of the fifteen (Illinois, Indiana, Maryland, and Texas) have penalties for hospitals that fail to comply with such requirements.[20] Even among states with minimum community benefit requirements, however, there is little congruity in level of detail or definition of community benefits.[21] Texas, for instance, requires that hospitals provide charity care at either five percent of net patient revenue, an amount equal to one hundred percent of the hospital's state tax exemption benefits, or a "reasonable level relative to community need, hospital resources, and tax-exempt benefit received."[22] Pennsylvania law differs in that it requires exempt hospitals to spend at least seventy-five percent of their net income, but not more than three percent of total operating costs on uncompensated care.[23]

With a minority of states requiring specific reporting of community benefits from nonprofit hospitals, it is unsurprising that no uniform national or multistate system extracts both qualitative and quantitative data from hospitals in order to determine a community benefit standard exists.[24] Thus, the "ambiguous state standards of community benefit, coupled with limited resources for monitoring and enforcement, have hampered state efforts to increase the provision of charity care by exempt hospitals."[25] One standard of community benefits reporting for a large number of hospitals was developed by the

18. *Id*.
19. *See* Lisa Kinny Helvin, *Caring For The Uninsured: Are Not-For-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421, 452-56 (2008).
20. GAO Report 2, *supra* note 5, at 16.
21. *Id*. at 17-18.
22. Lawrence E. Singer, *Leveraging Tax-exempt Status of Hospitals*, 29 J. Legal Med. 41, 52 (2008).
23. *Id*.
24. Helvin, *supra* note 19, at 455.
25. *Id*. (*citing Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways & Means*, 109th Cong. (2005) (statement of Nancy M. Kane, Professor of Mgmt., Harvard Sch. of Pub. Health).

VHA, formerly known as Voluntary Hospitals of America, an alliance which represents over 2,400 not-for-profit healthcare organizations, and the CHA, Catholic Health Association, the largest group of not-for-profit healthcare sponsors, systems, and facilities in the US, in a joint initiative to enhance community benefit reporting.[26] Its *Guide for Planning and Reporting Community Benefit* is perceived to be an excellent effort to standardize the reporting of community benefit, although controversial in its insistence to categorize bad debt and Medicare payment shortfalls as charity care.[27] The PPACA's new nationwide reporting standards may help alleviate this tension, as it requires hospitals to report bad debt and financial assistance and other community benefits at cost separately.[28]

b. Revocation of State Level Tax exemptions

Many states have requirements for tax exemption that are more stringent than federal 501(c)(3) standards.[29] Revocation of state tax exemptions may provide significant incentive to ensure that hospitals and other health care organizations make meaningful contributions to their communities in return for both state tax breaks. In a 1985 landmark case, the Supreme Court of Utah upheld a revocation of state tax exemptions because several hospitals in question used less than one percent of their revenues for free care for the poor.[30] In the same year, private nonprofit hospitals in Pennsylvania came under a high level of scrutiny when the Supreme Court held that Pennsylvania law required organizations to "donate or render gratuitously" a substantial portion of its services, in order to be considered charitable and thus eligible for state tax exemption.[31] By 1996, exemptions for 175 of the state's 220 private nonprofit hospitals had been challenged.[32] Following this increased scrutiny, however, few legislative or enforcement actions arose nationally, until recently, when the Illinois Supreme Court upheld the state property tax revocation of Provena Covenant Medical Center.[33] The Court ruled that the Medical

26. Singer, *supra* note 22, at 56.
27. *Id.*
28. IRS Form 990H instructions, available at http://www.irs.gov/pub/irs-pdf/i990sh.pdf.
29. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 925 N.E.2d 1131, 1144 (Ill. 2010)("tax exemption under federal law is not dispositive of whether real property is exempt from property tax in Illinois"); *Dialysis Clinic, Inc. v. Levin*, 938 N.E.2d 329 (Ohio 2010) (reconsideration denied).
30. *Utah County v. Intermountain Health Care Inc.*, 709 P.2d 265 (Utah 1985).
31. Hospital Utilization Project v. Commonwealth, 487 A.2d 1306 (Penn. 1985).
32. Colombo, *supra* note 15, at 442.
33. Singer, supra note 22, at 48; *Provena*, 925 N.E.2d at 1144 (Ill. 2010).

