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***KENNEDY V. BRAIDWOOD MANAGEMENT INCORPORATED*: THE U.S. SUPREME COURT IN 2025 HOLDS THAT THE ACA PREVENTIVE SERVICES TASK FORCE MEMBERS ARE PROPERLY APPOINTED INFERIOR OFFICERS**

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I. INTRODUCTION

“[The President] shall nominate, and by and with the Advice and Consent of the Senate, shall appoint Ambassadors, other public Ministers and Consuls, Judges of the supreme Court, and all other Officers of the United States, whose Appointments are not herein otherwise provided for, and which shall be established by Law: but the Congress may by Law vest the Appointment of such inferior Officers, as they think proper, in the President alone, in the Courts of law, or in the Heads of Departments.”¹

The United States Supreme Court decided in *Kennedy v. Braidwood Management, Inc.* on June 27, 2025, that the Preventive Services Task Force (“PSTF” or “Task Force”) members are now properly appointed under the Appointments Clause of the U.S. Constitution, above, because the Task Force members are inferior officers.² Under the Affordable Care Act, the Preventive Services Task Force is charged with recommending evidence-based preventive health items or services ranked “A” or “B” which health insurers must provide with no cost sharing.³ In *Braidwood Management*, the Supreme Court held six to three that the PSTF has been properly and Constitutionally appointed by the HHS Secretary since 2023.⁴ As a consequence of this Supreme Court precedent in *Braidwood Management*, all of the Task Force’s more than fifty current

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1. U.S. CONST. art. II, §2, cl. 2.

2. *Kennedy v. Braidwood Mgmt., Inc.*, 606 U.S. 748, 793–94 (2025); *see infra* notes 171–211 and accompanying text.

3. 42 U.S.C. § 300gg-13(a)(1).

4. *Kennedy*, 606 U.S. at 793–94.

recommendations remain in effect.⁵ This decision by the Court reversed and remanded the judgment of the Court of Appeals for the Fifth Circuit, which held that the PSTF members were principal officers not properly appointed⁶ and remanded.⁷

This article gives a brief overview of the Patient Protection and Affordable Care Act (“ACA”) and reviews prior Supreme Court precedent on the ACA. This article then analyzes the important Affordable Care Act and Appointments Clause precedents in *Kennedy v. Braidwood Management*, prior Appointments Clause precedents, and discusses *Braidwood Management*’s ramifications.

II. THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (ACA) was signed into law in March 2010, and this lengthy act ushered in many sweeping changes in healthcare and health insurance.⁸ A few of the major changes include: the coverage of preventive services⁹ which was an issue in this case; no lifetime or annual dollar limits or caps on health insurance payouts;¹⁰ extension of dependent coverage until age 26;¹¹ prohibiting preexisting condition exclusions in health insurance,¹² guaranteed availability¹³ and renewability¹⁴ of health insurance coverage, establishing qualified health plans¹⁵ which have essential health benefits requirements,¹⁶ and state health insurance exchanges.¹⁷ Under the ACA, individuals are required to have qualifying health insurance with the essential coverage.¹⁸ Large employers with 50 or more employees must provide minimum essential coverage or pay a penalty.¹⁹

5. See *A & B Recommendations*, U.S. PREVENTIVE SERVS. TASK FORCE, <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations> [https://perma.cc/26B3-CVHD] (last visited Nov. 16, 2025).

6. *Braidwood Mgmt., Inc. v. Becerra*, 104 F.4th 930, 940–47 (5th Cir. 2024), *rev’d sub nom.*, *Kennedy v. Braidwood Mgmt., Inc.*, 606 U.S. 748 (2025) (as a consequence, the PSTF requirement for Preexposure Prophylaxis HIV medication was not binding for religious objector plaintiffs); see *infra* notes 129–52 and accompanying text.

7. *Kennedy*, 606 U.S. at 794.

8. See generally Nicholas Bagley, *Legal Limits and the Implications of the Affordable Care Act*, 1604 U. PA. L. REV. 1715 (2016); see generally John G. Day, *The Patient Protection and Affordable Care Act: What Does It Really Do?*, 22 CONN. INS. L. J. 121 (2015).

9. See 42 U.S.C. § 300gg-13(a).

10. *Id.* § 300gg-11.

11. *Id.* § 300gg-14.

12. *Id.* § 300gg-3.

13. *Id.* § 300gg-1.

14. *Id.* § 300gg-2.

15. 42 U.S.C. § 18021.

16. *Id.* § 18022.

17. *Id.* § 18031.

18. *Id.* § 18091.

19. 26 U.S.C. § 4980H.

III. AFFORDABLE CARE ACT SUPREME COURT PRECEDENTS

The lawsuits started almost immediately after the enactment of the Patient Protection and Affordable Care Act.²⁰ The first case to reach the Supreme Court was *National Federation of Independent Business v. Sebelius*, decided in 2012.²¹ In that decision, twenty-six states and several individuals challenged both the Affordable Care Act's individual mandate and its required Medicaid expansion.²² The Court struck down the individual mandate under the Commerce Clause by a four-to-five vote²³ but upheld it, five to four,²⁴ as a valid exercise of Congress's taxing power.²⁵ At the same time, the Court held that the Medicaid expansion was unconstitutionally coercive and concluded by a seven-to-two vote that Congress could not condition existing Medicaid funding on state compliance.²⁶

In 2014, the Supreme Court decided *Burwell v. Hobby Lobby*, holding by a five-to-four vote that closely held corporations with sincerely held religious beliefs could not be required to provide employee health insurance coverage for items that violated those beliefs.²⁷ Under the essential health insurance coverage requirement of the Affordable Care Act, preventive services are covered without any cost sharing.²⁸ The Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (HHS) is authorized by the ACA to decide what these preventive services include.²⁹ In 2011, the HRSA promulgated guidelines that mandated that all qualified health insurance include all FDA approved contraceptive methods for women.³⁰ Hobby Lobby and other plaintiffs claimed that four of these types of FDA approved contraceptives, out of twenty approved at that time, could keep a fertilized egg from implanting, so requiring Hobby Lobby to provide health insurance which covered these four types of contraceptives would violate their sincerely held religious beliefs against abortion. The majority, in an opinion authored by Justice Alito, agreed

20. Abbe R. Gluck, Mark Regan, & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L. REV. 1471, 1472 (2010).

21. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); see generally Martha Minow, *Affordable Convergence: "Reasonable Interpretation" and the Affordable Care Act*, 126 HARV. L. REV. 117 (2012).

22. Sebelius, 567 U.S. at 520; see 26 U.S.C. § 5000A, 42 U.S.C. § 1396c.

23. Sebelius, 567 U.S. at 529, 561, 588 (it also was not constitutional under the necessary and proper clause).

24. *Id.* at 574.

25. U.S. CONST. art. I, § 8, cl. 1.

26. See Sebelius, 567 U.S. at 588.

27. *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 731 (2014); see generally Sue Ganske, *Burwell v. Hobby Lobby Stores, Inc. – The U.S. Supreme Court Holds that the Religious Freedom Restoration Act Trumps the Affordable Care Act*, 31 J. CONTEMP. HEALTH L. & POL'Y 1 (2015).

28. 42 U.S.C. § 300gg-13(a).

29. *Id.*

30. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8717, 8725 (Feb. 15, 2012).

with Hobby Lobby that providing health insurance which covered these four types would substantially burden their religious beliefs under the Religious Freedom Restoration Act.³¹

Back to the Supreme Court in 2015, the Court held six to three in *King v. Burwell* that the ACA language on a health insurance exchange established by a state³² is sufficient to include both state and federal exchanges.³³ The ACA allowed refundable tax credits for individuals who purchase health insurance on state exchanges.³⁴ If a state doesn't establish a health insurance exchange, then individuals in that state may purchase health insurance on the federal health insurance exchange.³⁵ If an individual doesn't have sufficient income, the individual isn't required to purchase health insurance.³⁶ Virginia was a state which did not have a state health insurance exchange at the time of this case, and thus Virginians needing qualified health insurance participated in the federal exchange.³⁷ King, a resident of Virginia, wanted to be exempt from the requirement to purchase health insurance.³⁸ King argued that without the tax credit, he didn't make enough money to be required to purchase health insurance.³⁹ An IRS regulation pursuant to the ACA discusses state and federal exchanges on the issue of the tax credit.⁴⁰ The majority of the Court, in an opinion authored by Chief Justice Roberts, held that the term "state exchange" was ambiguous, and Congress intended to mean any exchange which an individual used to purchase health insurance.⁴¹ Thus, King was required to purchase health insurance, using his credit from the national health insurance exchange, and was not exempt from the requirement.⁴²

In 2020, the Court ruled seven to two in *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania* that the Departments of Health and Human Services, Labor, and Treasury had legal authority to exempt religious and conscientious objectors from HHS's regulatory contraception mandate.⁴³ The HRSA, housed in HHS under the ACA, has the ability to recommend

31. *Burwell*, 573 U.S. at 733; see 42 U.S.C. § 2000bb(a)(1).

32. 42 U.S.C. § 18031.

33. *King v. Burwell*, 576 U.S. 473, 475–77 (2015).

34. 26 U.S.C. § 36B; see Andy S. Grewal, *King v. Burwell: Where Were the Tax Professors?*, 2015 PEPP. L. REV. 48, 50 (2015).

35. 42 U.S.C. § 18031.

36. 26 U.S.C. § 5000A(e)(2)

37. *King v. Burwell*, 576 US 473, 483 (2015).

38. *Id.* at 484.

39. *Id.* at 493–94

40. 45 C.F.R. § 155.20 (defining "Exchange," including state-based and federally facilitated Exchanges, for purposes of Affordable Care Act implementation).

41. *King*, 576 U.S. at 475.

42. *Id.* at 475–76.

43. *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania*, 591 U.S. 657, 687 (2020); see generally Kimberly A. Davis, *Administrative Agency has Authority to Promulgate Exemptions to ACA Requirement of Providing Contraceptive Coverage and Departs from Supreme Court Tradition*, 49 W. ST. L. REV. 141 (2022).

preventive services.⁴⁴ Under this delegation, the HRSA developed the contraceptive mandate with a safe harbor for religious nonprofits.⁴⁵ The Departments above, who oversee and enforce, streamlined the safe harbor for religious nonprofits and allowed for self-certification.⁴⁶ The Little Sisters of the Poor challenged the self-accommodation in court under the Religious Freedom Restoration Act.⁴⁷ The regulation was modified adding a moral component,⁴⁸ and the Commonwealth of Pennsylvania challenged the religious and moral exemptions.⁴⁹ The district court agreed with Pennsylvania and issued a nationwide injunction against the religious and moral exemptions,⁵⁰ and the Court of Appeals for the Third Circuit affirmed.⁵¹ The Supreme Court reversed, citing *Hobby Lobby*, holding that the agencies had the power to promulgate both the religious and the moral exemptions.⁵²

In 2021, the Court ruled seven to two in *California v. Texas* that the plaintiffs did not have standing to bring their ACA challenge.⁵³ In 2017, Congress set the penalty for not having qualified health insurance under the individual mandate at zero.⁵⁴ Texas and seventeen other states, along with two individuals, challenged ACA's individual mandate, stating that without a penalty, the minimal essential coverages is unconstitutional.⁵⁵ But the Court disagreed, holding that the plaintiffs lack standing because they haven't shown any injury, past or future, fairly traceable to the alleged illegal conduct.⁵⁶

44. 42 U.S.C. § 300gg-13(a)(3)–(4).

45. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8717, 8725–26 (Feb. 15, 2012).

46. Coverage of Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. 39870, 39874 (July 2, 2013).

47. Little Sisters of the Poor Saints Peter and Paul Home, 591 U.S. at 668.

48. Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47838, 47850 (Oct. 18, 2017) (to be codified at 45 C.F.R. pt. 147).

49. *California v. Texas*, 593 U.S. 659, 672 (2021).

50. *Pennsylvania v. Trump*, 281 F. Supp. 3d 553, 585 (E.D. Pa. 2017), *rev'd*, 816 F. App'x 632, 633 (3d Cir. 2020).

51. *Pennsylvania v. President United States*, 930 F.3d 543 (3d Cir. 2019), *rev'd*, 591 U.S. 657.

52. *California*, 593 U.S. at 687.

53. *Id.*; see generally Jon Lucas, *California v. Texas: Avoiding an Antidemocratic Outcome*, 37 J. L. & HEALTH 387 (2024).

54. See 26 U.S.C. § 5000A(c).

55. *California*, 593 U.S. at 666 (the suit was against the HHS Secretary and the Commissioner of the IRS; other states including California intervened); see 26 U.S.C. § 5000A(a); see Lucas, *supra* note 53.

56. *California*, 593 U.S. at 667.

IV. *KENNEDY V. BRAIDWOOD MANAGEMENT, INC.*

“This case arises out of yet another dispute over the Patient Protection and Affordable Care Act (“ACA”).”⁵⁷

A. *The ACA Preventive Services Mandate*

The preventive services mandate of the Affordable Care Act mandates that group health plans “provide coverage for and shall not impose any cost sharing requirements” for preventive health services.⁵⁸ This health insurance coverage without cost sharing must at a minimum include: “evidence-based items or services” with an A or B rating recommended by the U.S. Preventive Services Task Force; immunizations recommended by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices; “evidence-informed preventive care and screening” for infants, children, and adolescents in the guidelines of the Health Resources and Services Administration; and preventive care for women in the guidelines of the Health Resources and Services Administration.⁵⁹

The PSTF was charged by Congress in the ACA with recommending preventive services covered by all qualified health insurance with no cost sharing.⁶⁰ The PSTF created by the Department of Health and Human Services (HHS) in 1984 is a group of sixteen volunteers with appropriate expertise to make recommendations.⁶¹ In the Healthcare Research and Quality Act of 1999, Congress stated that the Director of the Agency for Healthcare Research and Quality (“AHRQ”), housed in HHS, “convenes” the Task Force,⁶² whose purpose is to “review the scientific evidence related effectiveness, appropriateness, and cost-effectiveness” of preventive services to develop and update recommendations.⁶³ “Before 2010, Preventive Services Task Force recommendations were purely advisory.”⁶⁴ In 2010, the Affordable Care Act modified the statute, requiring the PSTF members to be independent,⁶⁵ and “to the extent practicable, not subject to political pressure.”⁶⁶

There are over fifty current PSTF A- and B-rated recommendations on

57. *Kelley v. Azar II*, No. 4:20-cv-00283-O, 2021 U.S. Dist. LEXIS 193410, at *2 (N.D. Tex. Feb. 25, 2021).

58. 42 U.S.C. § 300gg-13.

59. 42 U.S.C. § 300gg-13(a)(1)–(4).

60. *Id.* at (a)(1).

61. 42 U.S.C. § 299b-4(a)(1); see Kerry Dooley Young, *The US Preventive Services Task Force: What to know about this influential panel of health care experts*, THE JOURNALIST’S RESOURCE (Aug. 6, 2025), <https://journalistsresource.org/home/the-us-preventive-services-task-force-what-to-know-about-this-influential-panel-of-health-care-experts/> [<https://perma.cc/2D6E-7JDS>].

62. 42 U.S.C. § 299b-4(a)(1).

63. *Id.*

64. *Kennedy*, 606 U.S. at 748.

65. 42 U.S.C. § 299b-4(a)(1).

66. *Id.* § 299b-4(a)(6).

numerous issues, including, but not limited to: screening for certain pregnancy risk; screening for osteoporosis; detecting suicide and depression risk; and intervening to protect falls in the elderly.⁶⁷ In 2019, the Task Force recommended with an “A” recommendation pre-exposure prophylaxis (“PrEP”) drugs, which help prevent HIV infection, for those at high risk of HIV.⁶⁸ The 2023 final recommendation statement on PrEP also states that, “recommendations made by the USPSTF are independent. They should not be construed as an official position” of AHRQ or HHS.⁶⁹

The U.S. Advisory Committee on Immunization Practices (“ACIP”) was charged by Congress in the ACA to recommend vaccines covered by qualifying health insurance without cost sharing.⁷⁰ The ACIP was created by the Secretary of Health and Human Services (“HHS”) in 1964 to guide the Department of Health and Human Services on vaccines. A vaccine recommended for routine use by the advisory committee is effective when adopted by the Centers for Disease Control and Prevention Director (“CDC”).⁷¹ The ACIP has recommended the human papillomavirus (HPV) vaccine for females aged eleven to twelve since 2007 and now recommends the vaccine for older adults to prevent new HPV infections and HPV-associated diseases.⁷²

The Health Resources and Services Administration (“HRSA”) was charged by Congress with developing evidence based preventive services for women and children.⁷³ HRSA was created in 1982 as a subagency in HHS to improve access to healthcare for those who are medically vulnerable, uninsured, or isolated.⁷⁴

B. The Lawsuit

The plaintiffs were individuals and businesses which objected to some of

67. U.S. PREVENTIVE SERVS. TASK FORCE, *supra* note 5.

68. *Braidwood Mgmt. Inc. v. Becerra*, 627 F. Supp. 3d 624, 632 (N.D. Tex. 2022), *aff’d*, 104 F.4th 930 (5th Cir. 2024).

69. *Prevention of Acquisition of HIV: Preexposure Prophylaxis*, U.S. PREVENTIVE SERVS. TASK FORCE (Aug. 22, 2023), <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis> [<https://perma.cc/DX8B-4C9E>].

70. 42 U.S.C. § 300gg-13(a)(2).

71. 42 U.S.C. § 412(a); see L. Reed Walton, Walter A. Orenstein, & Larry K. Pickering, *The History of the United States Advisory Committee on Immunization Practices*, 33 VACCINE 405 (2015) (before 1964, the American Academy of Pediatrics’ Committee on Infectious Diseases informed physicians); 45 C.F.R. § 147.130(a)(1)(ii) (a vaccine is for routine use if it’s listed on the Immunization Schedule of the CDC); see also Kayva Sekar, *The Advisory Committee on Immunization Practices (ACIP)*, CONGRESS.GOV (Sep. 15, 2025), <https://www.congress.gov/crs-product/IF12317> [<https://perma.cc/9BPK-7J7W>].

72. *Braidwood Mgmt. Inc. v. Becerra*, 627 F. Supp. 3d 624, 632–33 (N.D. Tex. 2022), *aff’d*, 104 F.4th 930 (5th Cir. 2024).

73. 42 U.S.C. § 300gg-13(a)(3)–(4).

74. Health Resources and Services Administration, FED. REG., <https://www.federalregister.gov/agencies/health-resources-and-services-administration> [<https://perma.cc/5D72-6HR4>] (last visited Nov. 16, 2025); The HRSA was formed by merging the Health Resources Administration and the Health Services Administration; *Id.*

the preventive care mandates on Constitutional bases, for religious and free market reasons. The religious objector plaintiffs who objected to some preventive care mandates based on their religious beliefs include Braidwood Management, which is the management company hiring about seventy employees for Steven Hotze's Christian self-insured companies Hotze Health & Wellness Center, Hotze Vitamins, and Physicians Preference Pharmacies.⁷⁵ Other religious objector plaintiffs are Kelley Orthodontics, and its owner John Kelley. As a Christian organization, Kelley Orthodontics objects to providing contraceptives and PrEP drugs due to Kelley's Christian beliefs.⁷⁶

The free market or non-religious plaintiffs, Miller and Scheideman, and Scheideman's company Fort Worth Oral Surgery, do not want to purchase unwanted or unneeded preventive services coverage in health insurance.⁷⁷ The suit was filed against former HHS Secretary Becerra, along with the former Secretaries of Treasury and Labor.⁷⁸

The plaintiffs' first amended complaint requested summary judgment on five Constitutional or statutory violations discussed below.⁷⁹ The defense cross motioned for summary judgment.⁸⁰ The district court decided whether: (1) the plaintiffs had standing, (2) the groups making the relevant preventive services recommendations were convened properly under the appointments clause of the Constitution, (3) these same three groups violated the nondelegation doctrine, (4) the PTSF members have removal protections which violate the vesting clause, and (4) the PrEP mandates violate the RFRA.⁸¹

C. District Court Ruling

The Constitution requires a case or controversy for federal jurisdiction, thus requiring standing. To have standing, the plaintiff must have an injury in fact

75. *Braidwood Mgmt., Inc. v. EEOC*, 70 F.4th 914 (5th Cir. 2023) (this case was the first appellate case interpreting *Bostock v. Clayton*, 590 U.S. 644 (2020); in *Braidwood Management v. EEOC* the 5th Circuit exempted Braidwood Management from Title VII's Title VII requirements due to Steven Hotze's sincerely held religious beliefs on homosexuality and transgender); see Bri Daniel-Harkins, Comment, *Battle of the Statutes: The Fifth Circuit's decision in Braidwood Management v. EEOC Highlights the Conflict Between Religious Freedom and Antidiscrimination Laws*, 99 TUL. L. REV. 161 (2024).

76. *Braidwood Mgmt. Inc. v. Becerra*, 627 F. Supp. 3d 624, 633–34 (N.D. Tex. 2022), *aff'd*, 104 F.4th 930 (5th Cir. 2024) (other religious objector plaintiffs include Joel Starnes, and Zach and Ashley Maxwell, who want to purchase health insurance without coverage for items such as PrEP drugs, contraception, and the HPV vaccine; in an earlier opinion, the religious objectors had their challenges to the contraceptive mandate dismissed due to res judicata); Kelley, 2021 U.S. Dist. LEXIS 193410, at *2.

77. *Braidwood*, 627 F. Supp. 3d at 634 (the complaint was originally filed with additional free market plaintiffs, Starnes and the Riddles); Kelley, 2021 U.S. Dist. LEXIS 193410, at *2.

78. *Braidwood*, 627 F. Supp. 3d at 634 (the suit was originally filed against Secretary Azar, as well as the Secretaries of Labor and Treasury at that time); Kelley, 2021 U.S. Dist. LEXIS 193410, at *2.

79. *Braidwood*, 627 F. Supp. 3d at 634–35.

80. *Id.* at 635.

81. *Id.*

caused by the conduct complained of, with a likelihood that a favorable outcome for the plaintiff would redress the injury.⁸² The district court held that Braidwood Management had standing for all its claims.⁸³ Since Braidwood Management had standing, the district court could address the merits of each claim.⁸⁴

Under the Appointments Clause of the Constitution, principal officers of the United States, like ambassadors and other public ministers and consuls, are appointed by the President and approved by the Senate. Inferior officers' appointments may be vested by Congress in the President, in the courts, or in department heads.⁸⁵ Officers are defined by precedent as having a continued position established by law, and exercise significant authority under U.S. law.⁸⁶ The plaintiffs contended that the PSTF, ACIP, and HRSA are all composed of principal officers, who were neither appointed nor confirmed properly.⁸⁷ Absent that, they are inferior officers who also were not appointed properly, according to the plaintiffs.⁸⁸

The plaintiffs contended that the PSTF members are officers, because have a permanent and continuing role, while the defendants contended that the PSTF members were uncompensated and part-time, thus not fulfilling the first requirement to be an officer.⁸⁹ The district court sided with the plaintiffs on this, stating that the PSTF members have statutory positions continuing indefinitely, in four year terms, and are compensated for their triannual meetings, with numerous duties in between.⁹⁰ The district court also agreed with the plaintiffs that the Task Force members are officers exercising significant authority under law, because they decide which preventive services have an A or B rating, and thus must be covered under health insurance.⁹¹

Since the district court found that PSTF members are officers, the court then had to determine if they were principal or inferior officers. The difference is the relationship to any superior officer, not the authority the officer has.⁹² The district court concluded that PSTF members are principal officers.⁹³ While the Director of the Agency for Healthcare Research and Quality ("AHRQ") convenes the Task Force,⁹⁴ the Director is not a member; the members are independent.⁹⁵ The ACIP and HRSA are part of HHS and subject to the

82. U.S. CONST. art. III, § 2; *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992).

83. *Braidwood*, 627 F. Supp. 3d at 638.

84. *Id.* at 638–39.

85. U.S. CONST. art. II, § 2, cl. 2.

86. *Lucia v. Sec. and Exch. Comm'n*, 585 U.S. 237, 245 (2018).

87. *Braidwood*, 627 F. Supp. 3d at 639.

88. *Id.*

89. *Id.* at 642.

90. *Id.* (these duties include emails, conference calls, and interaction with stakeholders, which could take about 200 hours per year).

91. *Id.* at 643–44.

92. *Edmond v. U.S.*, 520 U.S. 651, 662 (1997).

93. *Braidwood*, 627 F. Supp. 3d at 645.

94. 42 U.S.C. § 299b-4(a)(1).

95. *Braidwood*, 627 F. Supp. 3d at 645.

Secretary's control, and thus do not violate the Appointments Clause.⁹⁶ According to the district court, PSTF isn't part of HHS, and has no superior, thus the PSTF members are principal officers.⁹⁷ As principal officers, the district court concluded that the Task Force members are not Constitutionally appointed, but even if they were inferior officers, they are not Constitutionally appointed by Congressionally vested authority in a court, the President, or department head.⁹⁸

While the plaintiffs prevailed at the district court on the Appointments Clause issue for the PTSF, the plaintiffs lost on their removal argument.⁹⁹ The district court held that PSTF members may be removed at will and do not have tenure.¹⁰⁰

The plaintiffs also contended that since the Constitution grants legislative power to Congress,¹⁰¹ and since this power is vested in Congress and is not delegable to the other branches,¹⁰² that the preventive care mandates violate this.¹⁰³ The district court disagreed and granted summary judgment to the defendants on this issue.¹⁰⁴

The plaintiff Braidwood Management was granted summary judgment that the PrEP mandate violates the Religious Freedom Restoration Act,¹⁰⁵ under which the government may not substantially burden one's exercise of religion,¹⁰⁶ unless the government can show that there is a compelling governmental interest, and this is the least restrictive way to accomplish that interest.¹⁰⁷ According to the district court, Braidwood Management showed that the PrEP mandate substantially burdened its exercise of religion.¹⁰⁸ The defendants did not show that the PrEP mandate furthered a compelling governmental interest, and was the least restrictive way to accomplish that interest.¹⁰⁹

Back in the district court in 2023, Judge Reed O'Connor had to decide, after supplemental briefing, the additional issues of whether the non-Braidwood Management plaintiffs have standing like Braidwood Management does, whether the PrEP mandates violates the RFRA for the non-Braidwood Management plaintiffs as it does for Braidwood Management, and what is the appropriate remedy for prevailing plaintiffs.¹¹⁰ On the standing issue, the district

96. *Id.* at 645–46.

97. *Id.* at 646.

98. *Id.*

99. *Id.* at 648.

100. *Id.*

101. U.S. CONST. art. I, § 1.

102. *Whitman v. American Trucking Associations*, 531 U.S. 457, 472 (2001).

103. *Braidwood*, 627 F. Supp. 3d at 649.

104. *Id.* at 655.

105. *Id.*

106. 42 U.S.C. §2000bb-1(a) (1993).

107. 42 U.S.C. §2000bb-1(b) (1993).

108. *Braidwood*, 627 F. Supp. 3d at 653.

109. *Id.* at 653–54.

110. *Id.* at 620.

court split the plaintiffs, holding that the remaining religious objector plaintiffs met the requirements to have standing, while the non-religious objector plaintiffs did not.¹¹¹

Moving to the merits, the district court, using the same analysis, held that for the religious objector plaintiffs, the PrEP mandate violates the RFRA, just as it did for Braidwood Management.¹¹² These plaintiffs are substantially burdened because they have to choose between purchasing insurance that violates their religious beliefs, or not having health insurance.¹¹³ The defendants were not able to overcome this, and thus were enjoined from enforcing the PrEP mandates against all of the religious objector plaintiffs.¹¹⁴

The last issue for the district court was the appropriate remedy for the prevailing religious objector plaintiffs on their PSTF challenge under the Appointments Clause.¹¹⁵ The PrEP mandate violates the RFRA for the religious plaintiffs, and thus they do not have to comply, and the defendants may not force them to, according to the district court.¹¹⁶ Further, since the PSTF violates the Appointments Clause, all agency recommendations based upon the PSTF's recommendations on or after March 23, 2010 were vacated and enjoined by the district court.¹¹⁷

While on appeal, HHS Secretary Becerra ratified PSTF member appointments made by the AHRQ Director, by reappointing them, and started making new appointments to the PSTF.¹¹⁸

D. Court of Appeals for the Fifth Circuit

“Our decision today is something of a mixed bag.”¹¹⁹

On appeal, the Court of Appeals for the Fifth Circuit in 2024 affirmed that the district court properly enjoined the PSTF mandate for the religious plaintiffs since the Task Force was improperly convened under the Appointments Clause.¹²⁰ But, the appellate court reversed the district court on the remedy of universal relief, ruling that the district court should not have vacated all actions of the PSTF and should not have enjoined all agency actions related to the PSTF

111. *Id.* at 625 (neither class of plaintiffs have standing to pursue the contraceptive mandate challenge because HRSA does not have an Appointments Clause problem like the PSTF does; all HRSA and ACIP related claims were dismissed because they had no Appointments Clause problems); *Id.* at 633 (the claims of the non-religious, or free market plaintiffs, were dismissed).

112. *Id.* at 626; *see generally* Sabrina Geisler, *Braidwood Mgmt. v. Becerra & a Texas District Court's Decision to Stop Enforcement of Preventive Care Coverage Requirements under the ACA*, 49 AM. J.L. & MED. 112 (2023).

113. *Braidwood*, 666 F. Supp. 3d at 626.

114. *Id.*

115. *Id.* at 628.

116. *Id.*

117. *Id.*

118. *Kennedy*, 606 U.S. at 748.

119. *Braidwood*, 104 F.4th at 935.

120. *See id.*

by the defendants.¹²¹

The Court of Appeals for the Fifth Circuit examined whether the PSTF members were principal or inferior officers. The Fifth Circuit cited the Appointments Clause precedent of *Morrison v. Olson*,¹²² where the Court stated that the line isn't clear, and the Framers did not provide much guidance on the issue. In 1997 in *Edmond v. U.S.*,¹²³ the Court focused on the supervision of the officer; principal officers are not supervised, while inferior officers are supervised by someone appointed by the President and approved by the Senate.

*Edmond*¹²⁴ has been cited and affirmed twice by the Court. In *Free Enterprise Fund v. Public Company Accounting Oversight Board*,¹²⁵ members of the oversight board were deemed to be inferior officers because they had oversight by the Securities and Exchange Commission which could remove those members at will. In *United States v. Arthrex*, members of the Patent Trial and Appeal Board were deemed to be principal officers because they make final decisions on U.S. patents' validity without review by a superior officer.¹²⁶

The Court of Appeals agreed with the defendants that the HHS Secretary could remove PSTF members at will, but due to the statutory mandate of independence,¹²⁷ the Task Force members are not supervised by the HHS Secretary.¹²⁸ The former leans towards the PSTF members being inferior officers, while the latter indicates the Task Force members are principal officers.¹²⁹ But the Court's precedent in *Arthrex*¹³⁰ tilts towards the Task Force members being principal officers, according to the appeals court, because the cases are so close.¹³¹ Both the Patent Trial and Appeals Board and the PSTF make unreviewed unsupervised legally binding decisions.¹³² Thus, the appeals court deemed the PSTF members to be principal officers not Constitutionally appointed by the President and approved by the Senate.¹³³

The next issue for the Court of Appeals was whether the defendant was able to cure the Appointments Clause issue by ratification. "To our knowledge, neither we nor the Supreme Court has embraced ratification as a remedy for an Appointments Clause issue."¹³⁴ Some circuits have recognized such ratification

121. Braidwood, 104 F.4th at 939.

122. 487 U.S. 654 (1988).

123. 520 U.S. 654, 666 (1997) (Coast Guard Court of Criminal Appeals judges were deemed to be inferior officers).

124. *Id.*

125. 561 U.S. 477 (2010); see generally David Moon, *When Does Dual For-Cause Removal Protection Become Unconstitutional? Exploring the Scope of Free Enterprise Fund v. Public Company Accounting Oversight Board*, 2013 WIS. L. REV. 875 (2013).

126. 594 U.S. 1 (2021).

127. 42 U.S.C. §299b-4(a)(6).

128. Braidwood, 104 F.4th at 944.

129. *Id.*

130. *United States v. Arthrex*, 594 U.S. 1 (2021).

131. Braidwood, 104 F.4th at 946.

132. *Id.*

133. *Id.*

134. *Id.* at 947.

under agency law,¹³⁵ but this fails in *Braidwood Management*, according to the Court of Appeals,¹³⁶ because under agency law, a principal cannot ratify what the principal cannot do, and the HHS Secretary may not make preventive services recommendations, rather statutorily, the PSTF does. According to the Court of Appeals, the purported principal, HHS, cannot ratify what its purported agent did.¹³⁷ Similarly, the HHS Secretary may not supervise the PSTF through HHS's Assistant Secretary, which the defendants also purported.¹³⁸

Thus, “Secretary Becerra’s attempt to cure the constitutional defect” by ratification failed.¹³⁹ Finally, the defendants asked the court to “sever” or disregard the statutory lack of oversight, which the appeals court did not do, and observed that the constitutional problem would still exist anyway.¹⁴⁰

Moving to the remedy, the Fifth Circuit affirmed the party-specific relief, but held that the universal injunction was overbroad.¹⁴¹ The Fifth Circuit found no grounds to vacate all PSTF recommendations and similarly no grounds for the nationwide injunction.¹⁴² It is interesting to note that on the same day that the Supreme Court decided *Kennedy v. Braidwood Management*,¹⁴³ it also decided *Trump v. Casa Inc.*,¹⁴⁴ which limited universal nationwide injunctions by district courts. So, the Fifth Circuit ruled in line with subsequent Supreme Court precedent on this issue.

E. Certiorari Granted, Oral Arguments, and Additional Briefing

On January 10, 2025, the Supreme Court granted the defendants’ request for a writ of certiorari on the issue of whether the Fifth Circuit erred in holding that the PSTF violates the Appointments Clause and erred in not severing the statutory independence provision keeping the PSTF from HHS supervision.¹⁴⁵

Oral argument in *Kennedy v. Braidwood Management, Inc.* was held on April 21, 2025.¹⁴⁶ The petitioners, representing the federal government, contended

135. *Id.* (the D.C. Circuit, along with—according to the defendants—the Second, Third, and Ninth Circuits, has recognized this principle).

136. *Id.*

137. *Braidwood*, 104 F.4th at 948.

138. *Id.* at 949.

139. *Id.* at 949, 957 (whether Secretary Becerra effectively ratified the actions of HRSA and ACIP was not decided by the court of appeal).

140. *Id.* at 949–50.

141. *Id.* at 950.

142. *Id.* at 954.

143. *Kennedy v. Braidwood Mgmt.*, 606 U.S. 748 (2025).

144. *Trump v. Casa Inc.*, 606 U.S. 831 (2025).

145. *Becerra v. Braidwood Mgmt.*, No. 24-316, 2025 U.S. LEXIS 8 (U.S. Jan. 10, 2025); *Braidwood Mgmt. v. Becerra*, No. 24-475, 2025 U.S. LEXIS 157 (U.S. Jan. 13, 2025) (the Court denied *Braidwood Management*’s request for a writ of certiorari).

146. Oral Argument, *Kennedy v. Braidwood Mgmt., Inc.*, 606 U.S. 748 (2025) (No. 24-316), https://www.supremecourt.gov/oral_arguments/audio/2024/24-316 (Kennedy became the HHS Secretary in a new administration, which continued to uphold the PSTF’s composition despite potential Appointments Clause issues).

that the PSTF members were inferior officers because they could be removed at will by the HHS Secretary and replaced, and are subject to the Secretary's supervision.¹⁴⁷ The petitioners further contended that the Court could sever the statutory independence language, and then the Appointments Clause wouldn't be an issue.¹⁴⁸ When questioned, the petitioner stated that nowhere does it say who appoints the PSTF members, but since statutorily the Assistant HHS Director "convenes" the Task Force, this means inferentially that the Assistant Director also appoints the members.¹⁴⁹

The respondents contended that the Court of Appeals for the Fifth Circuit correctly affirmed that PSTF members are principal officers under Article II.¹⁵⁰ Under statutory law,¹⁵¹ the PSTF makes preventive care mandates for insurance companies, independently and whenever practicable, free from politics.¹⁵² Further, the Court of Appeals for the Fifth Circuit was correct in holding that this statute is not severable,¹⁵³ according to the respondents.¹⁵⁴ The respondents essentially said that a court should not rewrite the Affordable Care Act.¹⁵⁵ Further, according to the respondents, the remedy should be an injunction against the PSTF's recommendations while they were improperly convened.¹⁵⁶

On April 24, 2025, the Court requested supplemental letter briefings from the parties on the issue of whether Congress, by law, has vested the HHS Secretary with the authority to appoint PSTF members.¹⁵⁷ The respondents' supplemental brief said the answer to this question is no.¹⁵⁸ According to the respondents, Congress did not vest this authority in anyone, and "convening"

147. *Id.* at 3 (further, the Assistant Secretary could "delegate up" to the HHS Secretary under the Reorganization Act of 1966, making the Task Force members inferior officers).

148. *Id.* at 4–5.

149. *Id.* at 7–8 (when asked, the petitioner could give no other example of when "convene" was used this way).

150. *Id.* at 44.

151. 42 U.S.C. §300gg-13(a)(1).

152. 42 U.S.C. §299b-4(a)(1).

153. 42 U.S.C. §299b-4(a)(6).

154. Oral Argument at 45, *Kennedy v. Braidwood Mgmt., Inc.*, 606 U.S. 748 (2025) (No. 24-316), https://www.supremecourt.gov/oral_arguments/audio/2024/24-316 (navigate to oral argument transcript).

155. *Id.* at 46; *see id.* at 20–21 (further, being removable at will isn't sufficient to make the members inferior officers); *see id.* at 59 (the statute is silent about who appoints or where that authority is vested).

156. Oral Argument at 90, *Kennedy v. Braidwood Mgmt., Inc.*, 606 U.S. 748 (2025) (No. 24-316), https://www.supremecourt.gov/oral_arguments/audio/2024/24-316 (navigate to oral argument transcript).

157. Letter from D. John Sawyer, Solicitor General, to Hon. Scott S. Harris, Clerk of the Supreme Court on Robert F. Kennedy, Jr., Secretary of Health and Human Services, et al. v. Braidwood Management, Inc., et al., No. 24-316 (May 5, 2025), https://www.supremecourt.gov/DocketPDF/24/24-316/358112/20250505125705982_24-316%20letter%20brief.pdf [<https://perma.cc/M48U-URGS>].

158. Letter from Jonathan F. Mitchell to Hon. Scott S. Harris, Clerk of the Supreme Court on *Kennedy v. Braidwood Management Inc.*, No. 24-316 (May 5, 2025), https://www.supremecourt.gov/DocketPDF/24/24-316/358123/20250505133736868_24-316_Supplemental%20Letter%20Brief%20and%20Appendix.pdf [<https://perma.cc/D9PR-JVRP>].

does not mean “convening and appointing.”¹⁵⁹ The petitioners, however, answer this same question with yes; since no statutory authority decides who appoints, then the convener must also be the appointer.¹⁶⁰

F. The Supreme Court

The issue in *Kennedy v. Braidwood Management* was whether PSTF members, as executive officers since the ACA in 2010, were principal executive officers not properly appointed under the Constitution’s Appointments Clause, or inferior officers.¹⁶¹ The majority in *Braidwood Management* concluded that the PSTF members were inferior officers who are directed and supervised by the HHS Secretary, and who are removable at will by the Secretary.¹⁶² The majority thus agreed with both the Biden and Trump administrations that as inferior officers, the PSTF members may be and actually were, since 2023, properly appointed by the HHS Secretary.¹⁶³

Justice Kavanaugh wrote the majority opinion, joined by Chief Justice Roberts and Justices Sotomayor, Kagan, Barrett, and Jackson. Justice Kavanaugh. The Court concluded that the PSTF members were inferior officers because they were directed and supervised by a principal officer, the HHS Secretary, who could remove them at will, and who could review and preemptively block Task Force recommendations.¹⁶⁴ Under the ACA, the HHS Secretary sets a minimum time, at least a year, between the time the Task Force recommends something and when it is effective.¹⁶⁵ According to the majority, in addition to the removal power, this ability to set the time, or to set no effective time, enables the HHS Secretary to direct and supervise these inferior officers in the PSTF.¹⁶⁶

Examining how the majority reached this conclusion, the Court observed that an officer who can be removed at will by a principal officer is typically an inferior officer.¹⁶⁷ The Court stressed that under *Edmond v. United States*,¹⁶⁸ being removable at will by a principal officer is a “powerful tool for control.”¹⁶⁹ In *Braidwood Management*, the Court found no statute barring the removal of PSTF members, and concluded that the Task Force members were inferior officers,¹⁷⁰ and “a fortiori,” this conclusion flows from *Edmond*.¹⁷¹ This power

159. *Id.* at 6.

160. *Id.* at 1.

161. *Kennedy*, 606 U.S. at 753–54.

162. *Id.* at 749.

163. *Id.* at 793.

164. *Id.* at 749.

165. 42 U.S.C. §300gg-13(b).

166. *Kennedy*, 606 U.S. at 762.

167. *Id.*

168. *Edmond v. United States*, 520 U.S. 651, 664 (1997).

169. *Kennedy*, 606 U.S. at 749 (citing *Edmond*, 520 U.S. at 664).

170. *Id.* at 764.

171. *Id.* at 769 (citing *Edmond*, 520 U.S. at 665).

to remove at will empowers the HHS Secretary to supervise and direct.¹⁷²

Moving to the precedent in *Free Enterprise Fund*,¹⁷³ the PCAOB members were deemed inferior officers because they were removable at will by the SEC, even though they could make decisions largely independently. PSTF members are similar, according to the majority in *Braidwood Management*.¹⁷⁴

The majority in *Braidwood Management* then turned to *U.S. v. Arthrex*, where the Supreme Court held by a five-to-four vote that Administrative Patent Judges (APJs), who are not removable at will, are principal officers who were not properly appointed and confirmed under the Appointments Clause, and seven to two that the proper remedy is to give the Director of the PTO the ability to review decisions of the Patent Trial and Appeals Board (“PTAB”).¹⁷⁵ The Court in *Arthrex* thus fixed the Appointments Clause problem by giving the Director the ability to review PTAB decisions by APJs.¹⁷⁶ Just as in *Arthrex*, after the Court gave the PTO Director the ability to review decisions ensuring that APJs were inferior officers, according to the majority in *Braidwood Management*, there is “no doubt” the PSTF members are inferior officers.¹⁷⁷ The majority of the Court concluded that it would be “odd” to infer Congressional creation of a new agency requiring Presidential appointments with Senate approval when the statute did not say that.¹⁷⁸

Next, the majority addressed *Braidwood Management*’s contention, agreed to by the dissent, that the Appointments Clause¹⁷⁹ requires Congress to vest the appointment of inferior officers in a department head, and this did not happen. The majority in *Braidwood Management* held, though, that this did happen, in two steps.¹⁸⁰ First, when Congress codified the PSTF in 1999, it authorized the Director of AHRQ to “convene” the Task Force members.¹⁸¹ According to the majority, this ability to “convene” also means to appoint.¹⁸² Second, because Congress had already transferred all of the AHRQ Director’s functions to the HHS Secretary in 1984,¹⁸³ that convening, and thus appointing, authority

172. *Id.* at 764.

173. *Free Enterprise Fund*, 561 U.S. at 510.

174. *Kennedy*, 606 U.S. at 749.

175. *United States v. Arthrex*, 594 U.S. 1, 1 (2021); *see generally* Sue Ganske, *Arthrex and Minerva Surgical: The U.S. Supreme Court Issues Two Patent Decisions in 2021*, 32 ALB. L.J. SCI. & TECH. 1 (2022).

176. *Arthrex*, 594 U.S. at 1.

177. *Kennedy*, 606 U.S. at 769 (rejecting *Braidwood Management*’s arguments that PSTF members were insulated from at-will removal and therefore not inferior officers; holding that no statute restricts the Secretary’s removal authority, that the Secretary may prevent Task Force recommendations from taking effect, and that members who refuse to act may be removed and replaced).

178. *Id.* at 778.

179. U.S. CONST. art. II, §2, cl. 2.

180. *Kennedy*, 606 U.S. at 779.

181. *Id.*; *see* 42 U.S.C. §299b-4(a)(1).

182. *Kennedy*, 606 U.S. at 781.

183. 42 U.S.C. §299b-4(a)(1).

resided in the Secretary.¹⁸⁴ Then, in 2023 when the HHS Secretary reappointed and appointed PSTF members, they were inferior officers properly appointed, according to the Court in *Braidwood Management*.¹⁸⁵

In reaching the conclusion that the statutory term “convene” includes “appoint, the majority stated that “to be sure, the statute does not use the term appoint.”¹⁸⁶ But, according to the majority, “no magic words are necessary.”¹⁸⁷ The majority could not conclude that Congress, in 1999 and 2010, was “indifferent” about who would make the appointments, so the “sensible” reading of the statute is that the AHRQ director is both the convener and the appointer.¹⁸⁸

Taking it a step further, the majority explained that the HHS Secretary not only has the authority to appoint these inferior officers but, starting in 2023, has in fact exercised the authority.¹⁸⁹ Thus, the Appointments Clause has been satisfied, and the case was reversed and remanded.¹⁹⁰

Justice Thomas, joined by Justices Alito and Gorsuch, dissented.¹⁹¹

The dissent observed that everyone agrees that the PSTF was improperly appointed from 2010, the time of the ACA, to 2023, when the HHS Secretary appointed and reappointed Task Force members.¹⁹² First, the dissent begins its analysis by agreeing with the majority’s opinion that they would have remanded for the Fifth Circuit to consider the new argument by the government on appeal, versus arguing in the lower court.¹⁹³ The dissent further argues that on remand, the Fifth Circuit should have considered the threshold statutory issue of whether the HHS Secretary has the power to appoint PSTF members, as such statutory issues precede the Constitutional issues.¹⁹⁴ But if “forced to decide,” the dissent would have affirmed, reasoning that the HHS Secretary has not expressly been vested with the power to appoint PSTF members, and that convening the Task Force is not equivalent to appointing its members.¹⁹⁵ Thus, the Task Force is improperly appointed under the Constitution, according to the dissent.¹⁹⁶

V. CONCLUSION

The U.S. Supreme Court on June 27, 2025, decided a landmark ACA case, *Kennedy v. Braidwood Management, Inc.*,¹⁹⁷ holding that Preventive Services

184. *Id.* at 779–80.

185. *Id.*

186. *Id.* at 780.

187. *Id.*

188. *Id.* at 787.

189. *Id.* at 780.

190. *Id.* at 752.

191. *Id.*

192. *Id.* at 794–95 (Thomas, J., dissenting).

193. *Id.* at 795, 801 (Thomas, J., dissenting).

194. *Id.* at 803 (Thomas, J., dissenting).

195. *Id.* at 800, 804 (Thomas, J., dissenting).

196. *Id.* at 808 (Thomas, J., dissenting).

197. *Id.*

Task Force members, who recommend preventive services which must be covered by health insurance companies without cost sharing, were inferior officers properly appointed by the Secretary of the Department of Health and Human Services. According to the dissent and *Braidwood Management*, the Court majority may have stretched the Appointments Clause definition of “congressional vesting” by extending the appointment power given to a department head and correlating the AHQR Director’s statutory power derived from “convening” the Task Force to “appointing” the Task Force by the HHS Secretary.¹⁹⁸ The outcome remains that there is now Supreme Court precedent holding that the HHS Secretary has properly and constitutionally appointed the Task Force, at least since 2023, and its recommendations stand. It would have been cleaner if Congress had clearly stated in the ACA in 2010 that these PSTF members were inferior officers and directly statutorily vested their appointment with the HHS Secretary. The majority concluded that Congress wasn’t “indifferent” about who should appoint the PSTF; the majority interpreted two statutes to find that Congress meant the PSTF appointer to be the HHS Secretary.¹⁹⁹ But if Congress was not “indifferent,” it may have acted hastily when enacting the ACA. That possibility underscores the need for care and precision when drafting of such magnitude to avoid future litigation and interpretive disputes. A similar dynamic appeared in *King v. Burwell*, where the Court interpreted the ACA’s reference to an “exchange established by a State” to include both state and federal exchanges.²⁰⁰ Justice Scalia, joined by Justices Thomas and Alito, dissented, arguing that the majority effectively rewrote the statute. In his view, the statutory text could not reasonably be stretched to treat federal exchange as one “established by a State.”²⁰¹ Nonetheless, the Court upheld the availability of tax credits on both state and federal exchanges.²⁰² The point here is that both in *King* and in *Braidwood Management*, careful, clear drafting of this lengthy and important legislation by Congress could have deterred claims from being raised in subsequent litigation regarding questions as to whether state exchanges do not include federal exchanges and whether PSTF members were principal officers not constitutionally appointed.

As a consequence of *Braidwood Management*, the recommendations of the PSTF stand, for now. But *Braidwood Management* has set the precedent that these Task Force members are inferior officers, who may be both removed and appointed by the HHS Secretary, and they, in fact, have been appointed by the HHS Secretary since 2023. The HHS Secretary in June of 2025 replaced all inferior officer members of the Advisory Committee for Immunization Practices, all of whom had been appointed by the HHS Secretary in the prior administration, and most of whom were appointed in the last year of that prior

198. See Kennedy, 606 U.S. at 748.

199. Kennedy, 606 U.S. at 787.

200. King, 576 U.S. at 475 (2015); see *supra* notes 36–42 and accompanying text.

201. King, 576 U.S. at 498 (Scalia, J., dissenting).

202. King, 576 U.S. at 475.

administration.²⁰³ The HHS Secretary now has the ability to do the same with the PSTF members if the HHS Secretary so chooses. If the PSTF members were instead deemed principal officers, then either Congress would have to explicitly vest appointment power in the HHS Secretary or Task Force members would have had to be appointed by the President and confirmed by the Senate.

Further, as the majority observed, the HHS Secretary has the ability to never implement any Task Force recommendations by blocking them and never setting a time when they become effective.²⁰⁴ Statutorily, all PSTF members and any recommendations were to be independent and whenever practicable, free from politics.²⁰⁵ The PSTF's final recommendation on August 23, 2023 concerning Prevention of Acquisition of HIV: Preexposure Prophylaxis in fact starts with, "Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services."²⁰⁶ This author has a difficult time reconciling the statutory independence and the stated independence of the PSTF with the holding in *Braidwood Management* that the Task Force members are inferior officers subject to, and appointed by, the HHS Secretary. Nonetheless, the majority of the Court has held so on July 27, 2025, and the HHS Secretary has thus appointed members since 2023 and may continue to appoint members in accordance with the Appointments Clause of the U.S. Constitution. Thus, this challenge to the ACA on the Appointments Clause issue with the PSTF fails.²⁰⁷

203. Press Release, Dep't of Health & Hum. Servs., HHS Takes Bold Step to Restore Public Trust in Vaccines by Reconstituting ACIP (June 9, 2025), <https://www.hhs.gov/press-room/hhs-restore-public-trust-vaccines-acip.html> [<https://perma.cc/Y3VT-77KN>].

204. Kennedy, 606 U.S. at 764.

205. 42 U.S.C. 299b-4(a)(6).

206. U.S. PREVENTIVE SERV. TASK FORCE, *supra* note 69.

207. Kennedy, 606 U.S. at 794.

POLITICIZING PUBLIC HEALTH: A FIFTY STATE SURVEY OF STATE HATCH ACTS AND THEIR IMPACTS ON PUBLIC HEALTH POLICY

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TABLE OF CONTENTS

I. INTRODUCTION

II. POLITICIZATION OF PUBLIC HEALTH AT THE FEDERAL LEVEL

A. Federal Public Health Officials and Politics

B. The Federal Hatch Act or Big Hatch Act

III. POLITICIZATION OF PUBLIC HEALTH AT THE STATE LEVEL

A. State Hatch Acts

1. Alabama

2. Alaska

3. Arizona

4. Arkansas

5. California

6. Colorado

7. Connecticut

8. Delaware

**9. District of Columbia*

10. Florida

11. Georgia

12. Hawaii

13. Idaho

14. Illinois

15. Indiana

16. Iowa

17. Kansas

18. Kentucky

19. Louisiana

20. Maine

21. Maryland

22. Massachusetts

23. Michigan

24. Minnesota

25. Mississippi

26. Missouri

27. Montana

28. Nebraska

29. Nevada

30. New Hampshire

31. New Jersey

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32. *New Mexico*
33. *New York*
34. *North Carolina*
35. *North Dakota*
36. *Ohio*
37. *Oklahoma*
38. *Oregon*
39. *Pennsylvania*
40. *Rhode Island*
41. *South Carolina*
42. *South Dakota*
43. *Tennessee*
44. *Texas*
45. *Utah*
46. *Vermont*
47. *Virginia*
48. *Washington*
49. *West Virginia*
50. *Wisconsin*
51. *Wyoming*

IV. ANALYSIS AND IMPLICATIONS FOR PUBLIC HEALTH POLICY

V. SUGGESTIONS FOR THE FUTURE

VI. CONCLUSION

I. INTRODUCTION

“The aims of public health have often been compromised through political and legislative rhetoric resulting in tangible harm to the practitioners as well as the population served.”¹ One commentator has noted that “from sugary drinks to vaccines, and seatbelts to family planning—public health and politics have long intertwined.”² The inextricable intertwinement of politics and public health has led to the misuse of public health officials and policies to legitimize and buttress political campaigns.³ This intertwinement then raises three interesting

1. Christopher Ogolla, *First Do No Harm: The Manipulation of Public Health for Non-Public Health Purposes and Its Legal Consequences*, 50 IND. L. REV. 849, 850 (2017).

2. Carolyn Bernhardt, *The Politics of Public Health*, UNIV. OF MINN. (Fall 2022), <https://advances.umn.edu/fall-2022/the-politics-of-public-health/> [https://perma.cc/V4HM-CLUP] (noting that “[f]rom sugary drinks to vaccines, and seatbelts to family planning — public health and politics have long intertwined. But in recent years, that entanglement has become a gridlock.”).

3. See Christian Casale, *Florida Surgeon General to Campaign with Gov. Ron DeSantis in New Hampshire*, FLORIDA PHOENIX (Oct. 31, 2023, 2:53 PM), <https://floridaphoenix.com/briefs/florida-surgeon-general-to-campaign-with-gov-ron-desantis-in-new-hampshire/> [https://perma.cc/D4NT-UZY2].

questions: First, are there meaningful ways to separate politics from public health? Second, if not, should public health practitioners get involved in politics at all? Third, what are the implications for public health policy and practice?

Traditionally, one approach the government has taken to regulate the political involvement of public employees—which includes many public health practitioners who work for local, state, and federal government—is to enact laws restricting the ability of those employees to engage in various political activities. This is exemplified at the federal level by the Hatch Act,⁴ and at the state level through similar laws known as “State Hatch Acts” or “Little Hatch Acts” (collectively “State Hatch Acts”) because they are modeled after the Federal Act.⁵ But, whether these State Hatch Acts can prevent public health workers from getting involved in partisan politics is an open question. Although the State Hatch Acts apply to a wide swath of public employees, they only cover partisan, not nonpartisan, political activities.⁶ However, many of these acts do not clearly define what political activities are or even provide sanctions for violations. Finally, none specifically addresses public health. A review of the literature shows no specific publications on the impacts of the State Hatch Acts on public health policy and practice.⁷

This article seeks to fill this gap by: (1) carefully surveying the existence and contents of States’ Hatch Acts—and some regulations where applicable—with the goal of explaining their similarities and differences; (2) illustrating the dangers of politicizing public health policy both at the federal and state levels while at the same time acknowledging the essential role politics plays in public

4. 5 U.S.C. §§ 7323(a) and 7324(a); *see also* Rafael Gely & Timothy Chandler, *Restricting Public Employees’ Political Activities: Good Government or Partisan Politics?*, 37 HOUS. L. REV. 775, 777 (2000) (noting that “[g]enerally, government has taken two approaches to regulate the political involvement of public employees. One approach has been to enact laws restricting the ability of public employees to engage in various political activities (e.g., campaign, solicit contributions, or run for political office). This is exemplified at the federal level by the Hatch Act . . .”).

5. Shannon Azzaro, Note, *The Hatch Act Modernization Act: Putting the Government Back in Politics*, 42 FORDHAM URB. L.J. 781, 797 (2015) (noting that “[m]ost states have passed their own political activities laws, which have been commonly dubbed ‘Little Hatch Acts’ because they are typically modeled after the federal act”).

6. *See* Bowers v. Cornett, 865 F.2d 1517, 1524 (8th Cir. 1989) (noting in pertinent part “[w]e find no indication that Congress has at any time intended to restrict the nonpartisan political activities of State or local employees. We interpret the Hatch Act to cover only partisan political activity, that is, activity directed toward the success of a political party”).

7. A search on Westlaw using the terms “State Hatch Acts” results in about eight law review and journal articles published as of 2025. Using the search terms “Little Hatch Acts” results in thirty articles. Of those thirty, only three mention public health but mostly in passing. *See, e.g.,* Azzaro, *supra* note 5, at 795 (“noting that “[a] majority of employees covered under the Hatch Act work in programs connected to important federal projects, such as those related to public health, public welfare, housing, urban development, public works, agriculture, defense, transportation, and law enforcement.”); Steven Eberhard, Note, *The Need for the Hatch Act*, 1 HARV. J.L. & PUB. POL’Y 153, 186 n.221 (1978); Robert Lind & Allan Ullberg, *Institutional Regulation of Employee Expression: Writings as a Conflict of Interest Within Museums and Related Nonprofit Institutions*, 32 SANTA CLARA L. REV. 427, 489 (1992) (discussing whistleblower statutes).

health practice; and (3) offering suggestions to how public health workers can address partisan policies that seek to undermine their work. The article proceeds as follows: Because State Hatch Acts often borrow various components from the federal statute,⁸ Part II of this article begins by discussing the impacts of politicization of public health at the federal level, and the inadequacy of the Federal Hatch Act in certain circumstances, such as when senior government officials violate the Act.⁹ Part III surveys the State Hatch Acts in the fifty states noting that whereas some of the laws restrict the ability of public employees to engage in political activities, most are permissive in nature, giving public health workers some leeway to participate in the political process.¹⁰ Part IV explains the implications of the State Hatch Acts on public health policy, noting that even though the State Hatch Acts are meant to restrict politics in public service, they are unlikely to depoliticize public health practice and policy, because while some of the laws are restrictive, many are permissive. Additionally, the lack of enforcement mechanisms in some of these statutes essentially renders them advisory.¹¹ In Part V, the article offers suggestions for the future including calling for public health practitioners to actively get involved in politics, and the importance of effective public health messaging during a health pandemic.¹² Finally, Part VI concludes by noting that although the involvement of public health officials in politics at the state and federal level does not portend well for the health of the nation, there is some value in public health officials getting actively engaged in politics and having a seat at the table, so to speak.¹³

II. POLITICIZATION OF PUBLIC HEALTH AT THE FEDERAL LEVEL

In early 2025, the Trump administration ordered the Centers for Disease Control and Prevention (“CDC”) and the Food and Drug Administration (“FDA”) to remove scientific data that promotes gender ideology from public view. One news outlet reported that:

. . . [C]ontent from the CDC’s Youth Risk Behavior Surveillance System, which includes data from a national survey, has disappeared; so have parts of the Agency for Toxic Substances and Disease Registry’s Social Vulnerability Index and the Environmental Justice Index. The CDC’s landing page for HIV data

8. Shelby Shearer, Note, *Unfollowing’ Undue Influence: The Inadequacy of The Hatch Act in the Age of Twitter and Congressional Solutions for Reform*, 96 TUL. L. REV. ONLINE 1, 17 (June 2022) (noting that “[t]hese provisions, often referred to as ‘Little Hatch’ Acts, vary by state and often borrow various components from the federal statute, demonstrating that there are multiple routes for the enforcement of executive branch ethics laws”).

9. See *infra* Part II.

10. See *infra* Part III.

11. See *infra* Part IV.

12. See *infra* Part V.

13. See *infra* Part VI.

has also vanished. And the agency's AtlasPlus tool, which contains nearly 20 years of CDC surveillance data on HIV, hepatitis, sexually transmitted infections, and tuberculosis, is down.¹⁴

In February 2025, Doctors For America sued the Office of Personnel Management (“OPM”), CDC, and FDA alleging that the defendants “removed from publicly accessible websites a broad range of health-related data and other information used every day by health professionals to diagnose and treat patients and by researchers to advance public health, including through clinical trials meant to establish the safety and efficacy of medical products.”¹⁵ A U.S. District Court Judge for the District of Columbia ruled in favor of the plaintiff's and ordered the OPM, CDC, and FDA to restore websites and datasets that had been taken down.¹⁶

The Trump Administration has also cut or sliced research funding from the programs not aligned with its vision. For example, the administration has canceled hundreds of grants supporting research on topics such as vaccination; diversity, equity, and inclusion;¹⁷ and the health of LGBTQ+ populations.¹⁸ Additionally, President Trump signed several executive orders impacting public health, such as withdrawing the United States from the World Health Organization (“WHO”);¹⁹ limiting gender ideology to two sexes only, male and female;²⁰ and reinstating the Mexico City Policy that ensures that U.S. taxpayer dollars do not fund organizations or programs that support or participate in the management of a program of coercive abortion or involuntary sterilization,²¹ to

14. Katherine Wu, *CDC Data Are Disappearing*, THE ATLANTIC (Jan 31, 2025), <https://www.theatlantic.com/health/archive/2025/01/cdc-dei-scientific-data/681531/> [<https://perma.cc/5YHV-RX79>].

15. See Complaint at 1, *Drs. for Am. v. Off. of Pers. Mgmt.*, No. 1:25-cv-00322 (D.D.C. Feb. 4, 2025), available at https://storage.courtlistener.com/recap/gov.uscourts.dcd.200B277069/gov.uscourts.dcd.277069.1.0_5.pdf [<https://perma.cc/KK3M-PPHU>].

16. See Memorandum Opinion, *Drs. For Am. v. Off. of Pers. Mgmt.*, No. 1:25-cv-00322 (D.D.C., Feb. 11, 2025), available at https://storage.courtlistener.com/recap/gov.uscourts.dcd.277069/gov.uscourts.dcd.277069.12.0_1.pdf [<https://perma.cc/KK3M-PPHU>].

17. Exec. Order No. 14,151, Ending Radical and Wasteful Government DEI Programs and Preferencing, 90 Fed. Reg. 8339 (Jan. 20, 2025).

18. Rae Ellen Bichell & Rachana Pradhan, *Beyond Ivy League, RFK Jr.'s NIH Slashed Science Funding Across States That Backed Trump*, KFF HEALTH NEWS (Apr. 17, 2025), <https://kffhealthnews.org/news/article/nih-grant-cuts-red-states-science-research-vaccines-hiv-trump-rfk/> [<https://perma.cc/C6HC-NRY7>].

19. See Exec. Order No. 14,155, Withdrawing The United States From the World Health Organization, 90 Fed. Reg. 8361 (Jan. 20, 2025).

20. See Exec. Order 14,168, Defending Women From Gender Ideology, Extremism and Restoring Biological Truth To The Federal Government, 90 Fed. Reg. 8615 (Jan. 20, 2025).

21. The White House, *Memorandum for the Secretary of State, the Secretary of Defense, the Secretary of Health and Human Services, the Administrator of the United States for International Development*, THE WHITE HOUSE (Jan. 24, 2025), <https://www.whitehouse.gov/presidential-actions/2025/01/memorandum-for-the-secretary-of-state-the-secretary-of-defense-the-secretary-of-health-and-human-services-the-administrator-of-the-united-states-for-international-development/> [<https://perma.cc/QHE9-6FZS>].

mention but a few.

Not every cut to public health funding is driven by political or even partisan ideology. Indeed, in April 2025, a Kaiser Family Foundation Health Tracking Poll found that most of the public agree with the Trump administration that fraud, waste, and abuse are a problem in health care in the U.S, even if they disagree on whether the cuts will make any difference and on who is responsible for it.²² Additionally, about 40% of organizations whose grants the National Institutes of Health (“NIH”) cut in its first month of slashing are in states Trump won.²³ To the extent that these cuts are justified as efforts for reducing federal waste and improving government efficiency, this Article concedes that they are necessary. However, in a complaint filed by the American Public Health Association against the NIH seeking to restore funding to cancelled projects, plaintiffs allege, among others, that the NIH attempts to justify the ongoing ideological purge of hundreds of critical research projects because they assertedly have some connection to gender identity, Diversity, Equity, and Inclusion (“DEI”), or other vague, now forbidden language.²⁴ Among the defendants named in this lawsuit are Robert F. Kennedy Jr., in his capacity as the Secretary of the Department of Health and Human Services, and Dr. Jay Bhattacharya, in his official capacity as the director of the NIH.²⁵ But, what happens when federal officials themselves politicize public health? Put succinctly, the politicization of public health at the federal level is likely to lead to more polarization, and “polarization is a serious—if largely overlooked—determinant of health, whose impacts must be more thoroughly understood and mitigated.”²⁶

A. Federal Public Health Officials and Politics

The involvement of public health officials in partisan politics at the federal level does not portend well for the health of the nation. For example, Robert F. Kennedy Jr, the current Secretary for the Department of Health and Human Services is a well-known for his controversial and often unsupported health stances, including questioning the safety of vaccines, promoting drinking of raw milk, removing fluoride from drinking water, and stating that COVID “ethnically targeted white and Black people but not Ashkenazi Jews or Chinese

22. Grace Sparks et al., *KFF Health Tracking Poll April 2025: Public’s View on Major Cuts to Federal Health Agencies*, KFF.ORG, (May 1, 2025) <https://www.kff.org/medicaid/kff-health-tracking-poll-april-2025-publics-view-on-major-cuts-to-federal-health-agencies/>

23. Bichell & Pradhan, *supra* note 18.

24. See Complaint for Declaratory and Injunctive Relief at ¶116, Am. Pub. Health Ass’n v. Nat’l Inst. of Health, No 1:25-cv-10787 (D. Mass. Apr. 2, 2025). (In related case, a federal Judge issued a nationwide injunction against the funding cuts. See Memorandum and Order on Motion for Preliminary Injunction, Comm. Of Mass. v. Nat’l Inst. of Health, No 25-cv-10338 (D. Mass. Mar. 3, 2025), available at https://findfx.thomsonreuters.com/gfx/legaldocs/zgpojbqxnv/03052025nih_ruling.pdf).

25. See APHA Complaint, *supra* note 24, at ¶¶ 23, 25.

26. Jay J. Van Bavel et al., *Political polarization and health*, 30 NAT. MED. 3085 (2024).

people,”²⁷ to mention but a few of his unsubstantiated health claims. During a measles outbreak spanning multiple states with nearly 600 cases, Kennedy promoted the use of Vitamin A supplements as a cure,²⁸ even though this is not rooted in scientific evidence. According to the CDC, “Vitamin A does not prevent measles and is not a substitute for vaccination. Rather, Vitamin A supplementation has been found to reduce both overall measles mortality and pneumonia-specific measles mortality in children living in areas with high rates of vitamin A deficiency. In the U.S., prevalence of vitamin A deficiency is very low.”²⁹

Dr. Martin Makary, the current FDA commissioner, opposed COVID-19 mandates and other public health measures, and is likely to put political narratives ahead of science.³⁰ Interestingly, Makary himself has criticized health agencies under previous administrations for being too political.³¹ Dr. Jay Bhattacharya, director of NIH, was an outspoken critic of the COVID-19 lockdowns and mandates.³² Both doctors, Makary and Bhattacharya, now lead agencies they have previously criticized.³³ Whether the current public health

27. See Aria Bendrix, *RFK, Jr.’s controversial health stances, from vaccines to raw milk*, NBC NEWS (Nov. 15, 2024, 5:58 PM), <https://www.nbcnews.com/health/health-news/rfk-jr-health-stances-vaccines-fluoride-raw-milk-rcna180244> [<https://perma.cc/SD58-S245>].

28. Mary Kekatos, *RFK Jr. claims measles can be treated with vitamin A, linked to poor diet. Here’s what science says*, ABC NEWS (Mar. 14, 2025, 5:17 AM), <https://abcnews.go.com/Health/rfk-jr-claims-measles-treated-vitamin-linked-poor/story?id=119713193> [<https://perma.cc/357Q-YE4P>].

29. *Measles Treatment Overview*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 2025), https://www.cdc.gov/measles/media/pdfs/2025/05/HCP_Caring-for-Patients-with-Measles_Fact-Sheet_FINAL_3.pdf [<https://perma.cc/87RX-Q767>].

30. Phie Jacobs, *Mixed reactions greet Trump’s pick of longtime FDA critic to head agency*, SCIENCE (Nov. 26, 2024, 3:00 PM), <https://www.science.org/content/article/mixed-reactions-greet-trump-s-pick-longtime-fda-critic-head-agency> [<https://perma.cc/JRR3-LE5E>] (noting that “although some public health experts are cautiously optimistic he will bring needed changes to FDA, others worry Makary, a frequent guest on Fox News, will put political narratives ahead of science”).

31. See *id.* (noting that “Makary has criticized health agencies under previous administrations for being too political; now others will judge whether he bows to pressure himself or ultimately emerges as an independent leader of FDA”).

32. See *Decision*, INGRAM V. ALBERTA (Chief Medical Officer of Health), 2023 ABKB 453, (Alberta, CAN., K.B. July 31, 2023) at ¶ 199 https://www.jccf.ca/wp-content/uploads/2023/08/2023-07-31-DECISION-Ingram-v-Alberta-Chief-Medical-Officer-of-Health-FILED-July-31-20238.pdf?mc_cid=15345efd14&mc_eid=0d5021d036 (noting that “Dr. Bhattacharya is strenuously opposed to mandatory health measures, testifying that in his opinion, mandates build mistrust in public health. . .”).

33. Rachel Roubein & Mark Johnson, *Trump Picks to Lead the FDA, NIH Confirmed By Senate*, WASH. POST (Mar. 25, 2025), <https://www.washingtonpost.com/health/2025/03/25/bhattacharya-nih-director-cdc-makary/> [<https://perma.cc/JJ4R-UW9V>] (noting that “[b]oth Makary and Bhattacharya will lead agencies they themselves have criticized and as Trump has pledged to restore public trust in both institutions”).

leadership will restore public trust in both institutions remains to be seen.³⁴ The risk of political interference in government research, however, is real.³⁵ But how to guard against such political interference, particularly in public health activities, is no easy task. Like most federal agencies, the Department of Health and Human Services leadership consists of both political appointees and career officials who work together to oversee agency operations and implement the administration's policy priorities.³⁶ Whereas career employees are subject to the limitations of the Hatch Act,³⁷ political appointees are not; the limitations of the Hatch Act are briefly explained below.