Center in Urbana, Illinois had not demonstrated that it provided sufficient charity care to justify the state property tax exemption, citing the hospital's lack of availability of charity care, contracts with for-profit doctors, and aggressive collection methods.[34]

c. Federal Litigation Unsuccessful

The practice of tax-exempt hospitals charging uninsured patients far more than insured patients is a practice many citizens and lawmakers find troubling. In 2004, a group of plaintiffs' lawyers filed over seventy federal cases against over 600 hospitals that pursued aggressive billing and collections policies against indigent patients, alleging that the health care providers had breached their charitable obligations mandated by their tax-exempt status.[35] Yet, plaintiffs have had little success challenging the tax-exempt status of hospitals and have found themselves without any standing to oppose the allegedly abusive billing practices of hospitals. The Panel on Multidistrict Litigation refused to centralize the 2004 federal class actions and various district courts dismissed nearly all of the plaintiffs EMTALA, FDCPA, and § 1983 claims.[36] In response to claims that hospitals were unjustly enriched by their tax exemptions when they did not provide affordable care, Judge Preska of the Southern District of New York stated that formulating federal health care policy is not a proper function of the court, and "[p]laintiffs have come to the judicial branch for relief that may only be granted by the legislative branch."[37] Even a not-for-profit health group sued for allegedly charging uninsured patients four to five times more than it charged insured patients was not successfully litigated in court.[38]

Although the IRS has stripped health care organizations of tax-exempt status in the past, these types of administrative actions are not patient-driven, and only reach litigation stages when the organizations appeal the IRS decisions to federal courts.[39] These sporadic interventions from the federal government do not reflect that exemption from federal taxation plays a more prominent role in the affairs of nonprofit hospitals than state

34. *Provena*, *supra* note 29.
35. Helvin, *supra* note19, at 425.
36. Cohen, *supra* note 1, at 127-29.
37. Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 565-67 (S.D.N.Y. 2005).
38. *See* Amanda W. Thai, *Is Senator Grassley Our Savior?: The Crusade Against "Charitable" Hospitals Attacking Patients For Unpaid Bills*, 96 Iowa L. Rev. 761, 775 (Jan. 2011).
39. *See* IHC Health Plans, Inc. v. Comm'r ., 325 F.3d 1188 (10th Cir. 2003) (finding that a corporate operator of health maintenance organizations (HMOs), did not qualify as charitable exempt organizations

tax exemption.[40] The greater relative importance of federal tax exemption in relation to state tax exemption is not because more money is at stake, but because federal tax law reaches into many aspects of hospitals operations, including governance, relationships with other providers, and charity care policies.[41] By requiring nonprofit hospitals to perform specific community benefits reporting to keep this vital federal tax exemption, Section 9007 should lead to more uniform and transparent standards and expansion of charity care.

III. PPACA'S NEW REQUIREMENTS FOR NONPROFIT HOSPITALS

The PPACA replaced I.R.C. 501(c)(3) with new I.R.C. § 501(r), which outlines additional requirements that hospitals must abide by in order to keep their federal tax exemption.[42] The new Internal Revenue Code provision replaces the old "community benefit activity" requirement with new, more detailed and varied requirements, including both action and reporting on the part of nonprofit hospitals and other healthcare providers.[43]

a. Community Health Needs Assessments

Starting on March 23, 2012, PPACA will require hospitals to perform a "community health needs assessment" (CHNA) every three years in order to keep their federal nonprofit status.[44] The CHNA reporting process will replace the community benefit standard, a standard which resulted in extremely varied charity practices among U.S. nonprofit hospitals and which left regulators unable to track hospital performance in order to recognize disparities in charity care and/or inflated charges.[45] Under the CHNA standard, each hospital must not only analyze their communities' needs in writing, they must also implement a strategic plan to meet these health needs.[46] The strategic plan must be publicly available, and a result of input from both public health experts and local

within the meaning of 501(c)(3)).