B. The Federal Hatch Act or Big Hatch Act

The politicization of government activities and services, such as public health, is not unprecedented.³⁸ In 1939, during Franklin D. Roosevelt's New Deal era, Congress passed "An Act to Prevent Pernicious Political Activities," more affectionately known as the "Hatch Act"³⁹ after its sponsor, Carl Hatch of New Mexico.⁴⁰ The federal Hatch Act ("Big Hatch Act") was instituted after learning that the Works Progress Administration ("WPA") was allowing local politicians to use its resources to fund congressional and senatorial campaigns during the 1938 election cycle.⁴¹ The Senate Campaign Expenditures

34. *See id.* (noting that Dr Bhattacharya "promised to regain trust in science by encouraging open debate and focusing the agency's resources on Alzheimer's disease, cancer and other chronic illnesses that have lowered the life expectancy of Americans").

35. Coral Davenport, *Trump Targeted Scientists in His First Term. This Time, They're Prepared*, N.Y. TIMES (Jan. 17, 2025), <https://www.nytimes.com/2025/01/17/climate/trump-government-scientists.html> [<https://perma.cc/K7P3-TG6R>] (noting that "[s]teps taken include the creation and expansion of scientific integrity policies at many federal agencies that detail how government scientists should conduct and publish research, what to do if political appointees try to block that work, and outline the penalties for violations").

36. *See* U.S. Gov't Accountability Off., CARES Act: Experts Identified Safeguards to Help Selected HHS Agencies Protect Against Potential Political Interference. GAO-23-106529 (Sept. 14, 2023), <https://www.gao.gov/products/gao-23-106529> [<https://perma.cc/GSU7-KAWX>].

37. 5 U.S.C. §§ 7323(a) and 7324(a).

38. Trevor G. Samaha, *The Impact of Political Party Control on Health Outcomes in U.S. States* (2025) (Ph.D. dissertation, West Virginia University) at 12, <https://researchrepository.wvu.edu/cgi/viewcontent.cgi?article=13518&context=etd> (noting that "The relationship between political ideologies and public health outcomes has long been a subject of scholarly inquiry."); Jaime Johnson, Note, *O'Hare Truck Service Inc. v. City of Northlake: Further Limiting the spoils of the victor*, 14 GA. ST. U. L. REV. 489 (1998) (noting that "American society has considered political patronage an inherent element of federal, state, and local government for nearly 200 years.").

39. 5 U.S.C. §§ 7323(a), 7324(a).

40. Whitney K. Novak, *The Hatch Act: A Primer*, CONG. RSCH. SERV. (Apr. 20, 2020), <https://sgp.fas.org/crs/misc/IF11512.pdf> [<https://perma.cc/AR8C-RTEA>].

41. David Porter, *Senator Carl Hatch and the Hatch Act of 1939*, 48 N.M. HIST. REV. 151, 152–53 (1973); *see also* David Asp, *Hatch Act of 1939*, FREE SPEECH CTR., <https://firstamendment.mtsu.edu/article/hatch-act-of-1939/> [<https://perma.cc/8NBK-8B3X>] (last updated July 9, 2024).

Committee Report showed that WPA funds had been diverted for political purposes primarily in Kentucky, Tennessee, and Pennsylvania.⁴² In Kentucky, WPA employees contributed \$24,000 to campaign funds for Senator Alban Barkley.⁴³ In Tennessee, Senator Thomas Stewart was found to have received funds from civil service employees due to intimidation and coercion.⁴⁴ So too, in Pennsylvania, Senator Joseph Guffey's name was used to illegally solicit funds through the mailing of letters.⁴⁵ In addition, many WPA workers were threatened with the loss of their job if they did not change their voter registrations from republican to democrat,⁴⁶ and considering the United States was in the throes of the Great Depression, such a threat was not to be taken lightly. As a result, the Hatch Act restricted the political activity of federal employees and in 1940, was later amended to apply to state and local employees who worked in connection with federally funded programs.⁴⁷ Under the Act's current iteration, federal employees may take an "active part in political management or in political campaigns," however, a federal employee may not (1) use his official authority or influence for the purpose of interfering with or affecting the result of an election; (2) knowingly solicit, accept, or receive a political contribution from any person [subject to certain exceptions]; (3) run for the nomination or as a candidate for election to a partisan political office; or (4) knowingly solicit or discourage the participation in any political activity of particular persons.⁴⁸ Generally, there is a broad prohibition against participating in political activities while on duty.⁴⁹

In sum, the Hatch Act reduced the incidence of patronage practices at the federal level,⁵⁰ and "remains the primary means for limiting partisanship within the federal bureaucracy."⁵¹ However, the Hatch Act does not apply to all federal employees in the same manner. Instead, it designates employees to two categories, "less restricted" or "further restricted," with differing limitations on political activity.⁵² For example, less restricted employees "may take an active part in partisan political management or partisan political campaigns," and further restricted employees are "prohibited from engaging" in such activities.⁵³

42. Porter, *supra* note 41, at 153.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. HATCH MODERNIZATION ACT OF 2012, S. REP. NO. 112-211, at 2170 (2012).

48. 5 U.S.C. § 7323(a)(1)–(4).

49. *See* 5 U.S.C. § 7324.

50. Johnson, *supra* note 38, at 493.

51. Jason Miller, Note, *The Unwise and the Unconstitutional Hatch Act: Why State and Government Employees Should Be Free To Run For Public Office*, 34 S. ILL. U. L.J. 313, 315 (2010).

52. *Federal Employee Hatch Act Information*, U.S. OFF. SPECIAL COUNS., <https://osc.gov/Services/Pages/HatchAct-Federal.aspx> [<https://perma.cc/4DGW-5GMY>] (last visited Jan. 3, 2026).

53. *Id.*

However, even within this framework, the Act's enforcement mechanisms are limited. In practice, senior government officials may not face any repercussions for violating the Act, making it inadequate in certain circumstances.⁵⁴ The same inadequacies can be observed at the state level too.

III. POLITICIZATION OF PUBLIC HEALTH AT THE STATE LEVEL

The entanglement of public health officials with partisan political issues is also observable at the state level. A prime example of this political tango occurred in Florida. During Governor Ron DeSantis' Republican primary presidential campaign, then Florida's surgeon general, Dr. Joseph Ladapo joined the Governor on the campaign trail in New Hampshire.⁵⁵ Dr. Ladapo was appointed as Florida's Surgeon General in September 2021,⁵⁶ after rapidly gaining attention due to his articles in the Wall Street Journal speaking out against medical mandates that had surfaced during the COVID-19 pandemic.⁵⁷ Florida's Surgeon General is the head of the Florida Department of Health, an agency of the executive branch, and is appointed by the Governor and confirmed by the State Senate.⁵⁸ As such, the Office of Surgeon General is intended to be divorced from partisan politics as the leading public health official in the state.⁵⁹ However, prior to joining DeSantis on the campaign trail, Dr. Ladapo's appointment was construed to be political reward for his sentiments against widely recommended medical mandates aligned with Florida's Republican initiatives.⁶⁰ In his contentious confirmation hearing, many Florida Democratic state senators walked out of the hearing after he refused to provide direct

54. See e.g., Ian Hargreaves, Note, *Hatching A Plan: Filling the Enforcement Gap in the Hatch Act and the Extraordinary Case of KellyAnne Conway*, 21 U.C. DAVIS BUS. L. J. 225, 233 (2021) (noting that "[i]n using her taxpayer funded federal position to advocate for the President's election campaign, Ms. Conway directly contradicted the Hatch Act's purpose. Nonetheless, following OSC's June 2019 report and the letter of recommendation in which OSC advocated for Ms. Conway's termination from federal employment, President Trump refused to enforce any kind of discipline."); Shearer, *supra* note 8, at *16 (noting that "While there have been over thirty-six high-ranking members of the Trump Administration who have contributed to over one hundred and fifty alleged Hatch Act violations, the prevalence of violations without consequences is not a problem specific to this particular administration.").

55. Casale, *supra* note 3.

56. Annie Wang, *3 years into tenure and state surgeon general remains controversial*, THE INDEP. FLA. ALLIGATOR (Sept. 12, 2024), <https://www.alligator.org/article/2024/09/surgeon-general-ladapo-approaches-three-year-uf-tenure> [<https://perma.cc/7NUC-A8CK>].

57. Joseph A. Ladapo, *Vaccine Mandates Can't Stop Covid's Spread*, WALL STREET J. (Sept. 16, 2021, 6:48 PM), <https://www.wsj.com/articles/vaccine-mandate-covid-19-unvaccinated-breakthrough-delta-boosters-fluvoxamine-antibodies-11631820572?st=fjut6vs85bemxum&reflink=desktopwebshare> [<https://perma.cc/PWE7-64WR>].

58. FLA. STAT. § 20.43; see also *About Us*, FLA. HEALTH, <https://www.floridahealth.gov/about/index.html> [<https://perma.cc/K63J-4ZA5>] (last visited Jan. 3, 2026).

59. *Id.*

60. Anthony Izaguirre, *Florida Surgeon General Confirmed Despite Controversy*, AP NEWS (Feb. 23, 2022), <https://apnews.com/article/coronavirus-pandemic-health-florida-ron-desantis-ccea6d2ca421f837257b08cb0efe7b4c> [<https://perma.cc/VA9G-T6VU>].

answers on his stance to various public health initiatives. Despite this intransigence, he was confirmed on party line vote by the majority Republican senate.⁶¹

Since his appointment and confirmation, Dr. Ladapo has been accused of altering the results of a state driven study regarding the efficacy and safety of COVID-19 vaccines by falsely concluding that the vaccines posed high cardiac risks to young men despite the original results stating otherwise.⁶² In 2022, Dr. Ladapo advised against vaccinating children against COVID, contradicting federal public health leaders who recommend all children get the vaccine.⁶³ The Florida chapter of the American Academy of Pediatrics called the move “irresponsible.”⁶⁴ Many in the medical community have scrutinized Dr. Ladapo for his debunked claims, specifically regarding COVID-19 health initiatives.⁶⁵

Louisiana Surgeon General, Dr. Ralph Abraham has repeated misinformation about COVID-19 vaccine safety and the debunked link between vaccines and autism. He has stated that “masking, lockdowns and vaccination requirements were practically ineffective,” that COVID vaccine adverse effects have been “suppressed,” that “we don’t know” whether blood from people who’ve been vaccinated is safe for donation, and that “we hope and pray COVID vaccines don’t increase the risk of miscarriages.”⁶⁶ This views seems to align with Louisiana’s Governor Jeff Landry, who during his term as Attorney General, criticized the state’s COVID response and filed lawsuits over federal and state vaccine mandates.⁶⁷ As recently as 2025, Dr. Abraham issued a memo instructing the Louisiana Department of Health (“LDH”) staff to stop encouraging mass vaccinations. He wrote that “[t]he State of Louisiana and

61. Steve Contorno, *Florida Surgeon General Favorable Recommended after Democrats Walk Out of Confirmation Hearing*, CNN (Jan. 26, 2022), <https://www.cnn.com/2022/01/26/politics/joseph-ladapo-florida-surgeon-general-confirmation/index.html> [https://perma.cc/7XKR-DV28].

62. Arek Sarkissian, *Florida surgeon general altered key findings in study on Covid-19 vaccine safety*, POLITICO (Apr. 24, 2023), <https://www.politico.com/news/2023/04/24/florida-surgeon-general-covid-vaccine-00093510> [https://perma.cc/HT6W-69GU].

63. To be fair, in May 2025, the Department of Health and Human Services stopped recommendation of routine COVID-19 vaccines for pregnant women and healthy children. See Lena Sun, *CDC blindsided as RFK Jr. changes Covid-19 vaccine recommendations*, WASH. POST (May 28, 2025), <https://www.washingtonpost.com/health/2025/05/28/vaccines-cdc-rfk-jr-covid/> [https://perma.cc/VE8U-6922].

64. Maria Godoy, *What happens when a vaccine skeptic leads health policy? Ask Florida*, OPB (Nov. 14, 2024, 7:21 PM), <https://www.opb.org/article/2024/11/14/pediatricians-worry-rfks-vaccine-skepticism-will-influence-trump-health-policy/> [https://perma.cc/J8SW-HQA7].

65. Nina Golgowski, *Florida Surgeon General Cites Debunked Claims in Calling for Halt of COVID Shots*, THE HUFFINGTON POST (Jan. 4, 2024), https://www.huffpost.com/entry/joseph-ladapo-halt-covid-vaccines_n_6596c6bfe4b0bf73e1788bc6 [https://perma.cc/9E8Y-BZ9V].

66. Rosemary Westwood, *Louisiana forbids public health workers from promoting COVID, flu and mpox shots*, NPR (Dec. 20, 2024), <https://www.npr.org/sections/shots-health-news/2024/12/20/nx-s1-5223440/louisiana-ban-public-health-promoting-covid-flu-mpox-vaccines-landry-rfk-jr-anti-vaccine> [https://perma.cc/2G73-RFB4].

67. *Id.*

LDH have historically promoted vaccines for vaccine preventable illnesses through our parish health units (PHUs), community health fairs, partnerships and media campaigns. While we encourage each patient to discuss the risks and benefits of vaccination with their provider, LDH will no longer promote mass vaccination.”⁶⁸ This announcement was made, despite a surge of influenza cases in Louisiana.⁶⁹

In Montana, Dr. Annie Bukacek, a member of the Flathead City-County Board of Health, gained national attention for her views challenging the COVID-19 death toll, attending protests against COVID vaccinations, and organizing a protest against one of the city’s state-of-emergency declarations at the start of the pandemic.⁷⁰ Dr Bukacek was among a group of rural doctors who emerged as a huge source of misinformation. In December 2021, a group of Montanans filed a complaint against Dr Bukacek with Montana’s medical compliance unit, alleging that she questioned the accuracy of COVID-19 death certificates, discredited PCR testing, and—by virtue of her medical credentials and position on the Flathead City-County Board of Health—encouraged community participation in anti-masking efforts that endangered public health.⁷¹ Dr Bukacek later resigned from the Flathead City-County Board of Health to run for an elected position with the Montana Public Service Commission.⁷²

Finally, in Texas, the Texas Maternal Mortality and Morbidity Review Committee chose not to review pregnancy and childbirth related deaths from the first two years after the state banned almost all abortions—2022 and 2023—and instead began its analysis with data from 2024.⁷³ The committee studies maternal deaths to better understand why so many women are dying or nearly dying from pregnancy and childbirth in Texas.⁷⁴ Many researchers and

68. See Memorandum from Dr. Ralph Abraham on Public Health and Vaccines at LDH (Feb. 13, 2025), <https://www.brproud.com/wp-content/uploads/sites/80/2025/02/LDH-Vaccine-Policy-2025.pdf> [https://perma.cc/UD5N-YK48].

69. See Ramon Antoni Vargas, *Republican senator who voted for RFK Jr balks at Louisiana anti-vaccine move*, THE GUARDIAN (Feb. 16, 2025), <https://www.theguardian.com/us-news/2025/feb/16/louisiana-vaccines-rfk-jr> (noting that “[t]he announcement came as Louisiana grappled with a surge in cases of influenza, for which safe, effective vaccines that limit the spread and severity of the virus are offered seasonally”).

70. Matt Baldwin, *Bukacek resigns from Flathead County health board*, DAILY INTER LAKE (Mar. 17, 2022), <https://dailyinterlake.com/news/2022/mar/17/bukacek-resigns-flathead-county-health-board/> [https://perma.cc/27CB-873F].

71. Rob Kuznia et al., *They take an oath to do no harm, but these doctors are spreading misinformation about the Covid vaccine*, CNN (Oct. 20, 2021), <https://dailyinterlake.com/news/2022/mar/17/bukacek-resigns-flathead-county-health-board/> [https://perma.cc/3TCQ-AM28].

72. Montana Public Service Commission, *Commissioners*, MONT. PUB. SERV. COMM’N., <https://psc.mt.gov/About-Us/Commissioners/> [https://perma.cc/TN65-JJUM] (noting that Dr. Annie Bukacek was elected to the Public Service Commission November 8, 2022.) (last visited Jan. 27, 2026).

73. Eleanor Klibanoff, *U.S. House members want answers on Texas’ decision to not review maternal deaths after near-total abortion ban*, TEX. TRIBUNE (Dec. 19, 2024), <https://www.texastribune.org/2024/12/19/texas-congress-maternal-mortality/> [https://perma.cc/V32V-TRTN].

74. *Id.*

reproductive health care advocates anticipated an increase in maternal mortality as a result of new abortion restrictions.⁷⁵ Instead, the committee skipped 2022 and 2023 to paint a rosy picture. It has been alleged that by skipping the two years after the Supreme Court's *Dobbs* decision,⁷⁶ the committee was trying to "bury the truth of abortion-ban related deaths."⁷⁷

These examples from Florida, Louisiana, Montana and Texas, to mention but a few, illustrate the dangers of politicizing public health activities to the detriment of population's health.⁷⁸ In Texas for example, the decision not to report the maternal deaths in the two years after *Dobbs* likely skewed reproductive health data in the state, and possibly influenced funding decisions tied to that data. One commentator has noted that "[t]he extent to which a particular occupational category is dependent on state funds seems to correlate with the stringency of limitations placed on its political activity."⁷⁹ Notably, prior to the committee taking this action, Texas legislators had allocated money to create a new maternal death tracking system with the goal of ending the state's participation in national data sharing.⁸⁰

These patterns then raises the broader question of whether adequate state laws, similar to the federal Hatch Act, exist to curtail the political activities of unelected state and local public health employees. Enter "State Hatch Acts," or "Little Hatch Acts".

A. State Hatch Acts

In the United States, most of the fifty states have enacted equivalents of the Hatch Act.⁸¹ Many of them prohibit "(1) using official authority or influence to interfere or affect the results of an election; (2) soliciting financial or manpower contributions from any political organization or candidate; (3) campaigning for partisan positions in government; and (4) engaging in political activities while on duty, in uniform, or on government property."⁸² The following is a fifty state

75. *Id.*

76. See *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022) (overruling *Roe v. Wade* and holding that the Constitution does not confer a right to abortion).

77. See Klibanoff, *supra* note 73 (citing U.S. Rep. Jasmine Crockett of Dallas and noting that "Crockett said Texas was trying to 'bury the truth' of abortion-ban related deaths.").

78. See Matt Dixon, *2 top public health positions in Ron DeSantis' administration are vacant*, NBC NEWS (July 6, 2023), <https://www.nbcnews.com/politics/2024-election/2-top-public-health-positions-ron-desantis-administration-are-vacant-rcna92120> [https://perma.cc/VCM8-CXZU] (citing APHA director Georges Benjamin and noting that "Florida has a health department that has been seriously politicized and the support of good public health systems in Florida has been reported to be eroding over the past several years")

79. See Richard L. Abel, *Law Without Politics: Legal Aid Under Advanced Capitalism*, 32 UCLA L. REV. 474, 617 n.816 (1985) (on file with author).

80. Klibanoff, *supra*, note 73.

81. *Prohibitions on Political Activity for Legislative Staff*, NAT'L CONF. OF STATE. LEG., <https://www.ncsl.org/ethics/staff-and-political-activity-statutes> [https://perma.cc/B6X4-CXCP] (last updated Dec. 3, 2024).

82. Gely & Chandler, *supra* note 4, at 791.

survey of each States Hatch Act and some regulations where applicable, and what is generally forbidden or permitted.

1. Alabama

Generally, in Alabama, state employees are encouraged to participate in political activities including endorsing candidates of their choosing and contributing to those campaigns. However, if a state employee chooses to run for political office, the employee is required to either take an unpaid leave of absence or use accrued leave from the date the employee qualifies as a candidate. This requirement continues until the election results are certified, the employee is no longer a candidate, or there are no other candidates on the ballot. Any employee who violates this subsection shall forfeit his or her employment position. In no event shall this subsection apply to elected officials.⁸³ Another limitation is that no person shall use or promise to use any official authority or influence to secure or attempt to secure for any person an appointment or advantage in appointment to a position, or an increase in pay or other advantage in employment in any such position, for the purpose of influencing the vote or political action of any person, or for any consideration.⁸⁴ Alabama has further restrictions prohibiting the use of state funds for political purposes by state employees,⁸⁵ and also limits on-duty state employees from engaging in political activity.⁸⁶ However, if a state employee is considered to be in a “classified service position” as defined by statute,⁸⁷ then then employee may not be a member of any national, state, or local committee of a political party or an officer of a partisan political club or a candidate for nomination or election to any public office or take any part in the management or affairs of any political party or in any political campaign, except on his personal time and to exercise his right as a citizen privately to express his opinion and to cast his vote.⁸⁸

2. Alaska

Comparatively, Alaska’s statutes prohibiting political activities by state employees from engaging in political activities is far stricter than many. However, the statutes are limited to “legislators and legislative employees” rather than just state employees.⁸⁹ “Legislative employee” is defined as, a

83. ALA. CODE § 17-1-4 (2025).

84. *See* ALA. CODE § 45-37-121.22 (2025); *accord* ALA. CODE § 36-26-38 (2025).

85. ALA. CODE § 17-17-5(a) (2025).

86. ALA. CODE § 17-1-4(c) (“When off duty, out of uniform, and acting as a private citizen, no law enforcement officer, firefighter, or peace officer shall be prohibited from engaging in city, county, or state political activity or denied the right to refrain from engaging in political activity so long as there is compliance with this section”).

87. *See* ALA. CODE § 36-26-10 (2025).

88. ALA. CODE § 36-26-38 (2025).

89. *See* ALASKA STAT. § 24.60.030 (2025).

person, other than a legislator, who is compensated by the legislative branch in return for regular or substantial personal services, regardless of the person's pay level or technical status as a full-time or part-time employee, independent contractor, or consultant; it includes public members and staff of the committee; it does not include individuals who perform functions that are incidental to legislative functions, including security, messenger, maintenance, and print shop employees, and other employees designated by the committee.⁹⁰

Under Alaska's Legislative Ethics Act's prohibited conduct and conflicts of interest, legislators and legislative employees are prohibited from engaging in a number of actions, including a general prohibition against assisting with partisan political activities, using funds for a non-legislative purpose, and disseminating communications intended to influence the election of a candidate in public areas of state government buildings.⁹¹ Further, upon pursuing political office, an individual must take a leave of absence prior to engaging in campaign activities.⁹² Additionally, Alaska has specific rules regarding where, when, and from whom legislators may solicit and accept campaign funds.⁹³ Another statute places limitations on political activities of employees of vocational rehabilitation programs, stating that "[a]n officer or employee may not solicit or receive, and an officer or employee may not be obliged to contribute or render, a service, assistance, subscription, assessment, or contribution for a political purpose. An officer or employee violating this section is subject to discharge or suspension."⁹⁴

3. *Arizona*

Arizona's version of the Hatch Act matches closely with federal law.⁹⁵ Under Arizona law, state employees may not use their position with the state government to endorse a political candidate, use their authority to influence or coerce political action on behalf of any party, nor may state employees solicit funds or political action on behalf of any party.⁹⁶ Furthermore, public organizations are prohibited from participating in any form of political activity or being employed directly or indirectly for political purposes.⁹⁷ In addition to the typical punishment of suspension or dismissal, Arizona has added an additional civil penalty for violating campaign solicitation rules in the amount of three times the contribution.⁹⁸

90. ALASKA STAT. § 24.60.990(a)(11) (2025).

91. *See* ALASKA STAT. § 24.60.030 (2025).

92. *Id.* at § 24.60.030(h).

93. *See* ALASKA STAT. § 24.60.031 (2025).

94. *See* ALASKA STAT. § 23.15.200 (2025).

95. *See* ARIZ. REV. STAT. ANN. § 41-752 (2025).

96. *Id.*

97. ARIZ. REV. STAT. ANN. § 26-315 (2025).

98. ARIZ. REV. STAT. ANN. § 41-752(I).

4. Arkansas

Under Arkansas law, public servants are prohibited from, among other things, campaigning or working on their campaigns during business hours and improperly influencing or attempting to unlawfully influence the appointment or election of a candidate. Additionally, state employees may not participate in partisan political activities while in office, or unduly influence or coerce political activity on part of any party.⁹⁹ It is also unlawful for any public servant to use any office or room furnished at public expense to distribute letters, circulars, or other campaign materials, unless such office or room is regularly used by members of the public without regard to political affiliation, and for any public servant to use for campaign purposes any item of personal property provided with public funds.¹⁰⁰ If there is a violation of this law, the violating individual will either be ineligible to hold public office in the state and if the person is a state employee, they will be subject to immediate dismissal.¹⁰¹ Arkansas also provides criminal sanctions for violations of its election code.¹⁰² Other political activity limitations include those placed on officers of rehabilitation programs¹⁰³, civil service employees for cities of 20,000 to 75,000 people¹⁰⁴, and employees of cities of over 75,000 people.¹⁰⁵

5. California

Unlike many other states, California does not generally prohibit partisan political activities of its public employees while in office.¹⁰⁶ State and local employees are permitted to participate in all political activities so long as it does

99. ARK. CODE ANN. § 7-1-103 (2025).

100. *Id.* at § 7-1-103(a)(3).

101. *Id.* at § 7-1-103(b).

102. *See generally* ARK. CODE ANN. § 7-1-103(b)(1) (2025) (providing in pertinent part “(b)(1) [e]xcept as otherwise provided, the violation of any provision of this section shall be a Class A misdemeanor”).

103. ARK. CODE ANN. § 20-79-212 (2025).

104. ARK. CODE ANN. § 14-50-306 (2025).

105. *See* ARK. CODE ANN. § 14-49-306 (2025) (“ . . . [N]o employee in any department affected by this chapter shall engage in the solicitation of any subscription funds or assessments or contribute thereto for any political party or purpose . . . [A]n employee shall not be connected with any political campaign or political management except to cast his or her vote and to express his or her personal opinion privately”).

106. CAL. GOV’T CODE § 3203 (2025) (“Except as otherwise provided in this chapter, or as necessary to meet requirements of federal law as it pertains to a particular employee or employees, no restriction shall be placed on the political activities of any officer or employee of a state or local agency”); *accord* CAL. EDUC. CODE § 7052; *see also* CAL. LAB. CODE § 1101 (2025) (“[N]o employer shall make, adopt, or enforce any rule, regulation, or policy: (a) forbidding or preventing employees from engaging or participating in politics or from becoming candidates for public office, (b) controlling or directing, or tending to control or direct the political activities or affiliations of employees”).

not violate federal law.¹⁰⁷ In addition, California has comparatively lenient rules with regard to solicitations for campaign fundraising in that it only prohibits solicitations—either directly or indirectly—from employees of an agency, unless the solicitation is made to a “significant segment of the public which may include officers or employees of that local agency.”¹⁰⁸ The statute states that “[a] state officer or employee shall not engage in any employment, activity, or enterprise which is clearly inconsistent, incompatible, in conflict with, or inimical to his or her duties as a state officer or employee.”¹⁰⁹ The statute further enumerates other prohibited actions, none of which are specific to engaging in political activities.¹¹⁰ However, section 3204 of the Code prohibits anyone who holds or who is seeking election or appointment to any office or employment in a state or local agency, from using, promising to use, any office or authority to confer upon or secure for any individual person, any position, nomination, confirmation, promotion, or change in compensation on condition that the vote or political influence or action of such person or another shall be given for the benefit of any candidate, officer, or party, or upon any other corrupt condition or consideration.¹¹¹

6. *Colorado*

Under Colorado law, “[e]mployees in the state personnel system shall be selected without regard to political considerations; shall not use any state facility or resource or the authority of any state office in support of any candidate; and shall not campaign actively for any candidate on state time or in any manner calculated to exert the influence of state employment.”¹¹² The state also prohibits its political subdivisions from making any contribution in campaigns involving the nomination, retention, or election of any person to any public office or state ballot issues and measures.¹¹³ However, the rule does not bar a member or employee of any such political subdivision from responding to questions about any such issues if the member, employee, or public entity has not solicited the question, nor are they barred from expending personal funds, making contributions, or using personal time to urge electors to vote in favor of or against any issues.¹¹⁴

7. *Connecticut*

Under Connecticut law, an employee in the “classified service” is prohibited

107. CAL. GOV’T CODE § 3203 (2025).

108. CAL. GOV’T CODE § 3209 (2025).

109. CAL. GOV’T CODE § 19990 (2025).

110. *See id.*

111. CAL. GOV’T CODE § 3204 (2025).

112. COLO. REV. STAT. ANN. § 24-50-132 (2025).

113. COLO. REV. STAT. ANN. § 1-45-117 (2025).

114. *Id.*

from: (1) using his official authority or influence for the purpose of interfering with or affecting the result of an election or a nomination for office; or (2) directly or indirectly coercing, attempting to coerce, commanding or advising a state or local officer or employee to pay, lend or contribute anything of value to a party, committee, organization, agency or person for political purposes.¹¹⁵

Classified service is loosely defined as “every office or position in the state service, whether full-time or part-time, for which compensation is paid, except those offices and positions specified in section 5-198 or otherwise expressly provided by statute.”¹¹⁶ However, section 5-198 enumerates all twenty-nine (29) unclassified positions in the state, including all employees of the judiciary.¹¹⁷ Despite the judiciary’s general “unclassified” status, if a member of the judiciary or any other classified service employee for that matter, wants to run for elective office, he or she must take a personal leave of absence that is not to exceed “two consecutive terms of such office or for a period of four years, whichever is shorter.”¹¹⁸ Further, if the employee is elected into office, he or she must formally resign from his or her position prior to accepting the elected position.¹¹⁹ If a classified employee is found to have violated any of the provisions in section 5-266(a), the Commissioner of Administrative Service has the power to discipline the employee, and unlike its federal counterpart, wields more discretion in punishment in that the commissioner “may dismiss such employee from state service.” If the “commissioner finds that the violation does not warrant removal, the commissioner may impose a penalty on such employee of suspension from such employee’s position without pay for not less than thirty days or more than six months.”¹²⁰

The Office of State Ethics also prohibits certain activities that may run afoul of the Connecticut Code of Ethics. For example, there is a conflict of interests which precludes a person in state service from holding or continuing to hold elective municipal office when the State Constitution or a provision of the General Statutes prohibits a classified State employee or a person employed in the judicial department from: seeking or holding the municipal office or the classified state employee has an office or position which has discretionary power to remove the incumbent of the municipal office; approve the accounts or actions of the municipal office; institute or recommend actions for penalties against the incumbent of the municipal office incident to the incumbent’s election or performance of the duties of said office.¹²¹

8. Delaware

Under Delaware law, there is a general prohibition against using official

115. CONN. GEN. STAT. § 5-266a (2025).

116. CONN. GEN. STAT. § 5-196(6) (2025).

117. CONN. GEN. STAT. § 5-198 (2025).

118. CONN. GEN. STAT. § 5-266a(c) (2025).

119. *Id.*

120. CONN. GEN. STAT. § 5-266d (2025).

121. CONN. AGENCIES REG § 5-266a-1 (2025).

authority to influence, whether directly or indirectly, “the vote or political action of any person, or for any consideration.”¹²² Similar to other states, only those employed in “classified service” may not engage in any political activity or solicit contributions while engaging in business on behalf of the state.¹²³ Classified service is broadly defined as “all other state employment” as the statute lists twenty-five (25) enumerated exemptions including “all judges and employees of the state judicial branch,” “casual employees,” “dental director,” and “chief physician.”¹²⁴ However, the statute does not prohibit classified service employees from engaging in political activity, such as running for office, while employed with the state unlike other state and federal counterparts.¹²⁵ Interestingly, the statute provides for a general prohibition of all persons from inducing those in the classified service from contributing or subscribing to a particular political party under the guise that it may affect their employment with the state.¹²⁶ Despite its leniency, the penalties under the Delaware statute are more stringent as a violation of the section requires the individual to forfeit his or her position and will be ineligible for any other position with the state for a maximum of one (1) year.¹²⁷ Delaware also limits the political activities of law enforcement officers. The statute states that although law enforcement officers have the same rights to engage in political activity as are afforded to any other person, the right to engage in political activity shall not apply to any law-enforcement officer while on duty or when acting in an official capacity or while in uniform.¹²⁸

9. *District of Columbia*

While the District of Columbia (“D.C.”) is not a state, it too has contributed to the body of law prohibiting its employees from engaging in political activity.¹²⁹ Under D.C. law, a district employee may not engage in political activities, including soliciting, receiving, and making political contributions, while on duty.¹³⁰ Similarly, district employees may engage in general political activity such as voting, but may not run as a candidate nor use their official authority to improperly influence others to affect the result of an election.¹³¹ The enforcement provisions state that “[a] violation of this chapter shall constitute a violation of the Code of Conduct as defined in § 1-1161.01(7), and shall be enforceable by the Board in accordance with Chapter 11A of this

122. DEL. CODE ANN. tit. 29, § 5954(a) (2025).

123. DEL. CODE ANN. tit. 29, § 5954(b) (2025).

124. *See* DEL. CODE ANN. tit. 29, § 5903 (2025).

125. *See* DEL. CODE ANN. tit. 29, § 5954 (2025).

126. *Id.* at (c).

127. *Id.* at (d).

128. DEL. CODE ANN. tit. 11 § 9200(a) (2025).

129. *See generally* D.C. CODE § 1-1171.03 (2025).

130. D.C. CODE § 1-1171.02 (2025).

131. *Id.*

title.”¹³² A civil penalty is imposed for a violation of the Code of Conduct of not more than \$5,000 per violation, or three times the amount of an unlawful contribution, expenditure, gift, honorarium, or receipt of outside income for each violation.¹³³

10. Florida

Under Florida law, employees in “career service” may not directly or indirectly influence votes for political action, or secure appointment for a position, nor may the individual hold office, be a candidate, or actively participate in a political campaign while employed by the state.¹³⁴ Nor may an individual in “career service” use his or her authority to back a political party in a partisan election or coerce employee support or contributions for a political purpose.¹³⁵ Career service is broadly defined as those positions that are not specifically exempted by statute.¹³⁶ Florida has exempted positions such as the State Surgeon General, “judges, referees, and receivers,” “[a]ll members of state boards and commissions,” as well as various secretaries.¹³⁷ However, Florida’s election code has a separate provision seemingly providing a blanket prohibition unto all officers or employees of the state, county, or municipality, unless otherwise exempted, from engaging in impermissible coercion or influence regarding elections, engaging in a political campaign while on duty, or the improper solicitation of funds for political purposes.¹³⁸ While section 104.31 provides that a violation of the statute constitutes a misdemeanor, no other comparable penalty or civil penalty is provided under section 110.233 regarding a career service employee’s violation of the section’s prohibitions; other sections prohibiting political activities include Sections 106.15 and 106.113 of the Florida statutes.¹³⁹

11. Georgia

Under Georgia law, it is “unlawful for any officer or employee of [the] state

132. D.C. CODE § 1-1171.04 (2025). Chapter 11A involves the Code of Government Ethics and Accountability and various provisions can be found in § 1-1161.01 *et seq.*

133. D.C. CODE § 1-1162.21(a)(1) (2025).

134. FLA. STAT. § 110.233 (2025).

135. *Id.*

136. FLA. STAT. § 110.205 (2025).

137. *Id.*

138. FLA. STAT. § 104.31 (2025).

139. *See* FLA. STAT. §§ 104.31(3), 110.201, 106.15(2) (“No candidate, in the furtherance of his or her candidacy for nomination or election to public office in any election, shall use any state-owned aircraft or motor vehicle, as provided in chapter 287, solely for the purpose of furthering his or her candidacy”), 106.113(2) (“A local government or a person acting on behalf of local government may not expend or authorize the expenditure of, and a person or group may not accept, public funds for a political advertisement or any other communication sent to electors concerning an issue, referendum, or amendment, including any state question, that is subject to a vote of the electors”).

to coerce or attempt to coerce or command directly or indirectly any other state officer or employee to pay, lend, or contribute any part of his salary or to kick back any sum of money or anything else of value to any party, committee, organization, agency, or person for political purposes.¹⁴⁰ But rather than imposing any civil penalties, Georgia has criminalized violations of its law.¹⁴¹ Additionally, the Georgia Department of Administrative Services prohibits a bevy of political activities including but not limited to: conducting political activities of any nature during work time or on work premises and or using state property or resources to do so; soliciting other employees for any political purpose, whether or not during work hours or on work premises; soliciting or knowingly accepting any campaign contributions in a state building or office except when the space is rented for the specific purpose of holding a campaign fundraiser; and holding or being a candidate for political office that conflicts with current employment.¹⁴² The consequences for participating in prohibited or conflicted political activities include denial or termination of employment and resignation or forfeiture of employment upon assuming office.¹⁴³

12. Hawaii

In Hawaii, the political activities of state employees are governed by the Hawaii State Ethics Code. Under Hawaii law, “[t]he members of the ethics commission and its staff shall not take an active part in political management or in political campaigns during the term of office or employment.”¹⁴⁴ Additionally, state regulations prohibit legislators and employees from using state resources for private business purposes, including political campaign activities.¹⁴⁵

13. Idaho

Under Idaho law, employees of the State Departments may not use their authority to influence or attempt to influence elections, coerce or otherwise demand that other employees contribute to a political organization or agency, and may not be a candidate or hold office in a partisan election.¹⁴⁶ Additionally, Idaho law provides that no person may serve on the Worker’s Compensation and Related Laws Industrial Commission who is a candidate for political office.¹⁴⁷ However, Idaho statutes do not prohibit state employees from running in non-partisan elections or participate in other non-partisan activities of a civic,

140. GA. CODE ANN. § 45-11-10(a) (2025).

141. *Id.* at (c).

142. GA. COMP. R. & REGS. 478-1-.08(5) (2025).

143. *Id.* at (6).

144. HAW. REV. STAT. § 84-35.5 (2025).

145. HAW. CODE R. § 21-7-10 (2020).

146. *See* IDAHO CODE § 67-5311(1)(a)–(c) (2025).

147. IDAHO CODE § 72-1503 (2025).

community, social, labor, or professional organization, or of a similar organization, and otherwise encourages political participation of its employees.¹⁴⁸

14. Illinois

Under Illinois law, state employees are prohibited from intentionally performing any prohibited political activity during any compensated time—other than vacation, personal, or compensatory time off—or intentionally misappropriating any state property or resources by engaging in any prohibited political activity for the benefit of any campaign for elective office or any political organization.¹⁴⁹ Additionally, state employees may not have their employment conditioned on, nor be incentivized to participate in otherwise prohibited political activity.¹⁵⁰ Similar prohibitions extend to local government employees.¹⁵¹

15. Indiana

In Indiana, “a classified employee may not be compelled to make political contributions or to participate in any form of political activity.”¹⁵² Upon taking state or federal office, the employee is considered to have resigned from state employment on the day they take office.¹⁵³ The Indiana Administrative Code provides further limitations on political activities of state employees. For example, the code prohibits state employees or special state appointees from engaging in political activity including solicitation of political contributions from another employee or special state appointee, or any other person when on duty or acting in an official capacity and soliciting political contributions at any time from persons whom the employee knows to have a business relationship with the employee’s agency or are directly supervised by the soliciting employee.¹⁵⁴ The appointing authority of an agency and all employees or special state appointees with purchasing or procurement authority on behalf of the state

148. *See* IDAHO CODE § 67-5311(2) (2025).

149. 5 ILL. COMP. STAT. § 430/5-15(a) (2025).

150. *Id.* at (b)–(d).

151. *See e.g.*, 305 ILL. COMP. STAT. § 5/12-21.7 (2025) (providing that “in any local governmental unit receiving State funds, each employee whose duties pertain to determination of eligibility for or the amount of public aid is prohibited from engaging in at any time, whether during or outside of regular working hours, any of the following activities: (1) using or threatening to use the influence or authority of his position to coerce or to persuade any person to follow any course of political action; (2) soliciting money from any person for any political purpose; (3) selling or distributing tickets for political meetings; (4) assisting at the polls in behalf of any party or party-designated candidate on any election day, (5) initiating or circulating petitions on behalf of a candidate; (6) distributing campaign literature or material in behalf of any candidate”).

152. IND. CODE § 4-15-2.2-44(b) (2025).

153. IND. CODE § 4-15-2.2-45 (2025).

154. 42 IND. ADMIN. CODE 1-5-4 (2025).

are also prohibited from soliciting political contributions on behalf of any candidate for public office, unless that individual is a candidate for public office himself or herself.¹⁵⁵

16. Iowa

Iowa law stipulates that “[t]he state and the governing body of a county, city, or other political subdivision of the state shall not expend or permit the expenditure of public moneys for political purposes, including expressly advocating the passage or defeat of a ballot issue.”¹⁵⁶ The implementing regulation identifies situations in which the use of public resources for a political purpose is prohibited to include: using public resources to solicit or accept campaign contributions; using public resources to solicit votes, engage in campaign work, or poll voters on their preferences for candidates or ballot issues; using a publicly owned motor vehicle to transport political materials, placing campaign signs on a publicly owned motor vehicle, or traveling to campaign-related events in a publicly owned motor vehicle; using public resources to produce and distribute communications that expressly advocate for or against candidates or that expressly advocate for or against ballot issues and placing campaign materials on public property including the placement of campaign signs in the public right-of-way.¹⁵⁷

17. Kansas

Under Kansas law, no officer or employee of the state, or any municipality, shall use or authorize the use of public funds to expressly advocate for “the nomination, election, or defeat of any clearly identified candidate to state or local office.”¹⁵⁸ Further, no state employee may use his or her authority to influence or compel another employee to take part in any political activity.¹⁵⁹ If an employee is found to have violated this provision, the state of Kansas criminalizes such a violation as a class C misdemeanor, and if a classified member of state service is convicted, he or she will be removed from service.¹⁶⁰

18. Kentucky

Kentucky prohibits the unlawful use of one’s position with the state to influence or coerce political activity of others, as well as the solicitation of funds

155. *Id.*

156. IOWA CODE § 68A.505(1) (2025).

157. IOWA ADMIN. CODE r. 351-5.4 (68A) (2025).

158. KAN. STAT. ANN. § 25-4169a (2025).

159. KAN. STAT. ANN. § 75-2953 (2025).

160. *Id.*

for political purposes.¹⁶¹ Further, with regard to political activity, no employee in the classified service or member of the board or its executive director can be a member of any national, state, or local committee of a political party, or an officer or member of a committee of a partisan political club, or a candidate for nomination or election to any paid partisan public office. No employee shall take part in the management or affairs of any political party or in any political campaign, except to exercise his right as a citizen privately to express his opinion and to cast his vote. Further, in Kentucky:

Officers or employees of the classified service may be candidates for and occupy an elected office if the election is on a nonpartisan basis, the officers or employees have complied with the requirements of Kentucky Revised Statute § 61.080, and the duties of the elective office do not interfere with, or create any conflicts of interest with, the state duties of the officers or employees in the classified service. An employee shall give notice to his or her appointing authority of his or her intent to run for elective office upon filing to run for the office.¹⁶²

19. Louisiana

Interestingly, Louisiana is the only state that has made the prohibition against partisan political activity a part of its state constitution. Under Louisiana's constitution:

No member of a civil service commission and no officer or employee in the classified service shall participate or engage in political activity; be a candidate for nomination or election to public office except to seek election as the classified state employee serving on the State Civil Service Commission; or be a member of any national, state, or local committee of a political party or faction; make or solicit contributions for any political party, faction, or candidate; or take active part in the management of the affairs of a political party, faction, candidate, or any political campaign, except to exercise his right as a citizen to express his opinion privately, to serve as a commissioner or official watcher at

161. KY. REV. STAT. ANN. § 18A.140(2)–(3) (2025); *accord* KY. REV. STAT. ANN. § 161.164 (3) (2025) (“No person shall use or promise to use, directly or indirectly, any official authority or influence, whether possessed or anticipated, to secure or attempt to secure for any person an appointment or advantage in appointment to a position as teacher or employee of any district board of education, or an increase in pay or other advantage in employment in any such position, for the purpose of influencing the vote or political action of any person”).

162. KY. REV. STAT. ANN. § 61.080 (2025) (this section prohibits employees from holding incompatible offices, stating, “[n]o person shall, at the same time, be a state officer, a deputy state officer, or a member of the General Assembly, and an officer of any county, city, consolidated local government, or other municipality, or an employee thereof.”); KY. REV. STAT. ANN. § 18A.140(4) (2025).

the polls, and to cast his vote as he desires.¹⁶³

Louisiana law also prohibits employees from lobbying for or against any matter intended to have the effect of law pending before the legislature or any committee and entering into a contract with a lobbyist or a contract for lobbying services to lobby for or against any matter intended to have the effect of law pending before the legislature or any committee.¹⁶⁴ The Louisiana State Civil Service Agency also issues circulars on prohibited political activities by classified state employees such as: being a candidate for nomination or election to public office, becoming a member of any committee of a political party or faction or making or soliciting contributions for any candidate or political party or faction or actively engage on the official or unofficial social media page of a candidate for nomination or election to political office, political party, or faction of a political party.¹⁶⁵

20. *Maine*

In Maine, “[a]n officer or employee in the classified service or an employee from the executive branch in the unclassified service” is prohibited from using:

[T]hat officer’s or employee’s official authority, influence or supervisory position for the purpose of . . . interfering with or affecting the result of a partisan election or nomination for elective office . . . or attempting to intimidate, threaten, coerce, command or influence a person to give or withhold a political contribution or to engage or not to engage in any form of political activity. . .¹⁶⁶

Similarly, the employee

[M]ay not engage in political activity when the employee is on duty; in state-owned or leased work space occupied in the discharge of official duties or by using the facilities or services of the State; or when wearing a uniform or official insignia identifying the office or position of the employee or while using a vehicle owned or leased by the State or its agencies.¹⁶⁷

163. LA. CONST. art. X, § 9.

164. LA. STAT. ANN. § 24:56 (2025).

165. *See e.g.*, Memorandum from Byron P. Decoteau, Director on Reminder of Prohibited Political Activity, General Circular No. 2023-006 (Feb. 3, 2023), https://www.civilservice.louisiana.gov/files/general_circulars/2023/GC2023-006.pdf [[<https://perma.cc/QP78-8C23>]

166. 5 ME. REV. STAT. tit. 5 § 7056-A (2025).

167. *Id.*

However,

An officer or an employee of the classified service or an employee from the executive branch in the unclassified service may . . . campaign for and hold an elective office in political clubs and organizations . . . contribute money to political organizations or attend political fundraising functions . . . donate personal time and service to a political cause . . . be a candidate for public office in a nonpartisan election . . . and participate in any other activity not specifically prohibited by state or federal law.¹⁶⁸

Additionally, a partisan legislative employee is not prohibited from engaging in political activities but rather must limit his or her activities to his or her own personal time or otherwise take a leave of absence.¹⁶⁹ Finally, legislative employees may not use legislative equipment to work on their campaigns.¹⁷⁰

21. Maryland

In Maryland, “[a]n official or employee may not intentionally use the prestige of office or public position for that official’s or employee’s private gain or that of another; or to influence, except as part of his or her official duties, or as a usual and customary constituent service without additional compensation, the award of a State or local contract to a specific person.”¹⁷¹ The State also prohibits employees from engaging in political activity during working hours, advocating for the violent overthrow of the government,¹⁷² and improperly using political influence to sway decisions regarding promotions, transfers, and other like decisions in relation to employment.¹⁷³

22. Massachusetts

Under Massachusetts law, the prohibition of political activity of state employees is primarily limited to financial contributions and solicitations thereof on behalf of political organizations.¹⁷⁴ Although not specifically referring to political activities, Section 268A of the Massachusetts General Laws prohibits an officer or employee of a state, county or municipal agency from knowingly:

[A]ccepting other employment involving compensation of substantial

168. *Id.*

169. ME. STAT. tit. 3, § 170 (2025).

170. ME. STAT. tit. 3, § 170-A (2025).

171. MD. CODE ANN. GEN. PROVISIONS, § 5-506 (2025).

172. MD. CODE ANN. STATE PERS. & PENS. § 2-304 (2025).

173. *Id.* at § 2-307.

174. *See* MASS. GEN. LAWS ch. 55, §§ 13, 14, 16 (2025).

value, the responsibilities of which are inherently incompatible with the responsibilities of his or her public office; or solicit or receive anything of substantial value for such officer or employee, which is not otherwise authorized by statute or regulation, for or because of the officer or employee's official position.¹⁷⁵

This section has been read to prevent a public employee from using his public position to engage in political activity.¹⁷⁶

23. Michigan

Michigan, unlike many other states, expressly allows state employees to engage in various forms of political activity and only requires those running for legislative office, executive office, offices of the State Supreme Court, or Court of Appeals, to take a leave of absence.¹⁷⁷ However, as with the other states, Michigan prohibits the use of political stature to coerce or influence individuals to “contribute anything of value to a [political] party” or cause;¹⁷⁸ or engaging in political activities “during those hours when that person is being compensated for the performance of that person's duties as a public employee.”¹⁷⁹ Additionally, “public employees whose political activities are subject to restrictions imposed by laws or regulations of the United States” are required to “comply with those restrictions notwithstanding any contrary provisions of [the state laws].”¹⁸⁰ By deduction, the Federal Hatch Act would seem to apply to some Michigan public employees.

24. Minnesota

Under Minnesota law, “[n]o employee shall, directly or indirectly, during hours of employment solicit or receive funds for political purposes, or use official authority or influence to compel an employee in the classified service to apply for membership in or become a member of any political organization, to pay or promise to pay any assessment, subscription, or contribution or to take

175. MASS. GEN. LAWS ch. 268A, § 23 (2025).

176. See State Ethics Commission, *State Ethics Commission Advisory 11-1: Public Employee Political Activity*, MASS.GOV (Mar. 18, 2011), <https://www.mass.gov/advisory/state-ethics-commission-advisory-11-1-public-employee-political-activity#2-may-not-do-political-activities-by-public-employees-that-generally-are-prohibited-by-the-conflict-of-interest-law-https://perma.cc/LZ9B-JKA7> (focusing on 2. *May Not Do: Political Activities by Public Employees That Generally Are Prohibited by the Conflict of Interest Law*).

177. MICH. COMP. LAWS § 15.402 (2025).

178. MICH. COMP. LAWS § 15.405 (2025).

179. MICH. COMP. LAWS § 15.404 (2025).

180. MICH. COMP. LAWS § 15.407 (2025).

part in any political activity.”¹⁸¹ Further, certain individuals other than executive branch officials, are required to take a leave of absence:

- (1) . . . upon assuming an elected federal office or an elected state office other than state legislative office or, if elected to state legislative office, during times that the legislature is in session;
- (2) upon assuming any elected public office other than enumerated in clause (1), if, in the opinion of the commissioner, the holding of the office conflicts with regular state employment; and
- (3) upon request, be granted leave of absence upon becoming a candidate, or during the course of candidacy, for any elected public office.¹⁸²

25. *Mississippi*

In Mississippi, “[n]o person holding any office, place, position or employment subject to civil service, is under any obligation to contribute to any political fund or to render any political service to any person or party whatsoever, and no person shall be removed, reduced in grade or salary, or otherwise prejudiced for refusing so to do.”¹⁸³ No state employee is permitted to influence or coerce another employee to vote or not vote for a particular matter nor are state employees with authority to fire other employees permitted to make public or private statements “or give out or circulate any report or statement, calculated to intimidate or coerce or otherwise influence any vote of an employee.”¹⁸⁴ Further, state employees are not permitted to campaign or work on the campaign of another during business hours nor may an individual take a paid leave of absence to participate in a political campaign or render services to a campaign.¹⁸⁵ Whoever violates this law, upon conviction, can be imprisoned in the county jail, fined or both.¹⁸⁶

181. MINN. STAT. § 43A.32 (2025); *accord* MINN. STAT. ANN. § 211B.09 (2025) (“An employee or official of the state or of a political subdivision may not use official authority or influence to compel a person to apply for membership in or become a member of a political organization, to pay or promise to pay a political contribution, or to take part in political activity. . .”).

182. *Id.*

183. MISS. CODE ANN. § 21-31-75 (2025); *accord* 27 MISS. ADMIN. CODE PT. 120, R. 5.9 (2025).

184. MISS. CODE ANN. § 23-15-871 (2025).

185. *Id.*

186. *See* MISS. CODE ANN. § 97-13-37 (2025) (providing in relevant part, “whoever . . . shall violate any provision of Section 23-15-871 or 23-15-874, shall, upon conviction, be imprisoned in the county jail not more than one (1) year, or be fined not more than Three Thousand Dollars (\$3,000.00), or both”).

26. Missouri

In Missouri, “an employee may take part in the activities of political parties and political campaigns.”¹⁸⁷ However, an employee may not engage in political activity:

(1) while on duty; (2) in any room or building occupied in the discharge of official duties; (3) by utilizing any state resources or facilities; (4) while wearing a uniform or official insignia identifying the office or position of the employee; or (5) when using any vehicle owned or leased by the state or any agency or instrumentality of the state.¹⁸⁸

Moreover, an employee may take part in the activities of political parties and political campaigns except the employee may not:

(1) use the employee’s official authority or influence for the purpose of interfering with the results of an election; (2) knowingly solicit, accept or receive a political contribution from any person who is a subordinate employee of the employee; (3) run for the nomination, or as a candidate for election, to a partisan political office; or (4) knowingly solicit or discourage the participation in any political activity of any person who has an application for any compensation, grant, contract, ruling, license, permit or certificate pending before the employing department of such employee or is the subject of, or a participant in, an ongoing audit, investigation or enforcement action being carried out by the employing department of such employee.¹⁸⁹

Finally, Missouri makes it unlawful for:

[A]ny person to intimidate, threaten, command or coerce any employee of the state to engage or not to engage in any political activity including, but not limited to, voting or refusing to vote for any candidate or measure in any election, making or refusing to make any political contribution, or working or refusing to work on behalf of any candidate. . . Any person who violates the provisions of this section is guilty of a class 3 election offense, which is a misdemeanor punishable by a term of imprisonment for not more than one year and a fine of not more than \$2,500, or both. Any person convicted of a violation of this section shall lose such person’s position in the agency.”¹⁹⁰

187. MO. REV. STAT. § 36.155 (2025).

188. MO. REV. STAT. § 36.157 (2025).

189. MO. REV. STAT. § 36.155 (2025).

190. MO. REV. STAT. § 36.159 (2025).

27. Montana

Under Montana law, state employees may not be “involved in a proceeding before the employing agency that is within the scope of the public officer’s or public employee’s job duties; or [] attempt[] to influence a local, state, or federal proceeding in which the public officer or public employee represents the state or local government.”¹⁹¹ Further, apart from charitable activities, a state employee may not lobby on behalf of an organization or “association of local government officials, of which the public officer or public employee is a member while performing the public officer’s or public employee’s job duties.”¹⁹² Further, state employees may not coerce or command others to support or oppose any candidate or ballot provision nor can a state employee solicit contribution on behalf of any political organization.¹⁹³ The state itself cannot refuse employment to a person, bar a person from employment, or discriminate against a person in compensation or in a term, condition, or privilege of employment because of that person’s political beliefs.¹⁹⁴

28. Nebraska

Nebraska law provides that “[u]nless specifically restricted by a federal law or any other state law, no employee of the state or any political subdivision thereof, shall be prohibited from participating in political activities except during office hours or when otherwise engaged in the performance of his or her official duties.”¹⁹⁵ Additionally, “no such employee shall engage in any political activity while wearing a uniform required by the state or any political subdivision thereof.”¹⁹⁶

29. Nevada

In Nevada, it is unlawful for any person, firm or corporation doing business in the state to make any rule or regulation prohibiting or preventing any employee from engaging in politics or becoming a candidate for any public office.¹⁹⁷ On the other hand, under the Nevada Administrative Code, no employee may directly or indirectly solicit or receive, or be in any manner concerned in soliciting or receiving, any assessment, subscription, monetary or nonmonetary contribution for a political purpose from anyone who is in the same department and who is a subordinate of the solicitor or engage in political activity during the hours of his or her state employment to improve the chances

191. MONT. CODE ANN. § 2-2-121(4) (2025).

192. *Id.* at § 2-2-121(5).

193. MONT. CODE ANN. § 13-35-226 (2025).

194. MONT. CODE ANN. § 49-2-308 (2025).

195. NEB. REV. STAT. § 20-160 (2025); *accord* NEB. REV. STAT. § 81-1315 (2025).

196. *Id.*

197. NEV. REV. STAT. ANN. § 613.040 (2025).

of a political party or a person seeking office, or at any time engage in political activity to secure a preference for a promotion, transfer or increase in pay.¹⁹⁸ Nevada statutes also prohibit political activities of employees of various State agencies including but not limited to: Vocational Rehabilitation Program,¹⁹⁹ Aging and Disability Services Division,²⁰⁰ Services and Facilities For Care of Children,²⁰¹ Nevada Gaming Commission,²⁰² Nevada Gaming Control Board,²⁰³ Cannabis Compliance Board,²⁰⁴ and Commissioner of Insurance.²⁰⁵

30. *New Hampshire*

New Hampshire law prohibits coercion of political contributions. Specifically, the law provides that “[n]o person shall knowingly coerce, or attempt to coerce, any classified state employee to give or withhold a contribution to any political campaign or political committee, or to any candidate, or party or cause, for the purpose of promoting the success or defeat of any candidate or political party.”²⁰⁶ Additionally, the same law prohibits business organizations from coercing, or attempting to coerce, any employee of the business organization or of the enterprise, to make a contribution to any political campaign or political committee, or to any candidate, party or cause, for the purpose of promoting the success or defeat of any candidate or political party.²⁰⁷ Another statute prohibits any recipient of a grant or appropriation of state funds from using the state funds to lobby or attempt to influence legislation, participate in political activity, or contribute funds to any entity engaged in these activities.²⁰⁸ However, notwithstanding these rules, a person employed as a public employee in any capacity shall have a full right to publicly discuss and give opinions as an individual on all matters concerning any government entity and its policies.²⁰⁹

31. *New Jersey*

New Jersey law dictates that people who hold positions in career “or senior executive service shall not directly or indirectly use or seek to use the position to control or affect the political action of another person or engage in political

198. NEV. ADMIN. CODE § 284.770 (2024).

199. NEV. REV. STAT. ANN. § 615.300 (2025).

200. NEV. REV. STAT. ANN. § 427A.120 (2025).

201. NEV. REV. STAT. ANN. § 432A.120 (2025).

202. NEV. REV. STAT. ANN. § 463A.025 (2025).

203. NEV. REV. STAT. ANN. § 463.060 (2025).

204. NEV. REV. STAT. ANN. § 678A.380 (2025).

205. NEV. REV. STAT. ANN. § 679B.020 (2025).

206. N.H. REV. STAT. § 664:4-a (2025).

207. *Id.*

208. N.H. REV. STAT. § 15:5 (2025).

209. N.H. REV. STAT. § 98-E:1 (2025).

activity during working hours.”²¹⁰ New Jersey Administrative Code also specifies that no employee in the career, senior executive, or unclassified services whose principal employment is in connection with a program financed in whole or in part by federal grants or loans, shall engage in any activities prohibited by the federal Hatch Act.²¹¹ However, an appointing authority shall not take or threaten to take any action against an employee in the career service or an employee in the senior executive service with career status based on the employee’s permissible political activities or affiliations.²¹²

32. *New Mexico*

In New Mexico, a public officer is prohibited from coercing or attempting to coerce another public officer or employee to pay, lend or contribute anything of value to a party, organization or person for a political purpose; threatening to deny a promotion or pay increase to an employee who does or does not vote for certain candidates, or violating the employee’s duty not to use property belonging to a state or local government agency or allow its use, for other than authorized purposes.²¹³ Additionally, no person in the personnel office or employee in the service shall hold political office except for a non-partisan county or municipal office or be an officer of a political organization during his employment. Any employee who becomes a candidate for public office shall, upon filing or accepting the nomination and during the campaign, take a leave of absence.²¹⁴ Finally, no person engaged in administering any vocational education or vocational rehabilitation program shall use his official authority or influence to permit the use of the vocational education or vocational rehabilitation program to interfere with any public election or partisan political campaign, nor shall such person take any active part in the management of a political campaign, or participate in any political activity beyond the person’s constitutional rights of voting and of free speech. Moreover, such a person shall not be required to contribute or render service, assistance, subscription, assessment or contribution for any political purpose.²¹⁵ Violation of ethical principles of public service is equivalent to a fourth-degree felony with a sentence of eighteen months imprisonment.²¹⁶

33. *New York*

In New York, state and local social services officials and employees are permitted to engage in political activity except as proscribed, where applicable,

210. N.J. STAT. ANN. § 11A:2-23 (2025).

211. N.J. ADMIN. CODE § 4A:10-1.2 (2025).

212. N.J. ADMIN. CODE § 4A:2-5.1 (2025).

213. N.M. STAT. ANN. 1978 §10-16-3.1(2025); *accord* N.M. ADMIN. CODE. 1.7.6.10 (2025).

214. N.M. STAT. ANN. 1978 § 10-9-21(2025).

215. N.M. STAT. ANN. 1978 § 22-14-14 (2025).

216. N.M. STAT. ANN. 1978 § 10-16-3 (2025).

by the federal Hatch Act and section 107 of the civil service law.²¹⁷ Under this law, no person in the civil service shall: discharge or promote or reduce, or change the official rank or compensation of any other person for giving or withholding or neglecting to make any contribution of money or service or any other valuable thing for any political purpose; use official authority or influences to coerce the political action of any person or body or interfere with any election.²¹⁸ Complaints alleging a violation of the law by a statewide elected official or a state officer or employee are to be directed to the commission on public integrity.²¹⁹ With regards to political questions in employment decisions, New York prohibits asking an applicant during the hiring process, or in other employment decisions, about: (i) their political party affiliation; (ii) whether the applicant has made campaign contributions; or (iii) whether the applicant cast a vote for or against any elected official, candidate, or political party.²²⁰ Furthermore, employees are prohibited from declining to hire or promote, discharge, discipline, or in any manner change the official rank or compensation of any state official or employee, or applicant for employment, or promise or threaten to do so, based upon a refusal to answer any political question.²²¹ State employees are also prohibited from using their authority or influence to “compel or induce” another employee to make political donations.²²² Violations of this law may subject the defendant to a civil penalty in an amount not to exceed \$40,000 and the value of any gift, compensation or benefit received in connection with such violation. A state oversight body acting pursuant to its jurisdiction, may, in lieu of a civil penalty, refer a violation to the appropriate prosecutor and upon such conviction such violation shall be punishable as a class A misdemeanor.²²³

34. *North Carolina*

Under North Carolina law, State employees retain “all the rights and obligations of citizenship provided in the Constitution and laws of the United States and the State of North Carolina.”²²⁴ When a state employee is subject to the North Carolina Human Resources Act, he or she shall not:

(1) Take any active part in managing a campaign, or campaign for political office or otherwise engage in political activity while on duty or within any period of time during which he is expected to perform

217. N.Y. COMP. CODES R. & REGS. tit. 18, § 674.1 (2025).

218. N.Y. CIV. SERV. LAW § 107 (McKinney 2025).

219. *Id.*

220. N.Y. PUB. OFF. LAW § 73(17)(a) (McKinney 2025); *accord* N.Y. COMP. CODES R. & REGS. tit. 22, § 50.5 (2025).

221. N.Y. PUB. OFF. LAW § 73(17)(b) (McKinney 2025).

222. N.Y. PUB. OFF. LAW § 73(17)(c) (McKinney 2025).

223. N.Y. PUB. OFF. LAW § 73(18) (McKinney 2025).

224. N.C. GEN. STAT. § 126-13 (2025).

services for which he receives compensation from the State; (2) Otherwise use the authority of his position, or utilize State funds, supplies or vehicles to secure support for or oppose any candidate, party, or issue in an election involving candidates for office or party nominations, or affect the results thereof.²²⁵

It is also unlawful for a state employee or a person appointed to a state office to coerce another state employee or an applicant for a position within the state to support or contribute to a political candidate, committee or party; or to change the party designation of the individual's voter registration by threatening that change in employment status or discipline or preferential personnel treatment will occur with regard to an individual, or threaten discipline or promise preferential treatment with regard to that person's business with the individual's state office or that person's activities regulated by the individual's state office.²²⁶ Furthermore, heads of any state department, agency, or institution or other state employee exercising supervisory authority are prohibited from making, issuing, or enforcing any rule or policy the effect of which is to interfere with the right of any state employee as an individual to engage in political activity while not on duty or at times during which he is not performing services for which he receives compensation from the State.²²⁷ And like New York, the willful violation of this law is a Class 1 misdemeanor.²²⁸

Regarding local government employees, state board and county board of election members are prohibited from making written or oral statements intended for general distribution or dissemination to the public at large supporting or opposing the nomination or election of one or more clearly identified candidates for public office or a referendum proposal, and from soliciting contributions for a candidate, political committee, or referendum committee.²²⁹

35. *North Dakota*

In North Dakota, "except when on duty or acting in an official capacity and except as otherwise provided by state or federal law, no employee may be prohibited from engaging in political activity or be denied the right to refrain from engaging in such activity."²³⁰ Another law prohibits use of state or political subdivision services or property for political purposes, stating "no person may use any property belonging to or leased by, or any service which is provided to

225. N.C. GEN. STAT. § 126-13 (2025).

226. N.C. GEN. STAT. § 126-14 (2025).

227. N.C. GEN. STAT. § 126-13 (2025).

228. *Id.*

229. N.C. GEN. STAT. § 163.39 (2025).

230. N.D. CENT. CODE ANN. § 34-11.1-02 (2025); *accord* N.D. CENT. CODE ANN. § 44-08-19 (2025) (noting that "[n]o public employee may engage in political activities while on duty or in uniform").

or carried on by, either directly or by contract, the state or any agency, department, bureau, board, commission, or political subdivision thereof, for any political purposes.”²³¹

36. *Ohio*

Under Ohio law, restrictions on political activities of state employees hinge on whether they are classified or non-classified employees.²³² Officers and employees of the state, including those from the “counties, cities, and city school districts of the state, or the civil service townships” are prohibited from “directly or indirectly, orally or by letter, solicit[ing] or receiv[ing], or be in any manner concerned in soliciting or receiving, any assessment, subscription, or contribution for any political party or for any candidate for public office.”²³³ They are also prohibited from soliciting or receiving any payment from any officer or employee in the classified service of the state. Additionally, officers or employees in the classified service may not “be an officer in any political organization or take part in politics other than to vote as the officer or employee pleases and to express freely political opinions.”²³⁴

37. *Oklahoma*

In Oklahoma, no public employee or public official shall directly or indirectly coerce, attempt to coerce, command, advise or direct any state employee to pay, lend or contribute any part of his or her salary or compensation, time, effort or anything else of value to any party, committee, organization, agency or person for political purposes.²³⁵ Additionally, any person convicted of willfully violating the provisions of this section is guilty of a felony and shall be punished by the imposition of a fine of not more than ten thousand dollars or by imprisonment for not longer than two years, or by both fine and imprisonment.²³⁶ Under the Oklahoma Administrative Code, a state employee may not:

- (1) use his or her position for the purpose of interfering with an election to, or a nomination for, office or affecting the result thereof;
- (2) wear a campaign item, such as a button, hat, or badge during the hours he or she is officially in work status for the agency;
- (3) wear items, such as a uniform, badge, or anything that identifies him

231. N.D. CENT. CODE ANN. 16.1-10-02(1) (2025).

232. *See* OHIO ADMIN. CODE. § 123:1-46-02 (2025) (“Employees in the classified service of the state are prohibited by section 124.57 of the Revised Code from engaging in political activity”).

233. OHIO REV. CODE ANN. § 124.57 (2025).

234. *Id.*

235. OKLA. STAT. 21 § 360 (2025).

236. *Id.*

or her as a state employee while engaged in political activity or while campaigning for himself or herself, or any candidate for office;
(4) disseminate, either directly or indirectly, any political commentary, discussion, or advertisement for non-work purposes during the hours he or she is officially in work status for the agency;
(5) campaign for, or on behalf of, any candidate or ballot or election question, during the hours the employee is officially in work status for the agency; or
(6) become a candidate for an elective public office in a partisan election or in which the office has direct or indirect oversight of the agency.²³⁷

State employees whose regular duties include scheduling meetings, activities and events for elected state officers shall not be considered to have violated these rules if, while on duty, they engage in scheduling political activities or events for an elected state officer.²³⁸

38. *Oregon*

In Oregon, a public employee, while on the job during working hours is prohibited from engaging in several activities including: soliciting any money, influence, service or otherwise; promoting or opposing any political committee, appointment of a person to a public office, filing of an initiative, referendum or recall petition, the gathering of signatures on an initiative, referendum or recall petition, or the adoption of a measure or the recall of a public office holder.²³⁹ However, “this section does not restrict the right of a public employee to express personal political views, provided that a reasonable person would not infer that the views represent those of the public employer of the public employee.”²⁴⁰

39. *Pennsylvania*

Pennsylvania prohibits an individual in classified service from taking an active part in political management or in a political campaign. The law prohibits a bevy of political activities including serving as an officer of a political party; directly or indirectly soliciting, or receiving contributions or other money for a partisan political purpose; becoming a candidate or campaigning for an elective public office in a partisan election; serving as a delegate, alternate or proxy to a political party convention; addressing a convention, caucus, rally or similar gathering of a political party; or paying a contribution in the workplace to an employee who is the employer or employing authority of the individual making

237. OKLA. ADMIN. CODE § 340:2-1-4 (2025).

238. OKLA. ETHICS COMM. Rule 2.13.

239. OR. REV. STAT. ANN. § 260.432 (West 2025).

240. *Id.*

the contribution for a political party, political fund or other partisan recipient.²⁴¹ An individual in the classified service who violates this section shall be removed from employment and money appropriated for the position from which the employee was removed may not be used to pay the employee or individual. Alternatively, the Office of Administration may impose a penalty of suspension without pay for not more than 120 working days if the Office of Administration finds that the violation does not warrant termination.²⁴² However, the provisions of this law do not apply to employees who are on furlough, who are on a leave of absence, or who are on a leave covered under the State Employees' Retirement Code.²⁴³

40. Rhode Island

Rhode Island restricts classified employees, during working hours, from engaging in any form of partisan politics except that they may attend and vote at any party caucus, primary, or election held during working hours.²⁴⁴ Outside of working hours, a classified employee may attend any partisan political rally, club, or gathering and privately express his or her partisan political views but any further partisan political activity on his or her part shall be engaged in only in accordance with the personnel rules.²⁴⁵ A classified employee violating these provisions or of the personnel rules shall for a first offense, be either demoted or dismissed and for a second offense dismissed.²⁴⁶ The state further restricts classified employees or members of the personnel appeal board from soliciting contributions for nor shall they be solicited to contribute to any political party or campaign.²⁴⁷

41. South Carolina

In South Carolina, certain employees covered by the federal Hatch Act are prohibited from being candidates for elective office.²⁴⁸ Additionally, the state prohibits public employees from using government personnel or facilities for campaign purposes, although government personnel are permitted to work on campaigns on their own time.²⁴⁹ Likewise, no public official, employee, or committee may accept or collect campaign contributions on the grounds of or

241. 71 PA. CONS. STAT. § 2705 (2025).