40. Barry R. Furrow et al., Health Law: Cases, Materials and Problems 997 (6th ed. 2008).
41. *Id.*
42. PPACA § 9007, *supra* note 3.
43. *Id.*
44. All § 9007 requirements other than CHNA apply to taxable years beginning after March 23, 2010. PPACA § 9007 (f), *supra* note 3.
45. Helvin, *supra* note 19, at 455.
46. PPACA § 9007 (a)(1)(3), *supra* note 3.

community members who represent interests in the area served by the hospital.[47]

As a follow-up to performing a CHNA, PPACA requires hospitals to include in their I.R.S. Form 990 not only a description of how the organization is addressing the needs identified in the CHNA, but also which needs are not being addressed and an explanation as to why they remain unaddressed.[48] These increased requirements for Form 990 may be a result of concern over abuse of tax-exempt status by hospitals, which may not provide many significant benefits to their communities. From 2000 to 2005, the number of nonprofit nongovernmental healthcare systems increased by nineteen percent, with the American Hospital Association reporting a fifty-six percent increase in the number of nonprofit hospitals associated with these health systems.[49] Through the CHNA requirement, PPACA requires this growing group of hospitals to collect meaningful input on what their communities need and execute a plan to address these needs. Consequently, when this information is publicized, it is likely to attract more quality dialogue between hospitals and the communities they serve. Hopefully, this process will enable hospital administrators to understand more clearly the needs of their communities, and better inform patients of the ways in which nonprofit hospitals intend to impact their communities.

b. Financial Assistance and Emergency Medical Care Policies

One prevalent issue that PPACA attempts to alleviate is patient billing, which many perceive as confusing and inequitable. The PPACA requires hospitals to establish a written financial assistance policy, to include:

The criteria for eligibility for financial assistance,

The method for applying for financial assistance,

The basis for calculating amounts charged to patients,

The action to be taken in the event of nonpayment, and

A description of the procedures to publicize the policy[50]

While most hospitals already have a financial aid policy in place, these requirements are an important step towards changing both the inner workings of hospitals, and the

47. *Id.*

48. *Id.* at § 9007(d).

49. Rummana Alam, *Not What The Doctors Ordered: Nonprofit Hospitals And The New Corporate Governance, Requirements Of The Form 990*, 2011 U. Ill. L. Rev. 229, 242 (2011).

external interaction between hospitals and the public.[51] By requiring hospitals to have a plan to publicize their financial assistance policies, PPACA makes it more likely that hospital employees will be familiar with their hospitals' policies and better able to identify who will qualify for aid, as well as more prepared to explain financial repercussions to patients.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals provide patients who present with emergency conditions a medical screening examination and stabilizing treatment, as appropriate, regardless of patients' ability to pay.[52] In a facially similar provision, PPACA requires hospitals to establish a written policy concerning emergency medical care, requiring the organization to provide care for emergency medical conditions regardless of the patient's ability to pay.[53]

c. Charge Caps and Billing Practices

Perhaps the most radical departure from past requirements for tax-exempt hospitals is PPACA's limit on the amount a hospital may charge for emergency or non-emergency medical care to patients eligible for financial assistance.[54] Hospital's collection efforts are often indicative of whether the care they provide is actually charitable: "aggressive collection efforts can have a chilling effect on indigent patients, preventing them from seeking care even though a hospital has an 'open admissions' policy."[55] PPACA caps the charges for these types of patients at not more than the amount generally billed to insurance companies with significant bargaining power, and prohibits the use of gross charges.[56] The Joint Committee on Taxation defined gross charges as follows:

A hospital facility may not use gross charges (i.e., "chargemaster" rates) when billing individuals who qualify for financial assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.[57]

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50. PPACA § 9007 (a)(4), *supra* note 3
51. Thai, *supra* note 38, at 778.
52. 42 U.S.C. § 1395dd (2000).
53. PPACA§ 9007(a)(1)(4)(b), *supra* note 3.
54. PPACA, *supra* note 3 (a)(1)(5), § 10903(a).
55. Helvin, *supra* note 19, at 455 *citing* Reply Brief for the Appellant, St. David's Health Care Sys. v. United States, 349 F.3d 232 (5th Cir. 2003) (Nos. 02-50959, 02-51312).
56. PPACA, *supra* note 3 (a)(1)(5)
57. JOINT COMMITTEE ON TAXATION, JCX-18-10), TECHNICAL EXPLANATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010) (hereinafter "JCT report").

Section 9007 also requires that hospitals refrain from engaging in extraordinary billing and collection actions until after reasonable efforts have been made to determine whether a patient is eligible for financial assistance.[58] This provision is designed to prevent hospitals from pursuing overly aggressive billing practices such as lawsuits, liens on residences, arrests, body attachments, or other similar collection processes.[59] Congress intends the Secretary of the Treasury to issue guidance on what constitutes reasonable efforts to determine eligibility. Congress defines "reasonable efforts" as notification by the hospital of its financial assistance policy 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.[60]

Undoubtedly, PPACA's prohibition on hospitals engaging in extraordinary collections efforts is a direct response to the practices of some nonprofit hospitals such as putting liens on patient homes, garnishing wages, and even imprisoning debtors.[61] By defining what the government considers reasonable collection efforts and prohibiting gross charges, PPACA calls attention to the aggressive billing policies that some hospitals employ. The prohibition on hospitals charging exorbitant rates to those who can least afford may help the plight of those patients who cannot afford to advocate for themselves.

IV. HOW PPACA'S REQUIREMENTS MAY INCREASE PATIENT ACCESS

a. PPACA Requirements for the IRS

In addition to the new requirements for hospitals, PPACA also requires the IRS to take new action regarding the information they receive from CHNAs. It provides that the Secretary of the U.S. Treasury in consultation with the Secretary of Health and Human Services submit two reports to Congress.[62] Annually, Congress requires one report on the levels of charity care provided, bad debt expenses, and the unreimbursed costs of government programs with respect to both private tax-exempt, taxable, and government-

58. PPACA, *supra* note 3, at § 9007(a)(1)(6).
59. JCT Report, *supra* note 57, at 82.
60. *Id.*
61. Kane, *supra* note 11, at 462.
62. See PPACA, *supra* note 3, at § 9007(c).

owned hospitals, as well as the costs that private tax-exempt hospitals incur for community-benefit activities.[63] Additionally, the Secretaries must submit another report on trends within five years of the enactment of PPACA, which derives from reports submitted on levels of charity care in the annual reports.[64]

These reports will likely cause the IRS to allocate a significant amount of resources toward the evaluation of CHNAs and the analysis of the data presented by them. However, one major roadblock to this happening is the overall funding of the IRS. Without the resources to meaningfully evaluate the data PPACA requires of tax-exempt hospitals, IRS enforcement of the bill may exist largely in theory, leaving hospitals to comply on a largely voluntary basis. As federal tax exemption is so important to nonprofit hospitals, they may fully implement the policies PPACA requires of them without the looming threat of IRS audits of their actions. If properly executed, the IRS reports should include meaningful data on the broad levels of charity care hospitals provide their communities in return for their federal tax exemptions. If these reports are submitted to Congress as PPACA envisions them, the future may include even more legislation aimed at improving access in practical way for those who most need it, while also taking into account the financial constraints of hospitals.

b. Requirements of Hospitals: How Charge Caps May Benefit both Providers and Patients

Under PPACA, hospitals will be subject to review by the Department of Treasury at least once every three years.[65] Any hospital that fails to meet CHNA requirement for any taxable year will be subject to an excise tax of $50,000, which must be reported on the annual tax return, and may be faced with revocation of their federal tax-exempt status.[66] The broad changes that PPACA requires hospitals to make both internal/policy based and external/reporting based do call into question whether hospitals will be quick to make changes that will likely cost far more than the $50,000 fine.