242. *Id.*; accord 4 PA. ADMIN. CODE § 613.4 (2025).

243. 4 PA. ADMIN. CODE § 613.3 (2025).

244. 36 R.I. GEN. LAWS 1956 § 36-4-52 (2025).

245. 36 R.I. GEN. LAWS 1956 § 36-4-52 (2025).

246. *Id.*

247. 36 R.I. GEN. LAWS 1956 § 36-4-53 (2025).

248. S.C. Dep't of Admin., Laws, Regulations and Gen. Info., <https://www.admin.sc.gov/services/state-human-resources/hr-resources/laws-regulations-general-information> [https://perma.cc/63N8-FCJN] (last visited Jan. 3, 2026).

249. S.C. CODE ANN. 1976 § 8-13-765 (2025).

in any building which houses the office or residence of a statewide officer.²⁵⁰

42. *South Dakota*

In South Dakota, “employees whose positions are wholly funded by federal loans or grants are restricted from running for partisan office by the Hatch Act.”²⁵¹ Additionally, a civil service employee may not be discriminated against on the basis of political affiliation; required to participate in partisan political activities; or required to contribute to any political funds or collections or render political service.²⁵² Moreover, no instructor, teacher, or other employee of any institution under the jurisdiction of the Board of Regents is subject to loss of job or status on the job for becoming a candidate for any public office, unless the candidacy or public office entails neglect of duty.²⁵³

43. *Tennessee*

Tennessee law prohibits state employees from a plethora of political activities, including but not limited to: soliciting directly or indirectly contributions for political purposes or campaign expenses from persons or entities that are connected to the state or that do business with the state,²⁵⁴ promising state benefits as a reward for political activity,²⁵⁵ depriving or threatening to deprive any person of state benefits because of a person’s or entity’s political activity,²⁵⁶ using state property for campaign advertising or activities,²⁵⁷ and engaging in political activity not directly a part of that person’s employment during any period when the person should be conducting business of the state.²⁵⁸ Additionally, a person holding a position in the preferred service²⁵⁹ is not allowed to solicit, directly or indirectly, or require any other person to solicit, directly or indirectly, donations or contributions for any political party, candidate, cause or purpose in order to acquire or deny a position in state service or to materially affect the retention, promotion or demotion of any employee in state service.²⁶⁰

250. S.C. CODE ANN. 1976 § 8-13-1336 (2025).

251. South Dakota Bureau of Hum. Resources and Admin, State Employee Handbook 1, 12 (07/02/2025) <https://bhraonline.sd.gov/handbook.pdf>

252. S.D. CODIFIED LAWS § 3-6D-5 (2025).

253. S.D. CODIFIED LAWS § 13-49-14.1 (2025).

254. TENN. CODE ANN. § 2-19-203 (2025).

255. TENN. CODE ANN. § 2-19-204 (2025).

256. TENN. CODE ANN. § 2-19-205 (2025).

257. TENN. CODE ANN. § 2-19-206(b) (2025).

258. TENN. CODE ANN. § 2-19-207 (2025).

259. In Tennessee, a preferred service employee is an employee who holds a position in an agency in the state service, in which the employee has successfully completed the initial probationary period. *See* TENN. COMP. R. & REGS. 1120-01-.0 (40) (effective April 17, 2025).

260. TENN. CODE ANN. § 8-30-306(d) (2025).

44. Texas

In Texas, a state officer or employee may not use official authority or influence or permit the use of a program administered by the state agency of which the person is an officer or employee to interfere with or affect the result of an election or nomination of a candidate or to achieve any other political purpose. Additionally, a state employee may not coerce, command, restrict or prevent the payment, loan, or contribution of anything of value to a person or political organization for a political purpose.²⁶¹ Texas law is designed to be fairly permissive, with little or no restrictions on political activities of public employees.²⁶²

45. Utah

In Utah, career service employees may voluntarily participate in political activities subject to certain conditions, for example, if the official is elected to any partisan or full-time nonpartisan political office, he or she is “granted a leave of absence without pay for times when monetary compensation is received for service in political office.”²⁶³ Additionally, no officer or employee in career service may engage in any political activity during the hours of employment, nor may any person solicit political contributions from employees of the executive branch during hours of employment for political purposes.”²⁶⁴ Interestingly, although an employee in a career status may not, while in a pay status, be a state or federal officer in any partisan political party organization or in any statewide partisan political campaign, the employee may be an officer or delegate in a partisan political party organization at a county or inferior level or a delegate at a state or national level.²⁶⁵ Partisan political activity may not be a basis for employment, promotion, demotion, or dismissal, except that the director shall adopt rules providing for the discipline or punishment of a state officer or employee who violates any provision of this section. Finally, any employee who is prevented or restricted from engaging in political activity by the provisions of the federal Hatch Act, is also prohibited from engaging in partisan political activities.²⁶⁶

46. Vermont

There is no specific statute in Vermont dealing with prohibited political

261. TEX. GOV'T CODE ANN. § 556.004 (2025).

262. *See In re Carlisle*, 209 S.W.3d 93, 96 (Tex. 2006) (noting that “any constitutional or statutory provision which restricts the right to hold public office should be strictly construed against ineligibility.”).

263. UTAH CODE ANN. § 63A-17-904(2)(a) (2025).

264. UTAH CODE ANN. § 63A-17-904(2)(b) (2025).

265. UTAH CODE ANN. § 67-5-3 (2025).

266. UTAH CODE ANN. § 63A-17-904 (2025).

activities of state employees. However, according to the Vermont Agency of Administration Policy Manual, an employee may not use his or her official authority or influence for the purpose of interfering with or affecting nomination or election of candidate for political office. Prohibited activities include the use of government funds, facilities or equipment while participating in a political activity; coercing any person to participate in a political activity, soliciting or receiving uncompensated individual services from a subordinate for any political purpose or taking adverse action on the basis of an employee's political affiliations.²⁶⁷ Finally, members of the State Ethics Commission are prohibited from being candidates for state, legislative, or elected judicial office; or holding any office in a state, legislative, or elected judicial office candidate's committee, a political committee, or a political party.²⁶⁸

47. Virginia

Virginia law provides that “no locality shall prohibit an employee of the locality, including firefighters, emergency medical services personnel, or law-enforcement officers within its employment, or deputies, appointees, and employees of local constitutional officers from participating in political activities while these employees are off duty, out of uniform and not on the premises of their employment with the locality.”²⁶⁹ On the other hand, the Virginia Administrative Code prohibits a local department employee from: using the employee's official authority or influence to interfere with or affect the result of a nomination or election to public office or position; directly or indirectly commanding a state or local officer or employee to pay or contribute anything of value to a party, committee, organization, agency, or person for political purposes; or being a candidate for a partisan public elective office in a primary, general, or special election if the salary of the employee is paid completely, directly or indirectly, by loans or grants made by the United States or a federal agency.²⁷⁰

48. Washington

Interestingly, Washington state allows its state employees to participate in political activities, so long as it is not inconsistent with federal law.²⁷¹ The law

267. VT. DEP'T OF HUM. RES., Policy No. 5.7, at 2–3 (2015), https://humanresources.vermont.gov/sites/humanresources/files/documents/Labor_Relations_Policy_EEO/Policy_Procedure_Manual/Number_5.7_POLITICAL_ACTIVITY.pdf [<https://perma.cc/AXW5-2GR4>].

268. VT. STAT. ANN. tit. 3, § 1221(2)(D)–(E) (2025).

269. VA CODE ANN. § 15.2-1512.2(B) (2025).

270. 22 VA. ADMIN CODE § 40-675-210 (2025).

271. See WASH. REV. CODE. ANN. § 42.52.160(4) (2025) (noting that “[f]or persons employed in state agencies or agencies of any political subdivision of the state the operation of which is financed in total or primarily by federal grant-in-aid funds political activity will be regulated by the rules and regulations of the United States civil service commission.”)

provides:

employees of the state or any political subdivision . . . shall have the right to vote and to express their opinions on all political subjects and candidates and to hold any political party office or participate in the management of a partisan, political campaign. Nothing in this section shall prohibit an employee of the state or any political subdivision thereof from participating fully in campaigns relating to constitutional amendments, referendums, initiatives, and issues of a similar character, and for nonpartisan offices.²⁷²

However, the state prohibits any state officer or employee from employing or using any person money, or property under the officer's or employee's official control or direction, or in his or her official custody, for the private benefit or gain of the officer, employee, or another.²⁷³ This statute does not specifically mention the word politics, but it would seem to cover political activities if made for personal gain.

49. West Virginia

In West Virginia, a person may not, in any room or building occupied for the discharge of official duties by any officer or employee of the state or a political subdivision of the state, solicit any contribution of money or other thing of value for any party or political purpose, from any other officer or employee of the federal government, or officer or employee of the state, or a political subdivision of the state. Additionally a person may not promise any employment, position, work, compensation, or other benefit provided for by act of the legislature to any person as consideration, favor or reward for any political activity for the support of or opposition to any candidate, or any political party in any election.²⁷⁴ The law also places limits on political contributions in connection with any campaign for nomination or election to or on behalf of any statewide office.²⁷⁵ Violation of any provision of this section is a misdemeanor and if convicted, the individual shall be fined not more than \$1,000, or confined in jail for not more than one year, or both fined and confined.²⁷⁶

50. Wisconsin

Under Wisconsin law, those involved in classified civil service may not

272. WASH. REV. CODE. ANN. § 41.06.250 (2025).

273. WASH. REV. CODE. ANN. § 42.52.160 (2025); *accord* WASH. ADMIN. CODE § 292-110-010 (2025).

274. W. VA. CODE. § 3-8-12 (2025).

275. *Id.*

276. *Id.*

directly or indirectly solicit or receive any “contributions for any partisan political party or any political purpose while on state time or engaged in official duties as an employee.”²⁷⁷ They cannot orally or by letter while on state time or acting in official duties as an employee solicit “to a state office or be in any manner concerned in soliciting any assistance, subscription, or support for any partisan political party or purpose from any person holding any position in the classified civil service.”²⁷⁸ While on duty, they are not allowed to engage in any form of political activity calculated to favor or improve the chances of any political party or any person seeking or attempting to hold partisan political office, nor engage in any political activity when not on duty to such an extent that the person’s efficiency during working hours will be impaired or that he or she will be tardy or absent from work.²⁷⁹ If those engaged in classified civil service violate any of the above stated limitations it is enough for there to be “adequate grounds for dismissal.”²⁸⁰ If a member of the “classified service declares an intention to run for partisan political office” they are “placed on a leave of absence for the duration of the election campaign and if elected shall separate from the classified service on assuming the duties and responsibilities of such office.”²⁸¹ From a practical standpoint, there is only one significant difference between the provisions of the federal Hatch Act and Wisconsin law. While employees subject to the Hatch Act are prohibited from running for partisan political office, even if they are on annual leave or a leave of absence, Wisconsin law, on the other hand, allows such employees to run for political office while on a leave of absence for the duration of the election campaign and if elected, must be separated from service on assuming the duties and responsibilities of the elected office.²⁸²

51. Wyoming

Under Wyoming law, public officials, members, or employees are not allowed to “use public funds, time, personnel, facilities, or equipment for political or campaign activity.” The exceptions is when the “use is (i) [a]uthorized by law or (ii) [pr]operly incidental to another activity required or authorized by law and the public official, public employee or public member allocates and reimburses the governmental entity for any additional costs incurred for that portion of the activity not required or authorized by law.”²⁸³

277. WIS. STAT. § 230.40 (2025). *See also* WIS. STAT. § 11.1207 (2025) (restricting political solicitation involving public officials and employees).

278. WIS. STAT. § 230.40(1) (2025).

279. *Id.*

280. *Id.*

281. *Id.*

282. *See* Bulletin from Stacey Rolston, Deputy Administrator and Acting Director, on State Employee Political Activity, Locator No. DPM-0433-MRS (Oct. 10, 2016), <https://dpm.wi.gov/Bulletins/DPM-0433-MRS.pdf> [<https://perma.cc/8Q9J-EP8L>].

283. WYO. STAT. ANN. § 9-13-105(b)(i)–(ii) (2025).

IV. ANALYSIS AND IMPLICATIONS FOR PUBLIC HEALTH POLICY

It is evident that the State Hatch Acts prohibit a wide range of partisan political activities,²⁸⁴ from running for office, campaigning, promoting candidates to soliciting campaign funds. Many of the statutes prohibit the use of one's position to coerce or influence the political activities of others;²⁸⁵ using official authority to secure or deny employment to others based on their political views;²⁸⁶ influence or attempt to influence legislation or state ballot measures;²⁸⁷ or use any government facility or property for private business purposes including campaign activities.²⁸⁸ Some states such as Alabama,²⁸⁹ California,²⁹⁰ Hawaii,²⁹¹ Michigan,²⁹² Missouri²⁹³, Nebraska²⁹⁴, Nevada²⁹⁵, North Dakota²⁹⁶ and Washington²⁹⁷ do not expressly prohibit their public employees from participating in partisan political activities while in office. Others like Louisiana,²⁹⁸ Mississippi,²⁹⁹ and Tennessee³⁰⁰ are very strict, prohibiting their public employees from active engagement in partisan political activities with little or no exceptions. States also differ in their enforcement mechanisms. The sanctions for violation of the laws range from administrative dismissal,³⁰¹ suspension³⁰² fines,³⁰³ demotion or reduction in salary,³⁰⁴ and or criminal

284. Gely & Chandler, *supra* note 4, at 791.

285. *See e.g.*, Arizona, Connecticut, Florida, Georgia, Idaho, Kansas, Kentucky, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, New York, Oklahoma, Texas,

286. *See e.g.*, ALA. CODE 1975 § 45-37-121.22 (2025); CAL. GOV'T CODE § 3204 (2025); N.M. STAT. ANN. 1978 §10-16-3.1(2025).

287. *See e.g.*, LA. REV. STAT. 25:56 (2018); MONT. CODE ANN. § 13-35-226 (2025); N.H. REV. STAT. § 15:5 (2025).

288. *See e.g.* HAW. ADMIN. CODE. § 21-7-10 (2020); 5 ILL COMP. STAT. § 430/5-15 (2025); 5 MAINE. REV. STAT. ANN. § 7056-A (2025); MD. CODE. GEN. PROVIS., § 5-506 (MD 2025).

289. ALA. CODE §17-1-4 (2025).

290. Cal. Govt. Code. § 3203 (2025).

291. HAW. REV. STAT. § 84-35.5 (2025).

292. MICH. COMP. LAWS § 15.402 (2025).

293. MO. Rev. Stat. § 36.155 (2025).

294. NEB. REV. STAT. § 20-160 (2024).

295. NEV. REV. STAT. § 613.040 (2025).

296. N.D. CENT. CODE. § 34-11.1-02 (2025).

297. WASH. REV. CODE. § 42.52.160(4) (2025).

298. LA. CONST. art. X, § 9.

299. MISS. CODE ANN. § 23-15-871 (2025).

300. TENN. CODE. ANN. § 2-19-207 (2024).

301. *See e.g.*, 71 PA. CONST. STAT. § 2705.0 (2025); WIS. STAT. § 230.40 (2024).

302. *See e.g.* ARIZ. REV. STAT. ANN. § 41-752(G) (2025) (providing that "An employee who violates any of the provisions of this section is subject to suspension of not less than thirty days or dismissal").

303. *See e.g.*, W. VA. CODE § 3-8-12 (2025).

304. NEB. REV. STAT. § 81-1315 (2025) ("Any employee violating this section shall be subject to disciplinary action. . . Such disciplinary action may include demotion, dismissal, reduction of salary, or suspension").

prosecutions.³⁰⁵ A few states have no penalties listed in their statutes.³⁰⁶

Although the twists and turns of the State Hatch Acts are manifold, there are similarities in form and function. As noted above, many of them prohibit “(1) using official authority or influence to interfere or affect the results of an election; (2) soliciting financial or manpower contributions from any political organization or candidate; (3) campaigning for partisan positions in government; and (4) engaging in political activities while on duty, in uniform, or on government property.”³⁰⁷ Many states apply these restrictions only to classified employees,³⁰⁸ while exempting others such as elected officials,³⁰⁹ employees whose functions are not connected with federally funded programs or employees of the legislative branch.³¹⁰

The State Hatch Acts can have significant influence on public health policy. In 2014, researchers estimated the governmental public health workforce to be approximately 290,000.³¹¹ Previous enumeration efforts estimated 450,000 public health workers in governmental and voluntary agencies in 2000, and 326,602 governmental public health workers in 2012.³¹² This means most, if not all, of these workers are impacted by the State Hatch Acts.

But even though the State Hatch Acts are meant to restrict politics in public service, they are unlikely to depoliticize public health practice and policy for the following reasons. First, although the Hatch Acts are supposed to ensure that government programs are administered in a nonpartisan way, many state and local boards of health leaders are appointed by the governor, legislative leaders, or elected officials.³¹³ That means many of these leaders are likely to be under pressure to follow or implement the political ideologies of their appointing authorities rather than focus on evidence based public health measures. Case in point, a Florida public health official was put on leave after he had emailed his staff citing the low COVID-19 vaccines rates and urging them to get

305. See e.g., MISS. CODE. § 97-13-37 (2025); 21 OKL. STAT. § 360 (2025); N. M. Stat. Ann. 1978, § 10-16-3 (2025).

306. See e.g., HAW. REV. STAT. § 84-35.5 (2025); N.H. REV. STAT. § 664:4-a; N.D. Cent. Code § 44-08-19(2025).

307. Gely & Chandler, *supra* note 4, at 791.

308. See e.g., CONN. GEN. STAT. § 5-196(6) (2025); DEL. CODE ANN. tit. 29, §5954(b) (2025); 71 PA. CONS. STAT. § 2103 (2025).

309. TENN. CODE ANN. § 2-19-201(3) (2025).

310. See FLA. STAT. § 110.205 (2)(b) (2025) (exempting “[a]ll members, officers, and employees of the legislative branch, except for the members, officers, and employees of the Florida Public Service Commission.”).

311. Angela Beck et al., *Enumeration of the Governmental Public Health Workforce*, 47 AM. J. PREV. MED. 306, 306–13 (2014).

312. *Id.*

313. See e.g., *Boards, Councils, and Committees*, FLA. HEALTH, <https://www.floridahealth.gov/%5C/provider-and-partner-resources/advisory-councils-stakeholder-groups/index.html> [https://perma.cc/UF7M-XRZY] (last visited Jan. 1, 2026) (“Appointments vary by board, council, or committee and may be made by the Governor, Speaker of the House, President of the Senate, State Surgeon General, and other state agencies and organizations as specified by state or federal law.”).

vaccinated.³¹⁴ As noted in Part II of this article, the entanglement of public health officials with partisan political issues is palpable at the state level.³¹⁵ Moreover, as a result of the COVID-19 pandemic, we're now living in a rapidly changing public health and policy environment. Public distrust and disenchantment with the roles and utility of public health officials has increased.³¹⁶ As new mask mandates surfaced,³¹⁷ lock downs ensued,³¹⁸ and the introduction of the COVID vaccine³¹⁹ and its progeny became compulsory, what were once viewed as evidence-based policies intended for public health and safety, became dramatized political rhetoric leading some to indulge in conspiracy theories, falsehoods, and political biases rather than take advice from public health experts.³²⁰ Given that political partisanship and polarization permeates through the core of American society today, the principle of "you're either with us or against us" approach perpetuated by the two-party system has caused political alignments that may lead to negative effects on public health and policy.³²¹

Second, just like the federal act, the State Hatch Acts are no models of clarity.³²² Although they are meant to restrict the political activities of state employees, some don't even define what political activities are, or when they

314. Amir Vera et al., *Florida Health Official Sent an Email Calling Out His Unvaccinated Colleagues. He's Now on Administrative Leave*, CNN (Jan 19, 2022, 10:37 PM), <https://www.cnn.com/2022/01/19/us/orange-county-florida-health-director-email-leave>.

315. See *supra* Part III.

316. See Jack Leslie, *The Crisis of Trust in Public Health*, THINK GLOBAL HEALTH (Feb. 14, 2023), <https://www.thinkglobalhealth.org/article/crisis-trust-public-health> [<https://perma.cc/CF4Y-UV7N>] (noting that "...there is clear evidence that trust is declining—and during the COVID-19 pandemic, trust dropped significantly.").

317. Deborah Netburn, *A timeline of the CDC's advice on face masks*, L.A. TIMES (July 27, 2021), <https://www.latimes.com/science/story/2021-07-27/timeline-cdc-mask-guidance-during-covid-19-pandemic> [<https://perma.cc/Q5TJ-9SG9>].

318. Jiachuan Wu et al., *Stay-at-home orders across the country*, NBC NEWS, <https://www.nbcnews.com/health/health-news/here-are-stay-home-orders-across-country-n1168736> [<https://perma.cc/2T7U-E37M>] (last updated Apr. 29, 2020).

319. *State Efforts to Limit or Enforce COVID-19 Vaccine Mandates*, NAT'L ACAD. FOR STATE HEALTH POL'Y, <https://nashp.org/state-tracker/state-efforts-to-ban-or-enforce-covid-19-vaccine-mandates-and-passports/> [<https://perma.cc/48DY-5AXV>] (last updated Mar. 5, 2021).

320. Leslie, *supra* note 316 (noting that "About a third of the American public espouses conservative populist views rooted in anti-elitism, and in the United States, there is a large cohort of people predisposed not to believe advice from medical experts.").

321. See Farzana Kapadia, *Polarization, Partisanship, and Political Alignment Threaten Public Health: A Public Health of Consequence*, OCTOBER 2024, 114 AM. J. PUB. HEALTH, 974, 974-76 (2024) (noting that "A conservative political alignment following the November 2024 elections could prompt legislative and policy changes with significantly harmful effects on population health and well-being in the United States.").

322. Christopher Ligatti, *Everybody Knows: Amending the Hatch Act to End the Legal Fiction that Presidential Appointees are Apolitical*, 73 DEPAUL L. REV. 1, 9 (2023) (noting that "[t]he Hatch Act itself is not model of clarity. The definition of political activity and the distinction between acting in an official or personal capacity is not entirely clear.").

do, the definitions are either fairly broad,³²³ or utterly restrictive.³²⁴ In fact, one of the most prevalent attacks on state statutes or local governmental enactments restricting political activities of public officers and employees is that the statutes are so vague as to not fully apprise the officer or employee of exactly what conduct is proscribed.³²⁵ Moreover, many limit the ban to employees in “classified service only” but unsurprisingly, states define classified service differently.³²⁶ This, of course, creates a patch work of restrictions on different groups of public employees all over the nation. The prospect of confusion is not beyond fanciful.

Third, the lack of enforcement mechanism in some of these statutes essentially renders them advisory. In comparison, at the federal level, enforcement of the Hatch Act is carried out by the Office of Special Counsel (“OSC”).³²⁷ A federal employee who violates the act is subject to disciplinary action consisting of removal, reduction in grade, debarment from federal employment for a period not to exceed 5 years, suspension, or reprimand; an assessment of a civil penalty not to exceed \$1,000; or any combination of the penalties described in the law.³²⁸ On the other hand, the deterrent effect of the State Hatch Acts that do not have enforcement sections, is unknown. So where do we go from here?

V. SUGGESTIONS FOR THE FUTURE

“The backlash against public health and ongoing politicization of public health means that the path forward for both public health leaders and the workforce is complex.”³²⁹ Nevertheless, a few suggestions are still in order. First, a number of commentators have called for public health practitioners to

323. See e.g. D.C. CODE § 1-1171.03(c) (2025) (providing “[f]or the purposes of this section, the term ‘political activity’ is not limited to activities regulated by the District and includes soliciting, accepting, receiving, or making political contributions or *other political activities*.” (emphasis added)).

324. See N.Y. LAB. LAW § 201-d(1)(a) (“Political activities shall mean (i) running for public office, (ii) campaigning for a candidate for public office, or (iii) participating in fund-raising activities for the benefit of a candidate, political party or political advocacy group”).

325. See Francis Dougherty, *Validity, Construction and Effect of State Statutes Restricting Political Activities*, 51 A.L.R.4th 702 (last updated Dec. 30, 2025).

326. See 71 PA. CONST. STAT. § 2103 (2025) (defining classified service as a position filled under the merit system of employment; CONN. GEN. STAT. § 5-196(6) (“[E]very office or position in the state service, whether full-time or part-time, for which compensation is paid, except those offices and positions specified in section 5-198 or otherwise expressly provided by statute); ALA. CODE § 36-26-10(d) (2025) (“[T]he classified service shall include all other officers and positions in the state service except as to services denominated as exempt or unclassified services . . . the Governor shall have the power by executive order to extend the provisions of this article to include additional positions or classes of positions.”).

327. U.S. OFF. SPECIAL COUNS., *supra* note 52.

328. 5 U.S.C. § 7326.

329. Valerie Yeager, *The Politicization of Public Health and the Impact on Health Officials and the Workforce: Charting a Path Forward*, 112 AM. J. PUBLIC HEALTH 734, 734–35 (2022).

actively get involved in politics. I call this the “if you can’t beat them, join them” school of thought. Researchers at the Boston University School of Public Health examined how many state legislators have degrees in public health, including graduate and undergraduate. They found that less than 0.3 percent of the 7,383 state legislators making decisions with important public health implications have formal training in public health.³³⁰ They note that “as with most fields striving to be recognized as science, there is a concern that directly engaging in legislative policy making risks undermining the integrity and credibility of research”³³¹ However, the researchers aver that there is room for more people from public health to step into the political arena without undermining the credibility of good science.³³² Others argue that “[i]f more public health leaders become involved in politics, new policies can be created based on their knowledge and expertise.”³³³

This author mostly agrees with this school of thought because “for the most part, public health officials don’t talk to state legislators, county executives, city council members or mayors,”³³⁴ That means public health practitioners are not at the table when decisions are being made, or they cannot push back effectively when their work is undermined by rampant misinformation and disinformation.³³⁵ By eschewing the political arena, public health workers cede the ground to conspiracy theorists, anti-vaccination and anti-science groups.³³⁶ But getting involved in partisan politics comes with its own sword of Damocles. The involvement of public health officials in politics creates a dangerous conflict of interest as it encourages political ideology to infect and taint the

330. David K. Jones et al., *More Public Health Leaders Should Run for Office*, 27(1) J. PUB. HEALTH MGMT. PRAC. 1 (2021).

331. *Id.*

332. *Id.*

333. Sarah Handzel, *Why public health leaders should run for office*, WOLTERS KLUWER (Mar. 1, 2021), <https://www.wolterskluwer.com/en/expert-insights/public-health-leaders-running-office> [<https://perma.cc/N5XK-RPGS>].

334. Carl Smith, *Public Health Needs a Political Strategy, Not Just Funding*, GOVERNING (Jan. 14, 2023), <https://www.governing.com/work/public-health-needs-a-political-strategy-not-just-funding> [<https://perma.cc/WGY8-7CUB>].

335. See, e.g., Anne Beckett et al., *Misusing Public Health as a Pretext to End Asylum — Title 42*, 386 NEW ENG. J. MED. 1491, 1491 (2022) (noting that “[t]he deployment of unfounded public health arguments for political ends tarnishes the CDC’s reputation, at a time when public trust in science and medical evidence is already undermined by rampant misinformation and disinformation”).

336. These terms are not used in a pejorative way. Rather, they are meant to illustrate the danger of ceding ground to misinformation and distortions of scientific facts. See, e.g., Ayelet Evrony & Arthur Caplan, *The overlooked dangers of anti-vaccination groups’ social media presence*, 13 HUM VACCINES IMMUNOTHERAPEUTICS 1475, 1475–76 (2017) (noting that “[t]here is also growing concern that false and misleading claims about science and public health are having significant impact on politics and policy in the U.S. A Voice for Choice is an example of how an anti-vaccination group can harness the power of social media to promote uncorroborated claims that engender fear.”).

decision making of public health officials.³³⁷ Indeed in *Garcetti v. Ceballos*, the U.S. Supreme Court observed that “[p]ublic employees . . . often occupy trusted positions in society. When they speak out, they can express views that contravene policies or impair the proper performance of governmental functions.”³³⁸ This contravention of policies or impairment of government functions is exactly what the federal and state Hatch Acts were meant to prevent.³³⁹ Nevertheless, given all the considerations discussed above, it is better for public health to be at the table than not at the table.

Second, assuming, arguendo, that the “if you can’t beat them, join them” school of thought is impracticable, another option maybe be to decouple politics from public health.³⁴⁰ This, of course, would be the ideal solution, but it may be naïve to think that this can be truly done, since in many ways, public health is always political.³⁴¹ However, we can try. As one commentator observed “[w]ill science ever completely outweigh polarizing politics and people’s own loyalties, fixed ideas, and fears? It never has and it probably never will, but that doesn’t mean we can’t make strides in that direction with the aim of creating better health outcomes for individuals and communities.”³⁴² Just because politics is inextricably linked with public health policy does not mean we should insist upon keeping it that way. That is, public health practitioners should not sit back and wait for a political blood bath to descend before taking action. It is okay to try to decouple. One way to reduce the impact of politics in public health is to refrain from advocating purely political positions.³⁴³

337. See Gely & Chandler, *supra* note 4, at 777 (noting that “[o]n the one hand, the dangers associated with allowing politics to interfere in the delivery of public services have been clearly recognized. . .”).

338. *Garcetti v. Ceballos*, 547 U.S. 410, 418–19 (2006).

339. See generally *U.S. Civil Service Comm. v. Nat’l Ass’n of Letter Carriers*, 413 U.S. 548, 597 (1973) (Douglas, J. dissenting) (“But it is of no concern of Government what an employee does in his spare time, whether religion, recreation, social work, or politics is his hobby—unless what he does impairs efficiency or other facets of the merits of his job.”).

340. See Edward L. Hunter, *Politics and Public Health—Engaging the Third Rail*, 22 J. PUB. HEALTH MGMT. & PRAC. 436 (2016) (noting that “Among professionals in public health, the political system is commonly viewed as a subway’s third rail: avoid touching it, lest you get burned”).

341. Travis Bias, *Public Health Is Always Political*, THINK GLOBAL HEALTH (May 5, 2020), <https://www.thinkglobalhealth.org/article/public-health-always-political> [<https://perma.cc/5M6D-LMT9>].

342. Bernhardt, *supra* note 2.

343. Case in point is Florida’s Surgeon General, Dr. Joseph Ladapo, who appeared at a New Hampshire campaign rally to support Florida Governor Ron DeSantis’ candidacy for the Republican primary. See Kimberly Leonard, *Ladapo campaigns with DeSantis in New Hampshire*, POLITICO (Nov. 1, 2023, 7:04 AM), <https://www.politico.com/newsletters/florida-playbook/2023/11/01/ladapo-campaigns-with-desantis-in-new-hampshire-00124681> [<https://perma.cc/NC7E-VLG9>] (noting that “[i]t’s unusual for a government official to appear at a campaign event for his boss’ presidential bid”); see also Robert M. Califf, *Letter to Joseph A. Ladapo, M.D., Ph.D., State Surgeon General, Fla. Dep’t of Health*, U.S. FOOD & DRUG ADMIN. & CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 10, 2023), <https://www.cdc.gov/media/>

Third, is better communication. It has been widely acknowledged that during the pandemic, public health leaders bungled communication with the public about what should or should not be done.³⁴⁴ Some people were told that vaccines were a cure for COVID-19, rather than a means of preventing viral and bacterial diseases by boosting the body's natural immune responses. So, when those who were vaccinated still got COVID-19, some concluded that vaccines did not work. This may have led to a distrust of the public health system.³⁴⁵ For example, during the pandemic, despite ample studies that showed vaccine effectiveness, many conservatives said they did not believe the public health orders were effective in saving lives.³⁴⁶ This could have been avoided through better messaging.

Many a times, what we deem as politicization of public health maybe borne of the failure of public health practitioners to communicate effectively with the public regarding the efficacy of public health measures “Public health advocates often do not present their arguments in the same terms as others who seek political influence.”³⁴⁷ Better messaging requires an understanding of those who push back against public health measures, and why they do so. Public health practitioners have often viewed those opposed to public health measures as uneducated, uninformed, antivaxxers, or conspiracy theorists.³⁴⁸ But this is not always the case. Sometimes people have reasonable grounds for opposing public

pdf/releases/2023/CDC-FDA-Letter-to-FL-Dept-of-Health-03.10.2023.pdf [https://perma.cc/F93C-855T] (responding to Florida Surgeon General Joseph Ladapo's misinformation on vaccines and warning that “[m]isleading people by overstating the risks, or emphasizing the risks without acknowledging the overwhelming benefits, unnecessarily causes vaccine hesitation and puts people at risk of death or serious illness that could have been prevented by timely vaccination”).

344. See e.g., Erika Edwards, *How the CDC's communication failures during Covid tarnished the agency*, NBC NEWS (Oct. 1, 2022, 5:29 AM), <https://www.nbcnews.com/health/health-news/cdcs-communication-failures-covid-tarnished-agency-rcna46425> [https://perma.cc/9A7X-4HUF] (noting that “[p]roblems communicating guidance continued. The agency later flip-flopped on critical advice for the public, such as when people should wear masks, who should be tested after a Covid exposure and how the virus spreads.”).

345. See e.g., Katy Evans & Emma Dewhurst, *Communicating About Public Health in Turbulent Times*, DE BEAUMONT (Apr. 17, 2025), <https://debeaumont.org/news/2025/communicating-about-public-health-in-turbulent-times/> [https://perma.cc/5GMZ-6B3B] (noting that “The United States is facing a crisis of understanding, trust, and confidence in public health institutions and guidance, fueled by misinformation and politicization — and weak communication is at the core of these challenges”).

346. See Lauren Weber, *Covid backlash hobbles public health and future pandemic response*, WASH. POST (Mar. 8, 2023), <https://www.washingtonpost.com/health/2023/03/08/covid-public-health-backlash/> [https://perma.cc/DA7D-R86C] (noting that “many conservatives said they did not believe the public health orders were effective in saving lives, despite evidence to the contrary.”).

347. Hunter, *supra* note 340, at 437.

348. See Dr. A. v. Hochul, 142 S. Ct. 552, 553 (2021) (Gorsuch, J. dissenting) (noting that “[t]hese applicants are not [‘]anti-vaxxers[‘] who object to all vaccines.”).

health measures, be it political, religious or personal (fear or anger).³⁴⁹ A little understanding from public health practitioners may go a long way in assuaging their fears. Put succinctly, unscientific skepticism should be addressed with understanding and civility, not derision, animosity or expressions of incredulity.

VI. CONCLUSION

This article presents a fascinating discussion of an important question and nicely illuminates the conflicting considerations that lie at the heart of the debate over whether public health officials should get involved in partisan political activities. The article avers that the involvement of public health officials in politics at the state and federal level does not portend well for the health of the nation. Nevertheless, there is some value in public health officials getting actively engaged in politics. This is because “[p]olitics, for better or worse, plays a critical role in health affairs”³⁵⁰ A review of both the federal Hatch Act and the equivalent State Hatch Acts in the fifty states reveals that although some are more robust than others, they are unlikely to depoliticize public health practice either because many public health leaders serve as political appointees of the governor and are under pressure to conform with the administration’s political agendas. Additionally, some of the Hatch Acts are overly permissive or lack enforcement mechanisms. The comprehensive fifty state survey is particularly valuable and provides much-needed empirical data on this underexplored area of public health law. The article concludes by making three straight forward recommendations, namely, active involvement in political activities by public health workers where permissible, or in the alternative decoupling politics from public health, and finally, better communication with the public during a health crisis.

349. *Id.* at 559 (Gorsuch, J. dissenting) (noting “[t]oday, our Nation faces not a world war but a pandemic. Like wars, though, pandemics often produce demanding new social rules aimed at protecting collective interests—and with those rules can come fear and anger at individuals unable to conform for religious reasons”).

350. See Thomas R. Oliver, *The Politics of Public Health Policy*, 27 ANN. REV. PUB. HEALTH 195 (2006).

IMPROVING JUSTICE FOR CRIMINAL DEFENDANTS WITH SERIOUS MENTAL ILLNESSES: THREE STEPS INDIANA'S JUDICIARY SHOULD TAKE

PAUL D. MATHIAS* & JONATHAN B. WARNER**

Synopsis: Indiana is in the midst of a mental-health crisis, with a lack of community resources available to meet the needs of Hoosiers. Because of this, a disproportionate number of Hoosiers with serious mental illnesses become involved in the criminal justice system every year, a substantial number of whom may well have lacked the ability to form the requisite culpability for a charged criminal offense. To improve the identification of, monitoring and treatment of, and access to justice for these Hoosiers, this Article recommends that Indiana's judiciary: (1) use a freely available, one-page medical instrument at the initial hearing with a criminal defendant to assess whether he or she may suffer from a serious mental illness; (2) establish standards to allow Indiana probation officers to become qualified mental-health specialists within their departments so they may better supervise criminal defendants with mental-health needs and assist jail staff and others pending trial; and (3) reconsider and clarify appellate review of a fact-finder's rejection of an insanity defense when there is nonconflicting, credible expert testimony in support of the defense.

I. TABLE OF CONTENTS

- I. Table of Contents
- II. Introduction
- III. Current Statistics of Serious Mental Illnesses Among Indiana Offenders
 - A. Current Court Treatment of Indiana Criminal Defendants with Serious Mental Illnesses
 - B. Stakeholders Across the Political Spectrum, Across All Branches of Government, and Across all Levels of Government Plead for Community Investment
 - C. Indiana's Process for Criminal Defendants with Serious Mental Illnesses
- IV. Recommendations for Identification of Criminal Defendants with Serious Mental Illnesses; for Reduction of the Cost of Safely Treating Them; and to Improve Their Outcomes in Indiana's Criminal Justice System
 - A. Amend Indiana Criminal Rule 2.3 to Require Judicial Officers at an Initial Hearing to Administer a Peer-Reviewed Mental-Health Screening Instrument to Defendants
 - 1. Indiana's Current Initial Hearing Procedures Under

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Indiana Criminal Rule 2.3

2. *Judicial Officers Are Already Required to Ask Defendants Meaningful Questions at Initial Hearings*
3. *Adding a Brief Mental Health colloquy with the Defendant Would Be Easy and Effective*

B. Amend Criminal Rule 2.3 to Require Judicial Officers to Administer the BJMHS

C. Strengthen Mid-Stream Monitoring and Care by Enabling Indiana Probation Officers to Become Mental-Health Specialists

D. Back-End Review: Reconsider the Role of Appellate Review of Rejected Insanity Defenses

1. *Essential foundations*
2. *Cate and Barany: Our Supreme Court Allows Juries to Reject Unanimous Expert Testimony Based on Behavior That Fleetinglly Appears Rational*
3. *Gambill and Thompson: Our Supreme Court Allows Juries to Find That the Experts Have Been “Fooled”*
4. *Interlude: The Court of Appeals Questions Barany, and a Plurality of the Justices of our Supreme Court Take Note*
5. *Galloway v. State: Our Supreme Court Reconsiders the Probative Value of Apparently Rational Demeanor Evidence*
6. *Myers and Barcroft: Our Supreme Court Reads Galloway Narrowly*
7. *Payne v. State: Our Supreme Court Gives Preferred Status to Defendants with a Well-Documented Medical History in Support of an Insanity Defense*
8. *Reconsidering Appellate Review of Rejected Insanity Defenses*

V. Conclusion

II. INTRODUCTION

Indiana is in the midst of a mental-health crisis,¹ and Indiana’s criminal justice system, a system that is “antitherapeutic for most patients whose serious mental disorders prevent them from being able to control their behaviors,”² has

1. Suzanne Crouch, *Indiana must address its lack of behavior health beds—lives depend on it*, IND. CAP. CHRON. (Apr. 10, 2025), <https://indianacapitalchronicle.com/2025/04/10/indiana-must-address-its-behavioral-health-bed-shortage-lives-depend-on-it/> [https://perma.cc/AQ9F-YUL9].

2. Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U.L. REV. 1169, 1184 (1997). (As Dr. Miller explains: “mentally disordered inmates are at a significant disadvantage in correctional facilities. Their behavior exposes them to ridicule at best and abuse at worst, both from other

become the de facto repository for many Hoosiers who suffer from serious mental illnesses.³ Stakeholders throughout Indiana have brought to light, repeatedly, not just the prevalence of serious mental illnesses among Indiana's general population, but also the disproportionate prevalence of those same illnesses in our prison populations.⁴

The disproportionate prevalence of serious mental illnesses within our prison populations is an outcome of the lack of political and popular will to allocate already scarce resources into our local communities to treat mental illnesses.⁵ This lack of community resources makes Hoosiers with serious mental illnesses more likely to come into contact with the criminal justice system, but Indiana's judiciary is generally focused on what the law refers to, confusingly, as the defendant's "competency," *i.e.*, his ability to understand the judicial process and to assist his counsel at trial.⁶ And, when defendants with

inmates and from guards. They are frequently placed in maximum security facilities, are systematically denied placements at minimum security facilities, and are denied the opportunity to reduce their sentences significantly by participation" in credit-time programs. *Id.* Dr. Miller further notes that the placement of mentally disordered persons "in correctional facilities drastically compromises continuity of care for such persons." *Id.* Dr. Miller notes that changes to the civil commitment process in many states, including in Indiana, to require an overt showing of dangerousness to support an order of involuntary commitment has resulted in "large numbers of mentally disordered persons . . . being jailed" for offenses that historically "would have led to hospitalization..." *Id.* at 1183; *see also* IND. CODE §§ 12-26-5-0.5(c)(2), 5-1(c)(1), 6-1, 7-1 (2024). Moreover, potentially compounding matters in Indiana is the fact that the Indiana Department of Correction has, at least in part, relied on for-profit contractors for medical care of inmates, and the profit motives of those contractors might not align with providing inmates with quality medical care; *see, e.g.*, *Williams v. Ind. Dep't of Corr.*, 142 N.E.3d 986, 1005–06 (Ind. Ct. App. 2020) (holding that an inmate's for-profit care providers provided "systemic and gross deficiencies in her medical care throughout her incarceration, which deficiencies [her estate's] expert directly connected to her cause of death"), *aff'd on reh'g*, 142 N.E.3d 1009, 1009–10 (2020).

3. *See, e.g.*, JAIL OVERCROWDING TASK FORCE, 2019 REPORT 1, <https://www.in.gov/courts/iocs/files/jail-overcrowding-report.pdf> [<https://perma.cc/QY2J-E7VJ>] (last visited Nov. 15, 2025).

4. *See* Hannah Price, *Shattered Brains in Shackles: The Future of Mentally Ill Defendants Following Kahler v. Kansas*, 55 IND. L. REV. 831, 839–41 (2022).

5. *Id.* at 837.

6. As Judge Mathias has frequently observed, there is a "clear failure . . . of our criminal justice system to adequately and properly respond to and treat those with mental health issues" *Wampler v. State*, 67 N.E.3d 633, 634 (Ind. 2017) (quoting *Wampler v. State*, 57 N.E.3d 884, 890 (Ind. Ct. App. 2016) (Mathias, J., dissenting)). (In particular, there is a "large and ironic lapse in the logic of our criminal justice system" in which the "initial imperative is to determine the competency of defendants prospectively, to assist counsel at trial," rather than to determine whether the defendant was capable of forming a culpable mens rea at the time the crime was committed. *Habibzadah v. State*, 904 N.E.2d 367, 370–71 (Ind. Ct. App. 2009) (Mathias, J., concurring), *trans. denied*; *See also* *A.J. v. Logansport State Hosp.*, 956 N.E.2d 96, 117–18 (Ind. Ct. App. 2011) (Mathias, J., concurring); *Gross v. State*, 41 N.E.3d 1043, 1051–52 (Ind. Ct. App. 2015) (Mathias, J., concurring); *Robinson v. State*, 53 N.E.3d 1236, 1243–44 (Ind. Ct. App. 2016) (Mathias, J., concurring), *trans. denied* (all citing *Habibzadah*) ("[O]ur criminal procedure should permit a psychiatric examination of a defendant who likely suffers from serious mental illness

serious mental illnesses go to trial, the issue of their legal sanity or other mental state at the time of the offense will be adjudicated well after the fact, often by a number of years,⁷ and typically by fact-finders who are predisposed to reject a not-responsible-by-reason-of-insanity verdict as a “get out of jail free” card.⁸ Indeed, the competency-restoration process often results in *disguising* a defendant’s mental illness by having the defendant *appear* rational at trial.⁹ That appearance, coupled with a typical fact-finder’s predisposition against finding a defendant to be insane, all but guarantees guilty and guilty-but-mentally-ill verdicts, the latter having no practical difference from the former.¹⁰

Given the difficulties encountered by Indiana’s General Assembly to invest necessary resources into local communities to address Hoosiers’ mental-health needs outside of the criminal justice system, this Article advocates for the implementation of three adjustments that Indiana’s judiciary, as an independent branch of government, can implement within existing judicial infrastructures and processes to better ensure due process for and treatment of criminal defendants who may suffer from serious mental illnesses. The Indiana General Assembly has recognized Indiana Chief Justice Loretta H. Rush and Indiana’s judiciary for an “innovative mindset” and for being a national leader in innovation.¹¹ This innovation includes not only technological changes but also improving “litigation processes.”¹²

Article 1, Section 18 of the Indiana Constitution demands that Indiana’s criminal justice system “be founded on principles of reformation, and not of vindictive justice.” In the spirit of that innovative leadership and those rehabilitative principles, this Article first reviews current national statistics on serious mental illnesses and then reviews both Indiana stakeholders’ repeated pleas for resources and Indiana’s legal processes for criminal defendants with serious mental illnesses. This Article then recommends that Indiana’s judiciary can and should: (1) use a freely available, one-page medical instrument at the initial hearing with a criminal defendant to assess whether he or she may suffer

very early after arrest to determine whether the defendant could have possibly had the requisite scienter or mens rea at the time of the crime.” Gross, 41 N.E.3d at 1052 (Mathias, J., concurring)). (Part 1 of this Article describes a process in which Indiana’s judiciary can make real the opportunity to assess whether defendants suffer from serious mental illnesses at the judiciary’s first opportunity).

7. The length of time between an alleged offense and a trial is often compounded by the competency restoration process itself; *See, e.g.*, Payne v. State 144 N.E.3d 706, 709 (Ind. 2020) (noting that, after allegedly having committed offenses in 2005, the defendant spent the next eleven years undergoing competency restoration before being tried).

8. Price, *supra* note 4, at 836.

9. *Cf.* Dusky v. United States, 362 U.S. 402, 402 (1960) (per curiam) (noting that a defendant must have “a reasonable degree of rational understanding” of the proceedings against him to be tried).

10. *See, e.g.*, Richard E. Redding, *The Brain-Disordered Defendant: Neuroscience & Legal Insanity in the Twenty-First Century*, 56 AM. U. L. REV. 51, 79 n.179 (2006).

11. Derek R. Molter, *Joining the Indiana Supreme Court: Rookie Year Reflections*, 57 IND. L. REV. 1, 2 (2023).

12. *Id.* at 3.

from a serious mental illness; (2) establish standards to allow Indiana probation officers to become qualified mental-health specialists within their departments so they may better supervise criminal defendants with mental-health needs and assist jail staff and others pending trial; and (3) reconsider and clarify appellate review of a fact-finder’s rejection of an insanity defense when there is nonconflicting, credible expert testimony in support of the defense.

III. CURRENT STATISTICS OF SERIOUS MENTAL ILLNESSES AMONG INDIANA OFFENDERS

The population overlap between those who suffer from serious mental illnesses and offenders is well known. As the Substance Abuse and Mental Health Services Administration (“SAMHSA”) of the United States Department of Health and Human Services has explained:

A significant and growing number of people in the justice system have [mental and substance use disorders]. For example, over 70 percent of offenders have substance use disorders, and approximately 17-34 percent have serious mental illnesses¹³—rates that greatly exceed those found in the general population. Several populations, such as juveniles, female offenders, and veterans, are entering the justice system in increased numbers and have elevated rates of [co-occurring mental and substance use disorders], including substance use, trauma, and other mental disorders. These individuals often require specialized interventions to address their [disorders] and staff who are familiar with their unique needs.

People with [co-occurring mental and substance use disorders] present numerous challenges within the justice system. These individuals can at times exhibit greater impairment in psychosocial skills and are less likely to enter and successfully complete treatment. They are at greater risk for criminal recidivism and relapse. The justice system is generally ill-equipped to address the multiple needs of this population, and few specialized treatment programs exist in jails, prisons, or court and community corrections settings that provide integrated mental health and substance use services.¹⁴

In 2024, Indiana’s prosecutors filed more than 250,000 new criminal

13. Substance Abuse & Mental Health Servs. Admin., *Screening and Assessment of Co-occurring Disorders in the Justice System*, Dep’t Health & Hum. Serv., 1 (June 2019), <https://store.samhsa.gov/sites/default/files/pep19-screen-codjs.pdf> [<https://perma.cc/82WR-NMMV>]. (SAMHSA defines “serious mental illness” to include “depressive disorders, bipolar disorders, and posttraumatic stress disorder” along with “psychotic disorders.”).

14. *Id.* at 1.

cases.¹⁵ SAMSHA's assessment that 17–34% of offenders suffer from mental disorders means 42,500 to 85,000 of the people charged with criminal offenses in Indiana in 2024 likely suffer from some mental disorder.

But those are the broad numbers, and SAMSHA gets more specific. Namely, SAMSHA concludes that “approximately 3 percent of offenders” have serious “psychotic disorders,”¹⁶ which may implicate an offender's ability to appreciate the wrongfulness of his or her conduct. For Indiana defendants in 2024-filed criminal cases, that would imply that 7,500 people in 2024 were charged with an offense for which they may not have been legally culpable.

And SAMHSA's statistics are the most favorable to Hoosiers. Other reputable sources estimate that the number of Indiana inmates suffering from serious mental illnesses is significantly higher. For example, relying on recent data from the National Alliance on Mental Health, the December 2024 Annual Report of the Status of Indiana's Criminal Justice System, prepared by the Indiana Criminal Justice Institute and the Justice Reinvestment Advisory Council (“JRAC”), estimates that 6.8% of Indiana's *general* population suffers from a serious mental illness.¹⁷ That same report, relying on data from the Division of Mental Health and Addiction (“DMHA”) within Indiana's Family and Social Services Administration, estimates that 16% of Indiana's inmate population suffers from a serious mental illness.¹⁸ Applying that 16% to the 250,000 new criminal filings in 2024 implies that 40,000 Hoosiers were charged with a criminal act for which they may well not have been legally culpable or had the ability to appreciate the wrongfulness of their conduct.¹⁹

A. Current Court Treatment of Indiana Criminal Defendants with Serious Mental Illnesses

All three branches of Indiana's government are well-aware of both the scarcity of community-based resources to provide Hoosiers who suffer from serious mental illnesses with appropriate care as well as the prevalence of

15. Chief Justice Loretta H. Rush, *2025 State of the Judiciary: Your Indiana Judiciary*, IN.GOV 3 (Jan. 29, 2025), <https://www.in.gov/courts/supreme/state-of-judiciary/> [<https://perma.cc/NX2C-5X7U>] (of those 250,000-plus new criminal filings, 69,474 were felony cases); Ind. Crim. Just. Inst. & Just. Reinv. Advisory Council, *Annual Evaluation of the Status of Indiana's Criminal Justice System*, 7 (2024), https://www.in.gov/cji/grant-opportunities/files/1006_Report_2024_PDF.pdf [<https://perma.cc/S5KD-JDRK>].

16. Substance Abuse & Mental Health Servs. Admin., *supra* note 13, at 5.

17. Ind. Crim. Just. Inst., *supra* note 15, at 60 (JRAC's report does not define its use of the phrase “serious mental illness,” but the implication is that these are individuals whose mental or behavioral disorders require some measure of personalized care beyond a diagnosis and prescription).

18. *Id.* at 61.

19. *Id.* at 7 (The 16% statistic refers to the inmate population, which is nearly all felony convictions. Of course, the vast majority of the 250,000 new criminal filings in 2024 were misdemeanor charges; however, data with respect to all charged individuals rather than the inmate population has not been published by the DMHA).

serious mental illnesses within our criminal justice population. Nonetheless, the Indiana General Assembly has yet to adopt the repeated recommendations of numerous groups of stakeholders on these concerns. And that lack of community investment has limited the efficacy of well-intended diversion opportunities within the judiciary for these vulnerable Hoosiers.

B. Stakeholders Across the Political Spectrum, Across All Branches of Government, and Across all Levels of Government Plead for Community Investment

In the 1990s, Indiana's judiciary began implementing various "problem-solving courts" to "accommodate justice[-]involved individuals with specific needs and problems that were not or could not be adequately addressed in traditional courts."²⁰ Our problem-solving courts include mental-health courts that are "focused on addressing the mental health needs of individuals in the court system" by "bringing together mental health professionals, local social programs, and intensive judicial monitoring" as well as "linking eligible individuals to individually tailored programs or services."²¹ However, some thirty years later, Indiana has just fifteen mental-health courts in fourteen of our ninety-two counties.²² Meanwhile, Indiana has forty-nine adult drug courts in forty-seven counties.²³

In 2015, the Indiana General Assembly established JRAC.²⁴ JRAC consists of "leadership from the executive, legislative, and judicial branches of government" and is "charged with conducting state-level reviews of local corrections programs, county jails[,] and probation services," among other tasks.²⁵ Meanwhile, in 2019, the Indiana General Assembly also established the Jail Overcrowding Task Force to determine "why some Indiana jails are overcrowded and what can be done to ease or eliminate jail overcrowding."²⁶ Then-Justice Steven H. David chaired the Jail Overcrowding Task Force, and Justice Christopher M. Goff regularly participated in the Jail Overcrowding Task Force meetings.²⁷ The Jail Overcrowding Task Force concluded that at least one major reason for jail overcrowding in Indiana was due to "an increasing number of inmates with severe mental health issues and substance use disorders."²⁸

20. *What Are Problem-Solving Courts?*, IND. JUD. BRANCH, <https://www.in.gov/courts/iocs/pscourts/about/> [<https://perma.cc/5HAB-4M76>] (last visited Apr. 30, 2025).

21. IND. CODE §§ 33-23-16-7, 11(2) (2024).

22. Ind. Crim. Just. Inst., *supra* note 15.

23. *Id.*

24. Just. Reinv. Advisory Council, *About*, IN.GOV, <https://www.in.gov/justice/about/> [<https://perma.cc/9HPP-MLDA>] (last visited May 9, 2025).

25. *Id.*

26. JAIL OVERCROWDING TASK FORCE, *supra* note 3.

27. *Id.* at 2.

28. *Id.* at 1.

Justice Goff also chairs JRAC,²⁹ and JRAC publishes annual reports on its review of Indiana's prison populations and services.³⁰ In 2021, the Indiana General Assembly established local justice reinvestment advisory councils (local JRACs) in each Indiana county.³¹ The purpose of the local JRACs, among other things, is to collect local prison data and communicate them to JRAC.³²

JRAC's 2021 Report, the first after the establishment of the local JRACs, noted the utility of Indiana's problem-solving courts but lamented that "there is no system in place to capture the effectiveness of mental health or substance use programming in [county] jails, nor is there a system in place to capture the effectiveness of mental health programming in the [Indiana Department of Correction]."³³ JRAC's 2021 Report agreed with the recommendations of the Jail Overcrowding Task Force³⁴ and further recommended that the Indiana General Assembly:

enhance the accessibility of community-based mental health and substance use treatment programs that support the full range of needs for the criminal justice population, including recovery residences, medication-assisted treatment, and psychiatric services. It is recommended that these services be offered during and after incarceration, as both impact recidivism. State funding for behavioral health services has not increased with inflation and [t]he Indiana Behavioral Health Commission recommends a 60% increase in funding over the next four years. The Commission also recommends more mental health courts and more data collection on recidivism specific to mental health courts.³⁵

Those recommendations were repeated in JRAC's 2022 Report,³⁶ its 2023 Report,³⁷ and its 2024 Report.³⁸ And, in September 2022, Indiana's judiciary held a statewide mental-health summit with numerous stakeholders to discuss

29. Just. Reinv. Advisory Council, *Members*, IN.GOV, <https://www.in.gov/justice/members/> [<https://perma.cc/ZFD8-4KJ7>] (last visited May 9, 2025).

30. Just. Reinv. Advisory Council, *Reports*, IN.GOV, https://www.in.gov/justice/reports/#Annual_Reports [<https://perma.cc/2RWJ-A4TV>] (last visited May 9, 2025).

31. IND. CODE § 33-38-9.5-4(a) (2024).

32. IND. CODE § 33-38-9.5-6(6) (2024).

33. Christine Reynolds, et al., *Indiana Criminal Code Reform Annual Evaluation*, Ind. Crim. Just. Inst. & Just. Reinv. Advisory Council, 7 (Dec. 2021), <https://www.in.gov/justice/files/jrac-2021-12-01-annualreport.pdf> [<https://perma.cc/6DME-E6YR>].

34. *Id.* at 47.

35. *Id.* at 48.

36. *Id.*

37. *Id.* at 78.

38. *Id.* at 82.

these and related mental-health issues.³⁹

JRAC's 2023 Report added an additional recommendation, namely, that the Indiana General Assembly at least prioritize "program capacity, staffing, and follow-up services" for substance-use and mental-health programs in county jails "to increase program accessibility and success."⁴⁰ JRAC's 2024 Report repeated that prioritized need and expounded upon it:

In last year's survey of criminal justice stakeholders, prioritizing program capacity, staffing, and follow-up services would be most beneficial for substance use and mental health programs to increase program accessibility and success. In this year's focus groups, participants provided additional recommendations that counties need greater access to a mental health professional in county jails and more local mental health and dual diagnosis providers, especially in rural areas. Recent budgetary and legislative actions, as well as the long-term plans to improve mental health and substance use infrastructure in the state are all steps in the right direction. However, continued attention, funding, and evaluation of existing mental health and substance use programs are needed to provide these services to individuals currently and formerly involved in the justice system.⁴¹

At the same time the Jail Overcrowding Task Force and JRAC were making their repeated and overlapping recommendations for additional resources in our local communities, in March 2020, the Conference of Chief Justices and the Conference of State Court Administrators established the National Judicial Task Force to Examine State Courts' Response to Mental Illness.⁴² Chief Justice Loretta H. Rush served as a co-chair to the Education and Partnerships Work Group within the National Judicial Task Force, and Justice Goff was also a member of that Work Group.⁴³ The National Judicial Task Force published its revised findings in February 2023 under the leadership of Chief Justice Rush as the President of the Conference of Chief Justices.⁴⁴ As the National Judicial Task Force summarized:

39. Press Release, Indiana Judicial Branch, Community teams from 92 counties to attend Mental Health Summit (Sept. 19, 2022), <https://www.in.gov/courts/news/2022/0919/> [<https://perma.cc/UDP5-3YWZ>].

40. *Annual Evaluation: Indiana Criminal Code Reform* (9th ed.), Ind. Crim. Just. Inst. & Just. Reinv. Advisory Council, 78 (Dec. 2023), <https://www.in.gov/cji/grant-opportunities/files/1006-Report-2023.pdf> [<https://perma.cc/TMF3-G9NU>].

41. Ind. Crim. Just. Inst., *supra* note 15, at 82.

42. Nat'l Jud. Task Force to Examine State Courts' Response to Mental Illness, State Courts Leading Change: Report and Recommendations 4–5, <https://www.ncsc.org/behavioralhealth> [<https://perma.cc/LGV7-BLXL>] (last visited May 1, 2025).

43. *Id.* at 5.

44. Nat'l Jud. Task Force to Examine State Courts' Response to Mental Illness, State Courts Leading Change: Report and Recommendations 4, <https://www.ncsc.org/behavioralhealth> [<https://perma.cc/7XYX-XMGP>] (last visited May 1, 2025).

The prevalence of mental illness in the United States has an enormous impact on states and communities and a disproportionate impact on our state and local courts. According to the National Institute of Mental Health, nearly one in five U.S. adults live with a mental illness—over 50 million in 2020—and over 13 million adults live with serious mental illness. For too many individuals with serious mental illness, substance use disorder, or both, the justice system is the de facto entry point for obtaining treatment and services. There are many causes, not the least of which is the criminalization of mental illness and the lack of alternative approaches and resources to support the diversion of individuals from the courts and into treatment.

People with mental illnesses in the U.S. are 10 times more likely to be incarcerated than they are to be hospitalized. Every year, approximately 2 million arrests are made of people with serious mental illnesses. As a result, more than 70 percent of people in American jails and prisons have at least one diagnosed mental illness or substance use disorder, or both. Up to a third of those incarcerated have serious mental illnesses, a much higher rate than is found at large. On any given day, approximately 380,000 people with mental illnesses are in jail or prison across the U.S., and another 574,000 are under some form of correctional supervision.⁴⁵

After nearly three years of hard work, the National Judicial Task Force published a number of recommendations states may employ to address the mental-health needs of justice-involved individuals, including best practices for problem-solving courts and civil commitment proceedings.⁴⁶

The repeated requests for community investment in mental-health resources crosses the political spectrum and all branches and levels of government. They are not requests to whimsically dispose of scarce funds; they are requests for investments with well-established returns. As former Indiana Lieutenant Governor Suzanne Crouch recently recognized:

The United States is in a behavioral health crisis, and Indiana is no exception. Millions of Americans struggle with mental illness and substance use disorders. Yet, too many lack access to the vital care necessary due to the extreme shortage of behavioral health beds. To remedy the situation and avoid further dire consequences, we must prioritize action to expand access to treatment.

....

45. *Id.* at 9.

46. *Id.* at 23–44.

Indiana only has 11.9 psychiatric beds per 100,000 people, which is far below the recommended 50 beds per 100,000 necessary for adequate care. This means thousands of Hoosiers with severe mental illnesses are left without access to proper treatment, and health care providers are at risk of being overrun. In Marion County alone, 26,000 adults required but did not receive treatment for severe mental health conditions.

The consequences of this shortage are devastating. Individuals experiencing crisis who do not receive inpatient care often end up in emergency rooms where they can wait days or even weeks for a bed to open up. Others land in jails, where their conditions only worsen, or on the streets, where they struggle to survive without proper treatment.⁴⁷

As The Honorable Ms. Crouch further noted, the toll on Hoosiers is not only personal but also economic. In 2023 alone, Indiana lost an estimated \$4.2 billion to lost productivity, emergency care costs, and costs on the criminal justice system from untreated mental illnesses.⁴⁸ Thus:

Investing in more psychiatric beds is not just a moral obligation; it's a practical necessity. When patients receive the right care in the right setting, it ultimately improves their chances of recovery and reduces strain on other public systems. States that have prioritized mental health care have seen significant reductions in ER visits, incarceration rates, and overall health care costs.⁴⁹

And not only do investments in local substance-abuse and mental-health treatments produce positive returns, but they are also substantially cheaper than incarceration costs. Indiana's counties spend an average of about \$74 per inmate per day to keep an adult incarcerated.⁵⁰ Meanwhile, behavioral therapy is estimated to cost an average of \$105 per offender in total; home confinement with electronic monitoring is estimated to cost an average of \$2 to \$4 per defendant per day; pretrial probation is estimated to cost an average of \$3.42 per defendant per day; participation in a problem-solving drug court is estimated to cost an average of \$8 to \$14 per defendant per day; and placement in a halfway

47. Crouch, *supra* note 1.

48. *Id.*

49. *Id.*

50. Niki Kelly, *Indiana Department of Correction readies to pay \$12 million in jail back payments*, IND. CAP. CHRONICLE (June 11, 2025), <https://indianacapitalchronicle.com/2025/06/11/indiana-department-of-correction-readies-to-pay-12-million-in-back-jail-payments/> [https://perma.cc/5XLN-LLAP] (last visited June 11, 2025) (Incarceration of adults in the Indiana Department of Correction, by contrast, costs approximately \$52.61 per inmate per day); *Frequently Asked Questions, How much does it cost to keep an offender in prison?*, IN.GOV, <https://faqs.in.gov/hc/en-us/articles/115005238288-How-much-does-it-cost-to-keep-an-offender-in-prison> [https://perma.cc/CK4C-WLHK] (last visited May 9, 2025).

house is estimated to cost an average of \$31.47 per defendant per day.⁵¹

The following chart demonstrates the daily cost differentials of those placements using the data above that as many as 40,000 Hoosiers in 2024 may have been charged with an offense while suffering from a serious mental illness:

Placement	Average Cost <i>Per Day</i> Per Defendant	Average <i>Daily</i> Cost if 40,000 Defendants Suffering from Serious Mental Illnesses Were Placed Here	Average Cost Savings <i>Per Day</i> if 40,000 Inmates Were Moved from County Incarceration to this Placement
Incarceration in the County Jails	\$74	\$2,960,000	\$0
Placement in Halfway Houses	\$31.47	\$1,258,800	\$1,701,200
Release to the Supervision of a Problem-Solving Court	\$8 to \$14	\$320,000 to \$560,000	\$2,40400,000 to \$2,640,000
Release on Pretrial Probation	\$3.42	\$136,800	\$2,823,200
Release to Home Confinement with Electronic Monitoring	\$2 to \$4	\$80,000 to \$160,000	\$2,800,000 to \$2,880,000
Behavioral Therapy	\$105/defendant	\$4,200,000 <i>total</i>	Cheaper than just 35 hours of incarceration.

Further, the practices of the Indiana Department of Corrections (“DOC”) have exacerbated the drain of county-jail costs on local economies.⁵² Indiana law caps the per diem payment the DOC pays to county jails that are holding DOC-sentenced inmates who are awaiting transportation to a DOC facility at \$40 per day,⁵³ while the average cost to the DOC to house one adult inmate per day is \$52.61.⁵⁴ As a result, it is in the DOC’s fiscal interests to simply pay the

51. Linda Layton et al., *An Elected Official’s Guide to Community Correctional Options* (2d ed.), Bureau Just. Assistance, 48 (July 2010), <https://www.appa-net.org/eweb/docs/appa/pubs/EOGCCO.pdf> [<https://perma.cc/S9PJ-EWDB>] (last visited Nov. 15, 2025).

52. See Ind. Crim. Justice Inst., *supra* note 15, at 75.

53. *Id.* Indiana’s 2025 budget increases this amount to \$42 per day, which an executive officer of the Indiana Sheriffs’ Association described as “better than nothing.”; Niki Kelly, *Indiana Department of Correction readies to pay \$12 million in jail back payments*, IND. CAP. CHRONICLE (June 11, 2025), <https://indianacapitalchronicle.com/2025/06/11/indiana-department-of-correction-readies-to-pay-12-million-in-back-jail-payments/> [<https://perma.cc/5XLN-LLAP>] (last visited Nov. 15, 2025).

54. IN.GOV, *supra* note 50.

per diem and to not transport the inmate to a DOC facility.⁵⁵ Local officials have complained that the DOC's practice is especially prevalent with respect to level six felony offenders and inmates with "complex medical or mental health needs."⁵⁶ The DOC's practice results in substantial additional costs for our county jails and further prevents local communities from using their limited funds "toward things like mental health and substance use programs or professionals."⁵⁷

Many Hoosiers with mental illnesses could avoid the criminal justice system altogether with adequate local and state mental-health facilities and professional care. Indiana's current path of not investing necessary funds into local communities so that Hoosiers with mental illnesses can be diverted into medically appropriate programming below incarceration is the worst-case scenario for Hoosiers. Not only are Hoosiers overspending, we are overspending on prison care, which produces the worst return on investment.

C. Indiana's Process for Criminal Defendants with Serious Mental Illnesses

In Indiana, individuals who suffer from mental illnesses and who are charged with criminal offenses have limited placement opportunities and even more limited opportunities for relief at trial.⁵⁸ If they have counsel, and counsel is aware or becomes aware of mental-health issues with the defendant, or if the court becomes aware of those issues, they may be ordered to participate in competency-restoration services at any time.⁵⁹ Those services are not focused on whether defendants are legally culpable or have the ability to understand the wrongfulness of their conduct at a time of the alleged offenses. Instead, these services are narrowly focused on the defendant's ability to understand the judicial processes to which they are being subjected to and to assist their counsel at trial.⁶⁰

Pretrial diversion options for criminal defendants who may suffer from serious mental illnesses are scarce, even when the presiding judicial officer becomes aware of a mental-health issue. As noted above, there are only fifteen mental-health problem-solving courts in fourteen Indiana counties, and the ultimate focus of Indiana's problem-solving courts in general is just that—to solve the underlying "problem" that resulted in defendants' interactions with the justice system.⁶¹ For our mental-health courts, that means providing defendant-participants with "treatment plans" that address their mental-health issues by: "(a) identifying an individual participant's strengths and needs through

55. Ind. Crim. Just. Inst., *supra* note 15, at 75.

56. *Id.*

57. *Id.*

58. See IND. R. CRIM. P. 2.1 to 2.7 (2024).

59. IND. CODE § 35-36-3-1 (2024).

60. *Id.*

61. See, e.g., Elizabeth Nevins-Saunders, *Not Guilty as Charged: The Myth of Mens Rea for Defendants with Mental Retardation*, 45 U.C. DAVIS L. REV. 1419, 1478 (2012).

assessment, (b) defining goals and objectives based on identified need, and (c) establishing the services to be provided to assist with achieving the stated goals and objectives.”⁶² Because of Indiana’s substantial bed shortage, Indiana’s mental-health courts often refer defendant-participants to expensive private vendors and monitor their progress in those facilities.⁶³

The more serious the charged offense or the more serious the apparent mental illness, the less likely any trial judge may be to place defendants into a pretrial community placement option. Recognizing this, in 2023 the Indiana General Assembly added Indiana Code Chapter 33-23-18 as a new chapter to the Indiana Code.⁶⁴ According to the provisions of that chapter, local JRACs may establish mental-health referral programs in compliance with established DMHA rules.⁶⁵ If a sheriff, prosecutor, or defense counsel has reason to believe that a person who has been both detained and charged with an offense might benefit from the referral program, they may petition the trial court to select an appropriate mental-health professional to examine the defendant.⁶⁶ That mental-health professional must then evaluate the defendant and make a confidential written recommendation to the trial court regarding the defendant’s pretrial placement.⁶⁷

If the defendant has not been charged with or convicted of a crime of violence, the court may, as a condition of pretrial release, refer the defendant to an appropriate mental-health treatment provider.⁶⁸ If the defendant has been charged with or convicted of a crime of violence, the court may refer him or her to an appropriate mental-health treatment provider in a secure facility operated by the DOC or operated or licensed by the DMHA.⁶⁹

To date, however, DMHA has yet to establish the prerequisite rules for local JRACs to implement a mental-health referral program.⁷⁰ Accordingly, neither any local JRAC reports⁷¹ nor state-level JRAC reports⁷² indicates that any such programs have been implemented. And, again, it is not clear how effective a mental-health referral program, once established, might be without community resources. So, mentally ill defendants charged with violent crimes have no alternative to DOC placement.