"Bad debt" is a term used by hospitals to describe financial losses incurred from patient-pay balances.[67] A recent study illuminates how upfront discussions with patients

63. *Id*. at § 9007(e)(1)(A).
64. *Id*. at § 9007(e)(2).
65. PPACA § 9007(c) *supra* note 3.
66. *Id*. at § 9007(b).
67. Colombo, *supra* note 15, at 433 ("for-profits refer to [uncompensated care] as bad debt; nonprofits

and evaluations of their financial status may enable providers to decrease their bad debt levels.[68] It found that the value of the healthcare dollar decreases significantly once a patient leaves a facility without providing payment—with that dollar diminishing to thirty-three cents within six months, and plummeting to a paltry twelve cents in one year.[69]

The implementation and wide dissemination of financial aid policies required by PPACA may make significant strides in reducing both hospital "bad debt" and patient financial distress.[70] If hospitals consistently identify patients who require financial assistance at the point of service, verify their insurance status, and negotiate payment terms (including incentives such as prompt-payment discounts), patients will likely feel more comfortable and knowledgeable, enabling them to understand their financial responsibilities in return for services rendered. This is a stark contrast to current practices whereby uninsured or otherwise financially needy patients receive care, only to receive massive bills that they cannot pay, which may send them into bankruptcy, foreclosure, and prohibit them from seeking proper health care in the future, as well as increase the hospital's bad debt numbers.[71]

Capping the charges billed to patients who qualify for financial assistance is also likely to increase access, as well as increase the chances that a hospital will be repaid for services rendered to such patients. Ensuring that nonprofit tax-exempt hospitals do not charge uninsured and/or financially unstable patients premium prices for treatment is a key solution to both protecting such patients and making it possible for hospitals to receive payment for services they do render to them. PPACA addresses the fundamental issue that the least wealthy patients in the U.S. simply cannot afford to pay highest sticker price associated with different procedures, and capping the charges on these patients could help both the patients and hospitals alike.

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refer to it as charity care.")

68. *Patient Access and the PPACA*, 19 NO. 12 HEALTHCARE REGISTRATION 1, 8 (Sept. 2010) (this article also provides an excellent sample financial assistance policy and procedure).

69. *Id.*

70. McGregor, *supra* note 6, at 307 ("Since the average amount obtained through collection efforts is 'only seven cents on the dollar,' nonprofit health care organizations will recognize financial benefits to qualify these patients for charity instead.").

71. Kane, *supra* note 11, at 462.

V. CONCLUSION

The conflicting interpretations of the level of charity care that is appropriate for nonprofit tax-exempt hospitals to provide among hospitals themselves, regulators, and the media may be resolved through PPACA's new specific reporting standards, and leverage the benefits that hospitals receive in return for federal tax exemption into increased access to affordable care for needy patients. Hopefully, the transparency and consistency in charity care reporting required by Section 9007 of PPACA will enable IRS and Congress to better evaluate the clash between tax-exempt hospitals and those who feel that such hospitals do not "earn" their exemptions. Section 9007 provides for better communication between hospital, community, and patient than has typically existed in the past regarding the finance of healthcare. By catalyzing symbiosis rather than antagonism between low-income patients and nonprofit tax-exempt hospitals, the legislation may help resolve controversy surrounding the tax-exempt status of nonprofit hospitals and dramatically increase access to care.