62. IND. PROBLEM-SOLVING COURT RULE 3 (2024), <https://www.in.gov/courts/iocs/files/pscourts-psc-rules.pdf>.

63. *Id.*

64. IND. PUB. L. 205-2023, § 27 (eff. July 1, 2023).

65. IND. CODE § 33-23-18-2.

66. IND. CODE § 33-23-18-3.

67. IND. CODE §§ 33-23-18-4, 5.

68. IND. CODE § 33-23-18-5(a).

69. IND. CODE § 33-23-18-5(b).

70. *See generally* 440 IND. ADMIN. CODE 1-2-1 to 11-3-8 (2024).

71. *See generally* Just. Reinv. Advisory Council, *Local JRAC 2023 Annual Report Summary*, State of Ind. (Sept. 2024), <https://www.in.gov/justice/files/jrac-2023-localjracs-annual-report.pdf> [<https://perma.cc/T4F9-TMXT>].

72. Ind. Crim. Just. Inst., *supra* note 15; Ind. Crim. Just. Inst., *supra* note 40.

Defendants with the most serious of mental illnesses,⁷³ who proceed to trial and wish to challenge their ability to have appreciated the wrongfulness of their conduct at the time of the offense, must proceed by way of Indiana's statutory insanity defense.⁷⁴ That defense provides that:

(a) A person is not responsible for having engaged in prohibited conduct if, as a result of mental disease or defect, he was unable to appreciate the wrongfulness of the conduct at the time of the offense.

(b) As used in this section, "mental disease or defect" means a severely abnormal mental condition that grossly and demonstrably impairs a person's perception, but the term does not include an abnormality manifested only by repeated unlawful or antisocial conduct.⁷⁵

In general, to interpose the defense of insanity, defendants must file their notices of intent with the trial court no later than twenty days before the omnibus date.⁷⁶ However, the trial court may permit that notice to be filed "at any time before the commencement of the trial" when doing so is "in the interests of justice" and supported by a "showing of good cause."⁷⁷

The purpose of the notice requirement is to enable the trial court to "appoint independent experts to examine th[e] defendant's particular psychiatric characteristics and offer an opinion on the validity of the claim."⁷⁸ Indeed, once a defendant has provided the requisite notice, the trial court must then appoint two or three competent and disinterested medical experts, at least one of which must be either a psychiatrist or a psychologist, if a homicide has not been alleged, and at least one psychiatrist and one psychologist if a homicide has been alleged.⁷⁹ If a defendant refuses to cooperate with the court-appointed medical experts, the defendant may be excluded from presenting other evidence relevant to his or her defense unless the defendant can show that his or her lack of

73. Notably, the ability to *form* a criminal intent is not equivalent to the question of whether the defendant *had* any such intent; *See, e.g., State v. Brooks-Brown*, 246 N.E.3d 312, 317-23 (Ind. Ct. App. 2024), *trans. denied*.

74. Nationally, an insanity defense is raised in "less than 1%" of felony cases and is successful "only . . . 25% of the time" it is raised, with "approximately 70% of the cases in which the defense has been successfully employed" coming from a pretrial agreement between the defense and the prosecution; *In support of the insanity defense*, MENTAL HEALTH AM., <https://mhanational.org/position-statements/in-support-of-the-insanity-defense/#:~:text=Despite%20public%20fears%2C%20defendants%20do,successful%2025%25%20of%20the%20time> [https://perma.cc/7WH4-86CA] (last visited Nov. 16, 2025).

75. IND. CODE § 35-41-3-6 (2024).

76. IND. CODE § 35-36-2-1 (2024).

77. IND. CODE § 35-36-2-1 (2024).

78. *McClain v. State*, 678 N.E.2d 104, 109 (Ind. 1997) (citing IND. CODE § 35-36-2-2).

79. IND. CODE § 35-36-2-2(b), (c) (2024).

cooperation was caused by the mental illness.⁸⁰ And the Indiana Code permits both the defendant and the State to employ their own experts to testify with the court's experts.⁸¹

Once the defense of insanity is properly interposed, the legal truth of that defense will be determined by the fact-finder.⁸² To present an insanity defense, a defendant must prove by a preponderance of the evidence (1) that the defendant suffers from a "mental disease or defect" and (2) that the "mental disease or defect" rendered the defendant unable to appreciate the wrongfulness of his or her conduct at the time of the offense.⁸³ A "mental disease or defect . . . connotes a disorder naturally occurring or a condition of the mind, as opposed to an induced condition (whether self-induced or otherwise)."⁸⁴

The fact-finder may find the defendant guilty, not guilty, not responsible by reason of insanity ("NRBRI"), or guilty but mentally ill ("GBMI").⁸⁵ If the fact-finder agrees with the defendant's defense and finds the defendant NRBRI, the State must then initiate civil commitment proceedings.⁸⁶ If the fact-finder finds the defendant GBMI, the court "shall sentence the defendant in the same manner as a defendant found guilty."⁸⁷ However, the court may consider a physician's evaluation prior to sentencing, and, once incarcerated, the defendant "shall be further evaluated and then treated in such a manner as is psychiatrically indicated for the defendant's mental illness."⁸⁸ But the defendant will be in the custody of the Indiana Department of Correction,⁸⁹ which, again, is an "antitherapeutic" placement for those with serious mental illnesses.⁹⁰

While a GBMI finding may be established by proof of a mental illness at the time of the offense,⁹¹ "[p]roof of mental illness alone is not enough" to obtain an NRBRI finding.⁹² For that, a defendant must also demonstrate that, "as a result" of the mental illness, he or she was unable to appreciate the wrongfulness of his or her conduct at the time of the offense.⁹³ The Indiana Supreme Court has said that the statutory language of being "unable to appreciate the wrongfulness of the conduct at the time" simply means "the

80. IND. CODE § 35-36-2-2(d) (2024).

81. IND. CODE § 35-36-2-2(d) (2024).

82. IND. CODE § 35-36-2-3 (2024).

83. IND. CODE §§ 35-41-3-6(a) (2024); IND. CODE §§ 35-41-4-1(b) (2024).

84. *McClain v. State*, 678 N.E.2d 104, 109 (Ind. 1997) (the Indiana General Assembly has since included the mental condition of the "effects of battery" as a mental disease or defect that may proceed under the insanity defense); IND. CODE § 35-41-3-11(b)(1) (2024).

85. IND. CODE § 35-36-2-3 (2024).

86. IND. CODE § 35-36-2-4 (2024).

87. IND. CODE § 35-36-2-5(a) (2024).

88. IND. CODE § 35-36-2-5(b), (c) (2024).

89. IND. CODE § 35-36-2-5(a) (2024).

90. *Miller*, *supra* note 2, at 1183-84 (1997).

91. *Weeks v. State*, 697 N.E.2d 28, 29 (Ind. 1998).

92. *Barcroft v. State*, 111 N.E.3d 997, 1002 (Ind. 2018).

93. IND. CODE § 35-41-3-6(a) (2024).

inability to differentiate right from wrong.”⁹⁴ Following the Indiana General Assembly's revision of the insanity defense in 1984,⁹⁵ the Indiana Supreme Court has held that a fact-finder erred in rejecting an insanity defense on only two occasions: Once where the defendant had been diagnosed with chronic paranoid schizophrenia and delusional disorder,⁹⁶ and once where the defendant had been diagnosed with bipolar disorder, paranoid delusions, and intermittent psychosis.⁹⁷

IV. RECOMMENDATIONS FOR IDENTIFICATION OF CRIMINAL DEFENDANTS WITH SERIOUS MENTAL ILLNESSES; FOR REDUCTION OF THE COST OF SAFELY TREATING THEM; AND TO IMPROVE THEIR OUTCOMES IN INDIANA'S CRIMINAL JUSTICE SYSTEM

A. Amend Indiana Criminal Rule 2.3 to Require Judicial Officers at an Initial Hearing to Administer a Peer-Reviewed Mental-Health Screening Instrument to Defendants

This Article's first recommendation to improve the judicial processes received by criminal defendants with possible serious mental illnesses is to amend Indiana Criminal Rule 2.3, which establishes the procedure for initial hearings. The initial hearing is the judiciary's first contact with criminal defendants. As SAMHSA has explained:

The absence of adequate screening for [mental health disorders] prevents early identification of problems; often undermines successful progress in treatment; and can lead to substance use relapse, recurrence of mental health symptoms, criminal recidivism, and use of expensive community resources such as crisis care and hospital beds. Lack of screening for [mental health disorders] also prevents comprehensive treatment/case planning, matching justice-involved people to appropriate levels of treatment and supervision, and rapid placement in specialized programs to address [mental health disorders].

Screening for [mental health disorders] should be provided at the earliest possible point in the justice system to expedite consideration of these issues in decisions related to sentencing, release from custody, placement in institutional or community settings, and referral to treatment and other related services. Screening provides a brief review of symptoms, behaviors, and other salient background information that may indicate the presence of a particular disorder or psychosocial

94. *Benefiel v. State*, 578 N.E.2d 338, 350 (Ind. 1991).

95. *Baird v. State*, 688 N.E.2d 911, 915 n.3 (1997).

96. *Payne v. State*, 144 N.E.3d 706, 709 (Ind. 2020).

97. *Galloway v. State*, 938 N.E.2d 699, 703, 706 (Ind. 2010).

problems. Results of screening are typically used to determine the need for further assessment. Assessment provides a lengthier and more intensive review of psychosocial problems that can lead to diagnoses and placement in different types or levels of treatment and supervision services.⁹⁸

As explained below, Criminal Rule 2.3 already goes beyond constitutional and statutory requirements, albeit to ensure that criminal defendants do not receive abusive or unwanted processes. And Indiana's judicial officers at initial hearings already ask numerous questions of defendants to discern the need to appoint counsel and to set bail. Thus, the framework in which to add a process for judicial officers to administer a one-page, publicly available, and peer-reviewed screening instrument to identify those defendants with serious mental illnesses is already in place.

1. Indiana's Current Initial Hearing Procedures Under Indiana Criminal Rule 2.3

The criminal process in Indiana begins when a county prosecutor, or his or her deputy, files a charging information against a defendant.⁹⁹ The decision to charge a defendant is almost wholly within the prosecutor's discretion,¹⁰⁰ and our Rules of Professional Conduct require the prosecutor's decision to be based on his or her own assessment of probable cause.¹⁰¹

If a defendant is not already in custody at the time the information is filed, a judicial officer will issue an arrest warrant. This requires the judicial officer to determine, *ex parte*, that "probable cause exists" that "the person [identified as the defendant] committed a crime."¹⁰² Likewise, if a defendant is already in custody when the prosecutor files the information, the judicial officer must promptly determine (again, *ex parte*) that there exists probable cause that "any crime was committed and that the arrested person committed it."¹⁰³ These front-end probable-cause determinations by judicial officers are required under the Fourth Amendment to the United States Constitution and Article 1, Section 11 of the Indiana Constitution for the State to hold a defendant,¹⁰⁴ and, if the judicial officer finds probable cause to be lacking, the remedy is the defendant's

98. Substance Abuse & Mental Health Servs. Admin., *supra* note 13, at 2 (emphasis added).

99. IND. R. CRIM. P. 2.1 (2024) (Indiana also permits grand juries to issue indictments that allege the commission of a criminal offense, but grand jury indictments in Indiana are exceedingly rare); *See id.*

100. *Lamotte v. State*, 495 N.E.2d 729, 733-34 (Ind. 1986). (However, a prosecutor may not file charges out of vindictiveness or "based upon an unjustifiable standard such as race, religion, or other arbitrary classification;" *Oyler v. Boles*, 368 U.S. 448, 456 (1962)); *See also Warner v. State*, 773 N.E.2d 239, 243 (Ind. 2002).

101. IND. R. PROF. COND. 3.8(a) (2024).

102. IND. CODE § 35-33-2-1(b), (c)(2) (2024).

103. IND. CODE §§ 35-33-7-2 to 3 (2024).

104. *Gerstein v. Pugh*, 420 U.S. 103, 122-25 (1975).

release, not the dismissal of the information.¹⁰⁵

Upon arrest, a defendant is entitled to a “prompt[] . . . initial hearing.”¹⁰⁶ At that hearing, Indiana Code section 35-33-7-5 directs that the judicial officer “shall inform” the defendant of his or her right to counsel, including the right to counsel at public expense; the right to a speedy trial; the amount and conditions of bail; the right against self-incrimination; the nature of the charges; and that a preliminary plea of not guilty will be entered.¹⁰⁷ The court also must give a copy of any felony charges to the defendant¹⁰⁸ and set the omnibus date.¹⁰⁹ Additional advisements may be required depending on the circumstances.¹¹⁰

Indiana Criminal Rule 2.3 implements those statutory requirements and also supplements them:

(A) Advisements. The court must advise the defendant of all applicable constitutional rights and deadlines under Ind. Code § 35-33-7-5.

(B) Preliminary Plea. The court must enter a preliminary plea of not guilty unless a defendant enters a different plea.

(C) Unrepresented Defendant. If the defendant is unrepresented and has not waived the right to counsel, the state must not engage in plea negotiations or diversion agreements and the court must not accept a plea of guilty.

(D) Waiver of Hearing. Upon a request from defendant’s counsel, a court may waive an initial hearing.¹¹¹

Subparts (C) and (D) are unique to the Rule and are not codified in the Indiana Code.¹¹² Subpart (C) prohibits the State from engaging in plea negotiations prior to a judicial determination of a defendant’s representation by counsel, which prevents potentially abusive negotiation tactics by the State.¹¹³ Subpart (C) also prohibits the court from accepting a potentially uninformed plea of guilty prior to the determination of a defendant’s representation by counsel, which reinforces the constitutional guarantee that a guilty plea be made knowingly and voluntarily.¹¹⁴ Likewise, subpart (D) allows a defendant to waive his or her right

105. *Flowers v. State*, 738 N.E.2d 1051, 1054-55 (Ind. 2000).

106. IND. CODE §§ 35-33-7-1, 4 (2024).

107. IND. CODE § 35-33-7-5 (2024).

108. IND. CODE § 35-33-7-5 (2024).

109. IND. CODE § 35-36-8-1 (2024).

110. IND. CODE § 35-33-7-5(8) (2024).

111. IND. R. CRIM. P. 2.3 (2024).

112. *See* IND. CODE § 35-33-7-5 (2024).

113. *See* IND. R. CRIM. P. 2.3(C) (2024).

114. *See Ponce v. State*, 9 N.E.3d 1265, 1274 (Ind. 2014).

to an initial hearing only through counsel.¹¹⁵

While Criminal Rule 2.3's supplemental procedures are not inconsistent with Indiana's statutes, even if they were, Indiana law is well settled that a rule of procedure supersedes a conflicting statute on matters of procedure.¹¹⁶ As the Indiana Supreme Court has explained:

The Indiana Constitution vests the General Assembly with the “[l]egislative authority,” Ind. Const. art. 4, § 1, vests our state courts with the “judicial power,” *id.* art. 7, § 1, and instructs that neither independent branch “shall exercise any of the functions” of the other. *Id.* art. 3, § 1. Enacting laws to protect Hoosiers’ “‘peace, safety, and well-being’” is a legislative function. *Whittington v. State*, 669 N.E.2d 1363, 1369 n.6 (Ind. 1996) (quoting Ind. Const. art. 1, § 1). And promulgating procedural rules for litigating disputes about those laws is part of the judicial function. *State ex rel. Bicanic v. Lake Cir. Ct.*, 260 Ind. 73, 76, 292 N.E.2d 596, 598 (1973) (“The Supreme Court has the inherent power to create rules of procedure and [that] right has been recognized by the Indiana General Assembly.”).

Generally speaking, laws which establish rights and responsibilities are substantive (the legislative prerogative), and laws which “merely prescribe the manner in which such rights and responsibilities may be exercised and enforced” are procedural (the judicial prerogative). *Church [v. State]*, 189 N.E.3d [580,] 588 [(Ind. 2022)] (quotations omitted). So under our separation of powers, if a “statute is a substantive law, then it supersedes our Trial Rules, but if such statute merely establishes a rule of procedure, then our Trial Rules would supersede the statute.” *Id.* (cleaned up).¹¹⁷

Thus, it is inherently within the function of the judiciary to develop rules of judicial procedure, and that function includes the promulgation of rules like Criminal Rule 2.3. Indeed, Criminal Rule 2.3 proves the point, both implementing the statutory procedure for initial hearings and supplementing the Indiana Code by imposing on the State and our judicial officers’ additional requirements with respect to unrepresented defendants at initial hearings to provide them with more effective process.

2. Judicial Officers Are Already Required to Ask Defendants Meaningful Questions at Initial Hearings

Two of the essential purposes of the initial hearing are to determine a

115. IND. R. CRIM. P. 2.3(D) (2024).

116. *Mellowitz v. Ball State Univ.*, 221 N.E.3d 1214, 1221 (Ind. 2023).

117. *Id.* (first paragraph alterations original to *Mellowitz*).

defendant's ability to afford counsel and to set the conditions of his or her bail.¹¹⁸ In determining whether a defendant can afford counsel, the Indiana Supreme Court has stated:

The guarantee of the right to be represented by counsel includes the right for an indigent defendant in a criminal prosecution to have counsel provided for him at state expense. It is a judicial function to determine whether counsel shall be appointed at public expense, and this determination is within the sound discretion of the trial judge. While it is not possible to set specific monetary guidelines which would determine a defendant's indigency, there are several factors which must be considered. Since we are dealing with such a fundamental constitutional right, the record in each case must show that careful consideration commensurate with the right at stake has been given to the defendant.

....

The determination as to the defendant's indigency is not to be made on a superficial examination of income and ownership of property but must be based on as thorough an examination of the defendant's total financial picture as is practical. The record must show that the determination of ability to pay includes a balancing of assets against liabilities and a consideration of the amount of the defendant's disposable income or other resources reasonably available to him after the payment of his fixed or certain obligations. The fact that the defendant was able to post a bond is not determinative of his nonindigency but is only a factor to be considered.¹¹⁹

Similarly, in a recent opinion that reviewed Indiana's history of bail and our judiciary's modern practices in determining bail, our Supreme Court held that Indiana's trial courts "should consider *any* factor relevant to the [defendant's] risk of nonappearance and potential danger to the community."¹²⁰ These factors include the charges against the defendant; the defendant's criminal history; whether the defendant is already on pretrial release; and whether the defendant has a history of probation, parole, or other community supervision.¹²¹ They also include, among other things:

the length and character of the defendant's residence in the community;

118. IND. CODE § 33-35-7-5 (2024).

119. *Moore v. State*, 273 Ind. 4, 7-8, 401 N.E.2d 676, 678-79 (1980) (citations omitted).

120. *DeWees v. State*, 180 N.E.3d 261, 266 (Ind. 2022) (bold font removed; italicized font in original).

121. *Id.* at 267 n.6.

the defendant's employment status and history; the defendant's criminal history or juvenile record; the defendant's family ties and relationships; the defendant's character, reputation, habits, and mental condition; the nature and gravity of the offense and the potential penalty; and any other factors that may indicate that the defendant might not recognize and adhere to the authority of the court to bring the defendant to trial.¹²²

The presiding judicial officer's authority to obtain this information is by way of Indiana Criminal Rule 2.6 and Indiana Code Chapter 35-33-8. The information obtained is then input into a Court-approved evidence-based risk assessment tool to determine that defendant's likelihood to re-offend.¹²³

Notably, Criminal Rule 2.6(D) provides as follows with respect to statements made by a defendant to a judicial officer in the determination of bail or other pretrial release:

(1) Prohibited Uses. Evidence of an arrestee's statements and evidence derived from those statements made for use in preparing an authorized evidence-based risk assessment tool are not admissible against the arrestee in any civil or criminal proceeding.

(2) Exceptions. The court may admit such statements:

(a) in a pretrial proceeding involving the arrestee; or

(b) in any proceeding in which another statement made in preparing an authorized evidence-based risk assessment tool has been introduced, if in fairness the statements ought to be considered together.

(3) Statements. No statements made for these purposes may be used in any other court except in a pretrial proceeding.¹²⁴

Thus, Indiana's initial hearing requirements already require our judicial officers to ask meaningful questions of defendants to properly assess their

122. *Id.* at 267 (citations and quotation marks omitted).

123. IND. R. CRIM. P. 2.6(B) (2024). For adult offenders, Indiana's evidence-based risk assessment tool is called the Indiana Risk Assessment System ("IRAS"). See *Indiana's New Risk Assessment Tools: What You Should Know*, IND. CT. TIMES (Apr. 13, 2011), <https://times.courts.in.gov/2011/04/13/risk-assessment/> [<https://perma.cc/KFF3-GFQL>] (Although one of the six key "domains" upon which an IRAS assessment is based includes information relating to the defendant's "mental health," that information is derived from the defendant's self-reporting of the quality of his or her own mental health; IRAS itself is focused not on discerning the impact of the defendant's mental health on his or her ability to appreciate the wrongfulness of the alleged conduct but is instead focused only on determining "the individual's risk for re-offense").

124. IND. R. CRIM. P. 2.6(D) (2024).

ability to afford counsel and the conditions of any appropriate pretrial release. And, at least in some circumstances, a defendant's responses to the judicial officer's questions may not be used against the defendant later.

3. Adding a Brief Mental Health Colloquy with the Defendant Would Be Easy and Effective

In December 2023, the National Center for State Courts' National Judicial Task Force to Examine State Courts' Response to Mental Illness issued a Judges' Guide to Mental Health Diversion (the "Judges' Guide").¹²⁵ The Judges' Guide "is intended to serve as a resource framework for courts to use to promote and implement diversion strategies for individuals with behavioral health needs in their communities."¹²⁶ As the Judges' Guide recognizes, "[t]he goal" for judicial officers "should be to identify individuals who are appropriate for diversion based on objective criteria," as "subjective information leads to perceptions of, if not actual, implicit or explicit bias" as well as "poor public safety outcomes."¹²⁷ "Ideally, everyone who is booked, even if it is a book-and-release process, is screened."¹²⁸

The Judges' Guide then endorses the use of SAMHSA's Report on Screening and Assessment of Co-Occurring Disorders in the Justice System (the "SAMHSA Report") to identify the best tool for a given jurisdiction's needs.¹²⁹ The SAMHSA Report, in turn, identifies numerous peer-reviewed mental-health screening instruments.¹³⁰ For each instrument, the SAMHSA Report identifies the ideal context in which that instrument should be used as well as evidence-backed strengths and weaknesses.¹³¹ And the SAMHSA Report provides helpful internet links to access the identified instruments along with identifying each instrument as either a licensed product or a product in the public domain.¹³²

Included in the SAMHSA Report for general screening instruments for mental disorders is the Brief Jail Mental Health Screen (the "BJMHS").¹³³ The BJMHS is a one-page screening instrument, is in the public domain, and is included with this Article as Appendix A.¹³⁴ Policy Research Associates, Inc. developed the BJMHS to be administered by jail or judicial officers who have

125. Judges' Guide to Mental Health Diversion 1 (Dec. 2023), <https://cdm16501.contentdm.oclc.org/digital/collection/spcts/id/593> [<https://perma.cc/S2S5-8WBS>].

126. *Id.* at 2.

127. *Id.* at 7, n.12.

128. *Id.* at 7.

129. *Id.* at 9.

130. *See generally* Substance Abuse & Mental Health Servs. Admin., *supra* note 13.

131. *Id.*

132. *Id.*

133. *Id.* at 91.

134. *Id.*

little to no mental-health training.¹³⁵ The goal of the BJMHS is to provide those officers with “an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.”¹³⁶ The BJMHS consists of the following eight questions:

1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?
2. Do you *currently* feel that other people know your thoughts and can read your mind?
3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?
4. Have you or your family or friends noticed that you are *currently* much more active than you usually are?
5. Do you *currently* feel like you have to talk or move more slowly than you usually do?
6. Have there *currently* been a few weeks when you felt like you were useless or sinful?
7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?
8. Have you ever been in a hospital for emotional or mental health problems?¹³⁷

The BJMHS allows the defendant to answer “yes” or “no” to each of those questions.¹³⁸ If the defendant refuses to answer or does not know an answer, the BJMHS instructs the administering officer to not mark a response and instead to indicate in a provided comments section how the defendant responded along with any information the defendant provided with that response.¹³⁹ The BJMHS likewise instructs the administering officer to provide any additional information that the officer “feels relevant and important” in those comments,

135. *Brief Jail Mental Health Screen*, POL’Y RSCH. ASSOCS., INC., 2, <https://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf> [<https://perma.cc/CR37-8FR6>] (last visited Nov. 14, 2025).

136. *Id.*

137. *Id.* at 1.

138. *Id.*

139. *Id.* at 2.

especially if the defendant answers “yes” to any of the questions.¹⁴⁰ Finally, the BJMHS advises that the defendant should be referred for further mental-health evaluation if the defendant answered “yes” either to question 7 or question 8, or if he or she answered “yes” to any two of questions 1 through 6.¹⁴¹ The administrating officer may also refer the defendant for further mental-health evaluation if the officer “feel[s] it is necessary for any other reason.”¹⁴²

The SAMHSA Report notes, “The BJMHS has been tested in forensic populations and is readily adaptable for a range of correctional settings. The instrument has been widely used among jail populations and is recognized as an effective tool in identifying severe mental disorders.”¹⁴³ However, the SAMHSA Report cautions that the BJMHS “screens only for severe mental disorders and does not address anxiety or personality disorders.”¹⁴⁴ The SAMHSA Report also cautions that the BJMHS may produce higher false-positives among female defendants.¹⁴⁵

B. Amend Criminal Rule 2.3 to Require Judicial Officers to Administer the BJMHS

The Indiana Supreme Court should follow the guidance of the National Center for State Courts and SAMHSA and require all judicial officers presiding at initial hearings to administer the BJMHS to defendants. This can be readily accomplished by amending Criminal Rule 2.3. For good measure, the Court can include the BJMHS in an appendix to the Criminal Rules as it is in the public domain.

Amending Criminal Rule 2.3 in this manner would accomplish numerous goals. Mandating the administration of a mental-health screen at the time of the judiciary's first contact with a defendant would meet all the concerns noted by the National Center for State Courts and SAMHSA. Namely, it would provide a foundational record of the defendant's mental health at the judiciary's earliest opportunity relative to the alleged commission of the charged offenses. This, in turn, would enable the judiciary to divert those with serious mental illnesses away from prison populations and into more appropriate settings based on objective criteria as soon as practicable.

Further, the BJMHS appears to be an ideal instrument for Indiana's needs. It is a one-page screening instrument in the public domain designed to be administered by judicial officers who have little to no medical training. It is designed to be administered at the point of initial contact with a defendant. Requiring judicial officers to include the administration of a one-page, eight-

140. *Id.*

141. *Id.*

142. *Id.*

143. Substance Abuse & Mental Health Servs. Admin., *supra* note 13, at 91.

144. *Id.*

145. *Id.* at 92.

question screening assessment at initial hearings would not impose a meaningful additional burden; at most, this process would add a few minutes of additional time for any given defendant and judicial officer.

So long as the BJMHS is even moderately effective, the small burden of administering it is heavily outweighed by the substantial gain to those who would benefit from it—both defendants and the public at large. Defendants who need essential mental-health services can be identified and processed objectively and promptly, saving significant costs that occur from less-than-ideal placements and in the absence of proper treatment. Even if many defendants are not referred for further mental-health evaluation, for those who are, the proper placement for that defendant may be life-changing. And those who are not affected by the screening process will not have lost anything substantial in completing the assessment.

Moreover, once DMHA establishes rules to enable local JRACs to implement mental-health referral programs, amending Criminal Rule 2.3 to have judicial officers implement the BJMHS will supplement Indiana Code Chapter 33-23-18 much the same way the Rule already supplements the right to counsel and the setting of bail.¹⁴⁶ Sheriffs, prosecutors, or defense counsel may still refer a defendant to the court when they have a subjective reason to believe he or she would benefit from a mental-health referral program,¹⁴⁷ having the judicial officer always administer the BJMHS takes the initial burden off of our other officers. It also puts the question of a defendant's mental health onto a scientific instrument designed for that purpose and away from the subjective perceptions of our officers.

Perhaps, some of those who are not referred for further mental-health evaluation may later argue that they were suffering from a serious mental illness at the time of the offense. And, perhaps, some of those who are referred will be found by medically trained professionals to have been referred unnecessarily. Indeed, as noted in the SAMHSA Report, there is a higher risk of false positives among female defendants than males, but neither of those concerns should prevent the beginning of constitutionally required, rehabilitative treatment of criminal defendants.¹⁴⁸ The first scenario is simply the status quo of Indiana's current procedures, and the second scenario is likely an inevitable outcome to some degree. The BJMHS is limited to serious mental-health issues and is designed to err on the side of identifying the presence of a mental-health disorder when a defendant presents a close case on the questionnaire, a reasonable approach based on objective criteria. Further, if Criminal Rule 2.3 were amended to require the BJMHS assessment but the referral process then in

146. An administered BJMHS form may also be used by probation officers as a complementary assessment tool under Indiana Probation Standard 4.2. *See* INDIANA PROBATION STANDARDS, BD. OF DIRS. JUD. CONF. OF IND. 4.2, <https://www.in.gov/courts/iocs/files/prob-standards-standards-2024.pdf> [<https://perma.cc/G6NJ-YY3S>].

147. IND. CODE § 33-23-18-3 (2024).

148. IND. CONST. art. 1, § 18 (emphasizing that Indiana's penal system is constitutionally oriented toward reformation rather than punitive justice).

fact showed to be substantially misapplied by our judicial officers, nothing would prevent the Indiana Supreme Court from course-correcting based on new evidence at that time.

Additionally, in amending Criminal Rule 2.3 the Indiana Supreme Court should make clear that a judicial officer administering the BJMHS does not lose placement discretion based on the defendant's BJMHS answers. The BJMHS is a guide for determining best placement, but, if the administering judicial officer concludes that a defendant is likely not being honest in his or her answers, or otherwise concludes that circumstances outside the questionnaire compel a different placement, the judicial officer should state as much in the comments section and make the placement decision accordingly.

Criminal Rule 2.6 should also be amended, along with Rule 2.3, to make clear that a defendant's answers to the BJMHS are not admissible against him or her without later consent or if the defendant opens the door to those answers at trial. In this way, a defendant's responses to the one-page BJMHS assessment may hold some marginal probative value to a later-sought defense, but any attempt to admit those answers at trial would be subject to the court's exercise of discretion in the usual admission of evidence.

Finally, Indiana's Rules on Access to Court Records should also be amended to accommodate BJMHS responses. In particular, because a defendant's responses to the BJMHS are personal mental-health information of a party, access to Court Records Rule 5(B)(9), which requires the exclusion of "[m]ental health records compiled or created by a mental health services provider for treatment purposes," should be amended to include pretrial BJMHS responses under Criminal Rule 2.3 as excluded from public access. If the responses later become necessary to the merits of the case, the existing Access to Court Records rules would then take over. Further, to protect the privacy of the defendant's mental-health responses, the BJMHS could be administered by a court officer prior to the defendant's open-court initial hearing in accordance with part 2 below.

C. Strengthen Mid-Stream Monitoring and Care by Enabling Indiana Probation Officers to Become Mental-Health Specialists

Identifying at the initial hearing those criminal defendants who may suffer from serious mental illnesses is an important step forward both in ensuring both that some record of a mental illness is created as early as feasible and that those defendants receive proper placement and care pending trial. However, currently and for the foreseeable future, even with those individuals properly identified, many of them will continue to be placed in our county jails as they await trial. And, as JRAC made clear in its 2023 and 2024 reports, our county jails are understaffed and disproportionately burdened by inmates with serious mental

illnesses.¹⁴⁹

As our local communities await a comprehensive legislative response, Indiana's trial courts already have a structure in place that could be used to at least mitigate issues with seriously mentally ill inmates in our county jails. Trial courts have the statutory authority to hire their own probation officers,¹⁵⁰ and probation officers "shall serve at the pleasure of the appointing court and are directly responsible to and subject to the orders of the court."¹⁵¹ A probation officer's duties include: assisting the trial court in making pretrial release decisions; assisting in making decisions regarding the diversion of charged individuals to appropriate noncriminal alternatives; and supervising and assisting persons on probation consistent with conditions of probation imposed by the court.¹⁵²

The Indiana Code further requires the Board of Directors of the Indiana Judicial Conference to adopt minimum standards for the "educational and occupational qualifications for employment as a probation officer."¹⁵³ The Judicial Conference also prepares a written entrance examination with an established passing score for new probation officers and a set of minimum standards for hired probation officers.¹⁵⁴ In addition, the Indiana Code directs that the Judicial Conference:

shall, in cooperation with the [DMHA] and the division of disability and rehabilitative services . . . , provide probation departments with training and technical assistance concerning mental illness, addictive disorders, intellectual disabilities, and developmental disabilities, including evidence based treatment programs for mental illness and addictive disorders and cognitive behavior treatment.¹⁵⁵

The Judicial Conference has implemented that statutory direction by issuing guidance to Indiana's probation departments and officers with respect to suicide awareness and prevention¹⁵⁶ and by requiring probation officers, at their initial orientation, to complete a course on "Substance Use and the Mental Health

149. Ind. Crim. Just. Inst., *supra* note 15, at 82; Ind. Crim. Just. Inst., *supra* note 40, at 78.

150. IND. CODE § 11-13-1-1(a) (2024).

151. IND. CODE § 11-13-1-1(c) (2024).

152. IND. CODE § 11-13-1-3 (2024).

153. IND. CODE § 11-13-1-8(b)(1) (2024).

154. IND. CODE §§ 11-13-1-8(c)–(d) (2024).

155. IND. CODE § 11-13-1-8(g) (2024).

156. See INDIANA PROBATION SAFETY AND SECURITY GUIDE: JUDICIAL CONFERENCE OF INDIANA, IND. OFF. OF CT. SERVS., 26–27 (Sept. 6, 2018) <https://www.in.gov/courts/iocs/files/prob-standards-safety.pdf> [<https://perma.cc/XRL6-LC3R>].

Continuum.”¹⁵⁷

Indiana's judiciary can do more. While “most probation officers are inadequately prepared to handle persons with mental illness,” probation departments in New York, California, Chicago, and numerous federal districts have developed specialized programs for probation officers to become mental-health specialists within their departments.¹⁵⁸ Requirements and resources across and within these states vary greatly; however, in New York, probation officers becoming mental-health specialists receive mandatory training on:

understanding and responding to persons with serious mental illness and co-occurring substance abuse disorders, matching services to needs for [New York's] population, developing and improving partnerships between probation and other service providers—such as in the mental health arena—and identification of key issues pertaining to supervision of persons with serious mental illness and co-occurring substance abuse disorders.¹⁵⁹

Further, with a state-wide minimum baseline established in Indiana, local departments could then pick and choose the components and topics for additional mandatory training consistent with what makes the most sense for their particular jurisdictions, including serious mental illness issues, particular challenges for probation officers, red flags pertaining to safety issues, and best practices to meet needs and promote wellness.¹⁶⁰

The nuances of how to approach a training program through which Indiana probation officers would become qualified mental-health specialists within their departments is beyond the scope of this Article. There are numerous valid and reasonable paths forward here, and stakeholders in any such training include the Judicial Conference, the DMHA, our trial courts, JRAC, and local JRACs; Indiana's judiciary is already structured to hire and train probation officers and to place those probation officers in positions of engagement and monitoring of inmates with serious mental illnesses. Indeed, much of the groundwork may already be in place, as the Judicial Conference has established a number of *optional* mental-health educational programs that are already available to Indiana probation officers.¹⁶¹ Thus, the opportunity currently exists for Indiana's judiciary to promptly fill the urgent need for specialized attention to

157. Email from Vicki Davis, Dir. of the Educ. Div. of the Ind. Off. of Ct. Servs. in the Off. of Jud. Admin., to Jonathan B. Warner (May 19, 2025, at 11:18 a.m. EST) (on file with authors). Probation officers in Indiana have access to other mental-health educational content, but that content is optional. *Id.*

158. Risdon N. Slate et al., *Training Federal Probation Officers as Mental Health Specialists*, 68 FED. PROB. 3, 4–5 (2004), https://www.uscourts.gov/sites/default/files/68_3_2_0.pdf [<https://perma.cc/W9ZR-T4TB>].

159. *Id.* at 5.

160. *Id.*

161. Davis, *supra* note 157.

our most vulnerable inmates during the pretrial process.

*D. Back-End Review: Reconsider the Role of Appellate Review
of Rejected Insanity Defenses*

This Article's final recommendation is for the Indiana Supreme Court to reconsider and clarify its case law regarding appellate review of cases in which the fact-finder has rejected an insanity defense that was supported by nonconflicting¹⁶² and credible¹⁶³ expert testimony.

1. Essential Foundations

Indiana's statutory insanity defense traces back to 1843, when the English House of Lords announced what is known today as the M'Naghten Rule: criminal culpability requires defendants "at the time of doing the act" to have known "the difference between right and wrong."¹⁶⁴ That is, defendants cannot be held criminally responsible if, at the time of their offenses, they were unable to appreciate the moral wrongfulness of their conduct.¹⁶⁵

As the Indiana Supreme Court has made clear, "Indiana's test for insanity is a purely cognitive one, as it looks only to what the defendant was thinking and whether he or she could appreciate the wrongfulness of his or her conduct."¹⁶⁶ A "cognitive" test, in this context, thus refers to a defendant's *ability* to know *right from wrong*.¹⁶⁷ And "right" and "wrong" are not scientifically objective standards—the "ability to know right from wrong" or the ability to "appreciate the wrongfulness" of one's conduct are therefore references to a normal moral code or society's common morality.¹⁶⁸

162. The Indiana Supreme Court has referred to "unanimous" expert testimony and "nonconflicting" expert testimony with equal value; *See, e.g.,* Galloway v. State, 938 N.E.2d 699, 710–12 (Ind. 2010). ("Nonconflicting" expert testimony might occur where two experts agree that the defendant was insane while a third is unable to render an opinion. *See id.* It might also occur where the experts agree on the bottom line—the defendant was insane—but give varying degrees of confidence to that conclusion. *See* Payne v. State, 144 N.E.3d 706, 711 (Ind. 2020)).

163. An unstated assumption in Indiana's case law is that a GBMI finding is a finding that the medical experts were credible, even if the fact-finder declined to accept their conclusions on insanity, unless another basis for the GBMI finding was expressly identified by the fact-finder. *Cf.* Galloway, 938 N.E.2d at 711 (noting that the trial court, acting as the fact-finder, based its GBMI finding not on the experts' opinions but on other evidence).

164. M'Naghten's Case, 8 Eng. Rep. 718, 722 (H.L. 1843).

165. Galloway, 938 N.E.2d at 716.

166. Barcroft v. State, 111 N.E.3d 997, 1004 (Ind. 2018) (quotation marks omitted).

167. *Cognitive*, OXFORD ENGLISH DICTIONARY, https://www.oed.com/dictionary/cognitive_adj?tab=meaning_and_use#9078894 [<https://perma.cc/657P-J8QC>] (last visited May 20, 2025).

168. This is not to say that an "idiosyncratic, subjective sense that an action is morally correct . . . constitute[s] [an] exception[] to the generally coextensive nature of legal and moral wrong in society so as to support being excused from criminal responsibility." *State v. Winder*, 979 A.2d 312, 317 (N.J. 2009). Rather, it is the defendant's *ability to discern* the "legal and moral wrong in society" that matters for Indiana's insanity defense. *See id.* at 324.

The general rule in Indiana's case law is that the fact-finder may reject an insanity defense for any reason supported by the record. As the Indiana Supreme Court has summarized:

Whether a defendant appreciated the wrongfulness of his or her conduct at the time of the offense is a question for the trier of fact. Indiana Code section 35-36-2-2 provides for the use of expert testimony to assist the trier of fact in determining the defendant's insanity. Such expert testimony, however, is merely advisory, and even unanimous expert testimony is not conclusive on the issue of sanity. The trier of fact is free to disregard the unanimous testimony of experts and rely on conflicting testimony by lay witnesses. And even if there is no conflicting lay testimony, the trier of fact is free to disregard or discredit the expert testimony.¹⁶⁹

As noted above, defendants who seek to interpose the insanity defense must file an appropriate notice of the intent to raise that defense with the trial court.¹⁷⁰ Best practice for defense counsel in interposing the defense of insanity may well be to move to waive the defendant's right to a jury trial simultaneously with that notice, if such a waiver is not yet on record.¹⁷¹ An insanity defense is statistically more likely to be successful in a bench trial than in a jury trial by a difference of about thirty percent.¹⁷² That difference arises out of the public's well-known tendency to view and reject the concept of an NRBRI judgment as a "get out of jail free" card.¹⁷³

Once a fact-finder, whether the jury or the court, has rejected an insanity defense, appellate relief has proved to be unlikely. Considering only cases where our legislature's 1984 revision¹⁷⁴ of the insanity defense applied, in six of eight opinions, the Indiana Supreme Court has affirmed the fact-finder's decision to reject an insanity defense that was supported by nonconflicting expert testimony. Those six cases demonstrate the general difficulty of appellate relief. However, the other two cases create tension with that general body of law, and the Court's explanations and applications of its own precedents are inconsistent, difficult for practitioners to predict, and results in trial and appellate judges being unsure of how to apply the law.

169. Galloway, 938 N.E.2d at 709 (citations and footnote omitted).

170. IND. CODE § 35-36-2-1 (2024).

171. *See generally* Carmen Cirincione, *Revisiting the Insanity Defense: Contested or Consensus?*, 24 BULL. AM. ACAD. PSYCHIATRY L. 165, 168 (1996), <https://jaapl.org/content/jaapl/24/2/165.full.pdf> [<https://perma.cc/YHR9-A6MY>].

172. *Id.*

173. Hannah Price, *Shattered Brains in Shackles: The Future of Mentally Ill Defendants Following KAHLER V. KANSAS*, 55 IND. L. REV. 831, 836 (2022).

174. *See* Baird v. State, 688 N.E.2d 911, 915 n.3 (1997) (explaining Indiana's 1984 revision of the insanity defense and elimination of the volitional prong).

2. *Cate and Barany: Our Supreme Court Allows Juries to Reject Unanimous Expert Testimony Based on Behavior That Fleetinglly Appears Rational*

In its first two opinions reviewing a fact-finder's rejection of nonconflicting expert conclusions on insanity following the implementation of the 1984 statutory amendments to the insanity defense, the Indiana Supreme Court concluded that demeanor evidence and lay-witness observations of the defendant's behavior alone were sufficient to support the fact-finder's decisions. First, in *Cate v. State*, the defendant appealed the fact-finder's rejection of his insanity defense, which was unanimously supported by five expert witnesses.¹⁷⁵ In affirming the defendant's GBMI conviction, the Indiana Supreme Court stated that, while the experts were unanimous, their conclusions "were hardly uncontroverted."¹⁷⁶ The Court nevertheless relied on the following evidence, which it viewed as "conflicting," to support the defendant's conviction:

The record contains evidence of his lucidity after arrest, demonstrating both an awareness of what he had just done and his deliberation in accomplishing the killing. Furthermore, despite his subsequent claims that he was mimicking the biblical story of Abraham's willingness to sacrifice his son Isaac, Cate had previously denied such a motivation when asked by a coworker within a week of the murder.

Each of the psychiatrists, of course, evaluated Cate after the incident, based on his representations about his motivation on the evening in question. The jurors may have agreed with the prosecution's suggestion that Cate had a strong incentive to lie and could have told his doctors a tall tale to avoid a guilty verdict. . . .¹⁷⁷

Second, in *Barany v. State*, the Court affirmed the defendant's GBMI conviction and the fact-finder's rejection of his insanity defense based on the following explanation:

[T]he medical experts were unanimous in concluding that appellant was

175. *Cate v. State*, 644 N.E.2d 546, 547 (Ind. 1994). (The defendant in *Cate* received a sixty-year prison sentence; *Id.* At the current cost of \$52.61 to incarcerate one defendant per day, and assuming he spends that entire term in the DOC, his sentence will have cost Hoosier taxpayers \$1,152,159 by the time of his release); IN.GOV, *supra* note 50.

176. *Cate*, 644 N.E.2d at 547.

177. *Id.* at 548. (In *Galloway v. State*, the Court described its holding in *Cate* as demonstrative of feigning because the defendant inconsistently described the reasons for his own behavior. 938 N.E.2d 699, 713 (Ind. 2010). But "feigning" in medical contexts most often implies the fabrication of an illness, and, accordingly, the cases described in part 3.3 *infra* describe inconsistencies provided by a defendant with medical information specifically. *Cf.* *Barcroft v. State*, 111 N.E.3d 997, 1001 (Ind. 2018) (noting that the medical experts found no evidence of feigning or malingering). Indeed, in *Barcroft* our Supreme Court squarely described the evidence at issue in *Cate* as "demeanor evidence" rather than evidence of feigning. *Id.* at 1005.)

insane at the time of the killing. However, the State offered testimony from several lay witnesses that indicated that appellant was sane. Indiana State Police Detective Stotts described how, only a few hours after the crime, appellant talked about the victim's complaints and nagging. One of appellant's friends . . . testified as to unusual topics of conversation, such as conspiracies, but indicated that appellant "seemed O.K." In a conversation with his sister, appellant indicated that he believed that the victim was calling the police when he killed her. The jury could have decided that this testimony about appellant's behavior was more indicative of his actual mental health at the time of the killing than medical examinations conducted four weeks after the arrest. . . .¹⁷⁸

Thus, the Court's holdings in *Cate* and *Barany* allowed the fact-finders to reject the unanimous expert conclusions of insanity based on lay evidence of *fleeting*, *apparently* rational, or lucid demeanor evidence.

3. Gambill and Thompson: *Our Supreme Court Allows Juries to Find That the Experts Have Been "Fooled"*

The Court's next two opinions held that lay juries can tell when experts have been fooled. In *Gambill v. State*, the Court affirmed the defendant's GBMI conviction based on the following statement:

Although all four of the expert medical witnesses at this trial testified that Appellant was legally insane at the time of the murder, two lay witnesses testified otherwise. These witnesses testified that, in their opinions, the Appellant was able to appreciate the wrongfulness of her actions at the time the offense occurred. Sergeant Pierce, who had attended high school with Appellant, testified that after spending time with Appellant at the hospital on the morning after the murder, he believed that Appellant was able to appreciate the wrongfulness of her conduct. Also, the jail-house informant . . . testified that she believed that Appellant knew it was wrong to drown [her son]. Thus, there was a conflict of opinion on the question of Appellant's ability to appreciate the wrongfulness of her conduct. . . .

Additionally, Appellant failed to disclose to medical personnel that, in the hours before she took her son's life, she had ingested a substantial quantity of methamphetamine. Appellant lied to the individual who found her wandering on the street early on the morning after the murder.

178. *Barany v. State*, 658 N.E.2d 60, 64 (Ind. 1995). (The defendant in *Barany* received a sixty-year prison sentence. *Id.* at 62. At the current cost of \$52.61 to incarcerate one defendant per day, and assuming he spends that entire term in the DOC, his sentence will have cost Hoosier taxpayers \$1,152,159 by the time of his release); IN.GOV, *supra* note 50.

She told him that she had been beaten and raped, and that a former boyfriend had hurt her son. Such self-serving exculpatory statements might indicate to the jury that Appellant was aware of the wrongfulness of her actions. . . .¹⁷⁹

Likewise, in *Thompson v. State*, the Court affirmed the defendant's GBMI conviction after the trial court, acting as the fact-finder, expressly found that the defendant had a "history" of using her mental illness to "avoid[] criminal responsibility."¹⁸⁰ The trial court also found that the evidence demonstrated "conflicting stories about what happened to [the defendant's] medication, her decision to use illegal drugs and drink alcohol while on her medication, and lies she told one of the examining psychiatrists regarding the use of drugs and alcohol."¹⁸¹ After concluding that the trial court's findings were supported by the record, the *Thompson* Court added that conflicting evidence was "not required" at all because "fact[-]finders are not required to believe a witness's testimony even when it is uncontradicted."¹⁸²

Both *Gambill* and *Thompson* represent a straightforward conclusion, namely, that evidence the defendant feigned mental illness or failed to disclose relevant medical information is sufficient to support a fact-finder's rejection of expert testimony regarding the defendant's alleged mental illness.

4. Interlude: The Court of Appeals Questions Barany, and a Plurality of the Justices of Our Supreme Court Take Note

Before continuing with the Indiana Supreme Court's precedents, a notable dialogue between the Indiana Supreme Court and intermediate Court of Appeals emerged in 2003 and 2004 surrounding the application of *Barany*. In two opinions handed down on the same day and written by the same panel, the Court of Appeals concluded that the evidence rebutted the experts' nonconflicting conclusions on insanity in *Moler v. State*,¹⁸³ but the evidence failed to rebut the experts' nonconflicting conclusions on insanity in *Thompson v. State*.¹⁸⁴

The Court of Appeals reached its conclusion in *Moler* reluctantly. As the panel explained:

179. *Gambill v. State*, 675 N.E.2d 668, 672–73 (Ind. 1996). (The defendant in *Gambill* received a forty-year prison sentence. *Id.* at 678. At the current cost of \$52.61 to incarcerate one defendant per day, and assuming he spends that entire term in the DOC, his sentence will have cost Hoosier taxpayers \$768,106 by the time of his release); IN.GOV, *supra* note 50.

180. *Thompson v. State*, 804 N.E.2d 1146, 1150 (Ind. 2004). (The defendant in *Thompson* received a three-year prison sentence. *Id.* at 1148. At the current cost of \$52.61 to incarcerate one defendant per day, and assuming she spent that entire term in the DOC, her sentence cost Hoosier taxpayers \$57,607.95); IN.GOV, *supra* note 50.

181. *Thompson*, 804 N.E.2d at 1150.

182. *Id.* at 1149.

183. *Moler v. State*, 782 N.E.2d 454, 458 (Ind. Ct. App. 2003), *trans. denied*.

184. *Thompson v. State*, 782 N.E.2d 451, 454 (Ind. Ct. App.), *vacated*, 792 N.E.2d 46 (Ind. 2003) (table).

Barany has made it very difficult even for defendants with well-documented mental illnesses to successfully raise the insanity defense. Under the rule of *Barany*, even if all expert testimony regarding a defendant's state of mind points to the fact that the defendant could not have appreciated the wrongfulness of his actions at the time of a crime, the jury is free to disregard the experts' opinions in favor of lay evidence of the defendant's demeanor before and after the crime.

While the jury is the ultimate finder of fact, we fail to see how evidence of a defendant's demeanor before and after a crime can have much probative value when a schizophrenic defendant is involved. Persons that suffer from schizophrenia can experience unpredictable delusions and hallucinations. Am. Psychiatric Ass'n, DSM-IV: Diagnostic and Statistical Manual of Mental Disorders 274-75 (4th ed. 1994). A delusion is "a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary." *Id.* at 765. A hallucination involves "a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ." *Id.* at 767.

....

The proposition that a jury may infer that a person's actions before and after a crime are "indicative of his actual mental health at the time of the" crime is logical when dealing with a defendant who is not prone to delusional or hallucinogenic episodes. However, when a defendant has a serious and well-documented mental disorder, such as schizophrenia, one that causes him to see, hear, and believe realities that do not exist, such logic collapses. . . .¹⁸⁵

The Court of Appeals's concerns notwithstanding, a majority of the Indiana Supreme Court voted to deny the defendant's petition to transfer.¹⁸⁶ Then-Justices Sullivan and Boehm dissented from the denial of transfer.¹⁸⁷

However, after accepting the State's petition to transfer following the Court of Appeals' reversal in *Thompson*, the Indiana Supreme Court affirmed the fact-finder's judgment and relied in substantial part on evidence of the defendant's history of feigning mental illness.¹⁸⁸ Although Justice Sullivan concurred in

185. Moler, 782 N.E.2d at 458-59.

186. Moler v. State, 792 N.E.2d 43 (Ind. 2003) (table).

187. *Id.* (table).

188. Thompson v. State, 804 N.E.2d 1146, 1150 (Ind. 2004).

Thompson, he wrote separately to note that “[i]t [wa]s probably not coincidence that the same panel of the Court of Appeals decided two cases involving exactly the same issues on exactly the same day, one if favor of the State and the other in favor of the defendant.”¹⁸⁹ Justice Sullivan continued:

The Court of Appeals likely expected petitions to transfer with respect to both cases to reach our Court at the same time. However, *Moler* reached our court and we disposed of it (denying Moler’s petition to transfer by a vote of 3-2) prior to receiving the petition to transfer in *Thompson*. As such, we did not consider them together.¹⁹⁰

Justice Sullivan then explained that he did not read our Supreme Court’s precedents to require affirming a finding of sanity when “(1) there is unanimous credible, expert testimony that a defendant is insane at the time of the crime at issue and (2) there is no other evidence of probative value from which a conflicting inference can be drawn.”¹⁹¹

5. *Galloway v. State: Our Supreme Court Reconsiders the Probative Value of Apparently Rational Demeanor Evidence*

In 2010, the Indiana Supreme Court took the opportunity to reconsider the probative value of apparently rational demeanor evidence, as sought by the Court of Appeals in *Moler* and noted by Justice Sullivan in his separate opinion in *Thompson*. In particular, in *Galloway v. State*, authored by Justice Sullivan, the Court concluded that the fact-finder erred as a matter of law in rejecting an insanity defense.¹⁹² In reaching that conclusion, the Court first noted that the expert testimony was not in conflict even though two of the experts had concluded that the defendant was insane and the third expert had no opinion.¹⁹³ From there, the Court turned to whether “other evidence of probative value” existed to support the conclusion of legal sanity.¹⁹⁴ Looking first to lay-witness testimony, the Court noted that those witnesses’ observations “support[ed] the experts’ opinions.”¹⁹⁵

The Court then considered demeanor evidence, but it did so with some novel caveats.¹⁹⁶ Specifically, the Court noted that demeanor evidence in insanity

189. *Id.* at 1151 (Sullivan, J., concurring).

190. *Id.* (Sullivan, J., concurring).

191. *Id.* at 1152 (Ind. 2004) (Sullivan, J., concurring) (emphasis added).

192. *Galloway v. State*, 938 N.E.2d 699, 714–16 (Ind. 2010). (The defendant in *Galloway* received a fifty-year prison sentence. *Id.* at 708. Had our Supreme Court affirmed his conviction, and applied the current cost of \$52.61 to incarcerate one defendant per day while also assuming he would have spent his entire term in the DOC, his sentence would have cost Hoosier taxpayers \$960,132.50); IN.GOV, *supra* note 50.

193. *Galloway v. State*, 938 N.E.2d 699, 711–12 (Ind. 2010).

194. *Id.* at 712.

195. *Id.* at 714.

196. *Id.* at 714–15.

cases must be “considered in light of other evidence” in order to “permit[] a reasonable inference of sanity to be drawn.”¹⁹⁷ This is because demeanor evidence invites the fact-finder “to infer what the defendant was thinking based on his or her conduct,” and, to do so, the fact-finder “uses its common knowledge of what is normal and what is abnormal.”¹⁹⁸ But, in the insanity context, the probative value of such “common knowledge” is dubious, at best. As the Court stated, “insanity is not limited to the stereotypical view of a ‘raging lunatic,’” and “a person experiencing a psychotic delusion may appear normal to passersby.”¹⁹⁹ Thus, the *Galloway* Court concluded that demeanor evidence is not a blank check for fact-finders to reject an insanity defense and is “most useful where there is some indication” in the evidence of “feigning mental illness and insanity.”²⁰⁰ The Court noted that demeanor evidence carried more significance prior to our legislature’s 1984 amendment to the insanity defense.²⁰¹

The Court explained that a contrary understanding would mean that not even a defendant with a “long history of mental illness with psychosis” would be immune to having demeanor evidence used against him or her.²⁰² On that point, the Court specifically acknowledged the following language from Court of Appeals’ opinion in *Moler*:

While the jury is the ultimate finder of fact, we fail to see how evidence of a defendant’s demeanor before and after a crime can have much probative value when a schizophrenic defendant is involved. . . .

. . . .

The proposition that a jury may infer that a person’s actions before and after a crime are indicative of his actual mental health at the time of the crime is logical when dealing with a defendant who is not prone to delusional or hallucinogenic episodes. However, when a defendant has a serious and well-documented mental disorder, such as schizophrenia, one that causes him to see, hear, and believe realities that do not exist, such logic collapses. . . .²⁰³

Acknowledging this language, the Court added that evidence of the defendant’s demeanor “before and after a crime is of more limited value than the defendant’s demeanor during the crime.”²⁰⁴ The Court recognized that during the commission of an offense, a defendant may have been suffering from

197. *Id.* at 712.

198. *Id.* at 713.

199. *Id.* at 713–14.

200. *Id.* at 712.

201. *Id.* at 714.

202. *Id.* at 713.

203. *Id.* (quoting *Moler v. State*, 782 N.E.2d 454, 458–59 (Ind. Ct. App. 2003), *trans. denied*) (quotation marks omitted).

204. *Id.* at 714.

“temporary insanity” and Indiana law “allows for the possibility that a defendant will be legally insane at the time of the crime[] but *compos mentis* [, *i.e.*, sane,] immediately before and immediately after the crime.”²⁰⁵

The Court’s holding on the facts before it demonstrates how demeanor evidence must be evaluated in light of a defendant’s documented mental illness. The Court recognized that evidence of the *Galloway* defendant’s behavior before and after the offense may have “indeed represent[ed] the normal events of daily life” to an observer who does not suffer from a serious mental illness.²⁰⁶ However, when that same evidence was “viewed against the defendant’s [twenty-year] long history of mental illness with psychotic episodes, the defendant’s demeanor *during* the crime . . . , and the absence of any suggestions of feigning or malingering,” the *apparently rational* demeanor evidence from before and after the offense was “neutral and not probative of sanity.”²⁰⁷

The best reading of *Galloway* is that where demeanor or behavior evidence may be consistent with *either* rational behavior *or* delusional behavior, that evidence cannot be used by lay fact-finders and jurists to impeach the assessment of the medical experts on their nonconflicting conclusions of insanity.²⁰⁸ In this sense, as Justice Goff would later argue in a dissenting opinion, *Galloway* established that the nonconflicting opinions of the medical experts creates a “rebuttable presumption of insanity.”²⁰⁹ *Galloway* then recognized that, at least in some circumstances, demeanor evidence that may appear to support the fact-finder’s decision is legally insufficient to rebut the established presumption because the actual meaning of that evidence has become speculative and, therefore, cannot carry probative value.²¹⁰ And those circumstances occur most notably when there is no affirmative evidence of feigning.²¹¹

Moreover, while the Court in *Galloway* acknowledged the defendant’s long medical history, the Court’s holding is not *premised* on that medical history.²¹² Indeed, the Court made it a point to recognize that temporary insanity is a viable defense in Indiana—which of course would be a questionable proposition if only a “long history of mental illness” were required to support an insanity defense.²¹³ Thus, the Court’s reference in *Galloway* to that defendant’s medical history was only in conjunction with other potentially probative evidence to demonstrate that there was no legitimate evidentiary conflict on those facts. The Court was

205. *Id.*

206. *Id.* at 715.

207. *Id.*

208. *See generally id.*

209. *Barcroft v. State*, 111 N.E.3d 997, 1010 (Ind. 2018) (Goff, J., dissenting) (Justice Slaughter joined Justice Goff’s dissent).

210. *Galloway*, 938 N.E.2d at 715.

211. *Id.*

212. *See id.*

213. *Id.* at 715–16.

not saying that such medical history is required to negate demeanor evidence.²¹⁴

The Court's holding in *Galloway* is clearly contrary to its holdings in both *Cate* and *Barany*. Again, *Cate* relied *exclusively* on demeanor evidence with no affirmative evidence of feigning illness to support the fact-finder's rejection of the nonconflicting experts' conclusions on insanity.²¹⁵ Likewise, *Barany* relied *exclusively* on lay-witness observations of the defendant's behavior with no affirmative evidence of feigning to support the fact-finder's judgment.²¹⁶ And *Galloway* furthered a dialogue with the Court of Appeals that was critical of *Barany*'s viability. Thus, the Court's holding in *Galloway* that demeanor evidence without affirmative evidence of feigning is "not probative of sanity" is contrary to *Cate* and would at least appear to be equally contrary to the logic of *Barany*.²¹⁷ However, the Court in *Galloway* did not expressly overrule or disapprove of either of the Court's prior opinions but, instead, distinguished them on their facts.²¹⁸

Similarly, *Galloway* quoted the general-language rule from *Thompson* that conflicting evidence is "not required" at all to affirm the fact-finder's rejection of an insanity defense because fact-finders are not required to believe a witness's testimony even when it is uncontradicted.²¹⁹ Clearly, *Galloway*'s holding is completely contrary to that statement. Indeed, *Galloway* demonstrates that where all the evidence points one way but the fact-finder reached the opposite conclusion, the fact-finder erred and reversal is appropriate.²²⁰ That is not a novel proposition of normal appellate review.²²¹ However, in the insanity context, the history of appellate review has not followed that standard. Thankfully, *Galloway* appears to at least clarify, if not supersede, the Court's earlier statement in *Thompson* that the fact-finder needs no reason at all to reject an insanity defense.²²² *Galloway* demonstrates that the fact-finder may not willy-nilly reject credible expert evidence.

6. Myers and Barcroft: Our Supreme Court Reads Galloway Narrowly

But *Galloway* has been quickly fenced in. At the Court's next opportunity to consider a fact-finder's rejection of nonconflicting experts' conclusions on insanity, in *Myers v. State*, the Court affirmed the defendant's GBMI

214. *Id.*

215. *Cate v. State*, 644 N.E.2d 546, 548 (Ind. 1994).

216. *Barany v. State*, 658 N.E.2d 60, 64 (Ind. 1995).

217. *See Galloway*, 938 N.E.2d at 715.

218. *Id.* at 713.

219. *Id.* at 709.

220. *Id.* at 714-15.

221. *See, e.g., Corcoran v. State*, 246 N.E.3d 1223, 1225 (Ind. 2024).

222. *Thompson v. State*, 804 N.E.2d 1146, 1149-50 (Ind. 2004).

conviction.²²³ The Court explained that the evidence showed that, despite a long history of mental illness, the defendant “had seemingly been coping better with [it] over the past several years,” and the alleged delusions underlying the instant offense were unlike prior delusions in his medical record. The defendant’s “demeanor” during the offense—that is, evidence of the his behavior at times proximate to the offense—“did nothing” to demonstrate that he was suffering from a delusion at that time. and the manner in which the defendant both committed the offense and responded to law enforcement indicated that he had acted “in a rational manner.”²²⁴

Thus, the Court’s analysis in *Myers* relied in substantial part on the *newness* of the defendant’s specific mental illness at the time of the offense to affirm the defendant’s GBMI conviction.²²⁵ But *Galloway* had stated that a claim of “temporary insanity” is viable under Indiana law.²²⁶ The Court’s opinion in *Myers* provided no mention of that component of *Galloway* and instead incorrectly read *Galloway* to require that a defendant claiming an insanity defense must act in accordance with his historical illness, which the defendant in *Myers* had not done.²²⁷ Further, the Court in *Myers* cited no scientific authority for its apparent assumption that using evidence of a current diagnosis that is inconsistent with historical diagnoses is unreasonable to establish insanity and is instead probative of feigning.

Shortly after *Myers*, in *Barcroft v. State* the Indiana Supreme Court affirmed the defendant’s GBMI conviction for the following reasons:

- “demeanor evidence” that included planning for the offense, concealing the weapon prior to the offense, not killing a witness to the offense, fleeing from the scene, and telling arresting officers that she “planned on not getting caught”;²²⁸
- “conflicting diagnoses” among the experts, even though the experts were unanimous in their conclusions that the defendant was unable to appreciate the wrongfulness of her conduct at the time of the offense;²²⁹
- “[t]he lapse in time” between the commission of the offense and the

223. *Myers v. State*, 27 N.E.3d 1069, 1082 (Ind. 2015). (The defendant in *Myers* received an aggregate sentence of 120 years. *Id.* at 1073. At the current cost of \$52.61 to incarcerate one defendant per day, and assuming he actually serves half of his sentence, his sentence will cost Hoosier taxpayers \$1,152,159 by the time of his release); IN.GOV, *supra* note 50.

224. *Myers*, 27 N.E.3d at 1076–77.

225. *Id.* at 1077.

226. *Galloway*, 938 N.E.2d 699, 714 (Ind. 2010).

227. *See Myers*, 27 N.E.3d 1069, 1076–78 (Ind. 2015).

228. *Barcroft v. State*, 111 N.E.3d 997, 1005–06 (Ind. 2018). (The defendant in *Barcroft* received a fifty-five year sentence with five years suspended. *Id.* at 1001. At the current cost of \$52.61 to incarcerate one defendant per day, and assuming she spends her entire term in the DOC, her sentence will cost Hoosier taxpayers \$960,132.50 by the time of her release); IN.GOV, *supra* note 50.

229. *Barcroft*, 111 N.E.3d at 1006.

- experts' later examinations of the defendant;²³⁰
- inconsistencies in the experts' reviews of underlying records;²³¹ and
- "[t]he lack of a well-documented history of mental illness" consistent with the present diagnoses.²³²

The Court in *Barcroft* relied in substantial part on *Cate*'s demeanor analysis and gave *Galloway* short shrift as a case where the evidence was simply "without conflict,"²³³ with no mention of *Galloway*'s analysis that such evidence was without conflict *because* the Court had concluded that the demeanor evidence there *could have no probative value of sanity*.²³⁴ Thus, *Barcroft* appears to have given *Cate* new life despite the Court's contrary holding in *Galloway*.

7. *Payne v. State: Our Supreme Court Gives Preferred Status to Defendants with a Well-Documented Medical History in Support of an Insanity Defense*

The Court's final opinion on this topic reversed the fact-finder's rejection of the nonconflicting experts' opinions on insanity but did so in a way that may have exacerbated, rather than mitigated, the *Moler* panel's concerns that our Supreme Court's precedents make it "very difficult even for defendants with well-documented mental illnesses to successfully raise the insanity defense."²³⁵ In particular, in *Payne v. State*, the Court relied on the defendant's twenty-year medical history which showed that he had "long suffered from acute mental illness, having spent most of his life under psychiatric care for chronic paranoid schizophrenia and delusional disorder."²³⁶ The Court also noted that, after the State had charged the defendant with his offenses, he spent the next eleven years undergoing competency restoration before he was able to stand trial.²³⁷ The Court, relying again on the same reading of *Galloway* that it had relied on in *Myers*, then concluded that the purported demeanor evidence—the defendant's planning of the offenses, attempts to cover them up, and flight—was "insufficient . . . to rebut *both* the unanimous expert opinion[s] *and* [the defendant's] well-documented history of" acting in accordance with delusional

230. *Id.* at 1006–07.

231. *Id.* at 1007.

232. *Id.* at 1008.

233. *Id.* at 1005, 1008 (emphasis removed).

234. *Galloway v. State*, 938 N.E.2d 699, 715 (Ind. 2010).

235. *Moler v. State*, 782 N.E.2d 454, 458–59 (Ind. Ct. App. 2003), *trans. denied*.

236. *Payne v. State*, 144 N.E.3d 706, 709 (Ind. 2020). (The defendant in *Payne* received an aggregate sentence of ninety years. *Id.* at 709. Assuming he actually served two-thirds of that sentence at the current cost of \$52.61 to incarcerate one defendant per day, his sentence would have cost Hoosier taxpayers \$1,152,159 had our Supreme Court affirmed his convictions); IN.GOV, *supra* note 50.

237. *Payne*, 144 N.E.3d 706, 709 (Ind. 2020).

beliefs.²³⁸

Similarly critical to the Court's analysis in *Payne* was the following distinction of the Court's opinion in *Barcroft*, which had relied in substantial part on nearly identical demeanor evidence to affirm a GBMI conviction:

[Defendant's] well-documented and consistent history of mental illness, along with the unanimous expert opinion[s], fully undermines the probative value of any relevant demeanor evidence. And with no reasonable or logical inferences to draw from the evidence in support of the [GBMI] verdict, we come only to the conclusion that [the defendant] was insane when the crime[s were] committed. To be sure, the fact[-]finder's determination that a defendant was not insane at the time of the offense warrants substantial deference from an appellate court. But this standard does not and should not deprive this Court of meaningful appellate review. To conclude otherwise would amount to an abdication of our constitutional duty.²³⁹

Notwithstanding the Court's distinction, *Payne* is difficult to reconcile with *Barcroft* and the Court's historical practices. It may seem easy enough to say that *Payne* simply required both nonconflicting expert testimony and also a long-standing and consistent history of the specific mental illness at issue to warrant reversal of a rejected insanity defense. But, again, the premise for that analysis turns on a reading of *Galloway* that is not supported by the full context of that opinion.

Further, if demeanor evidence alone is sufficient to reject an insanity defense, as *Barcroft* and *Cate* make clear, then how does demeanor evidence become insufficient based on other evidence (namely, health records), as *Payne* holds, without reweighing the evidence on appeal? *Galloway* held that demeanor evidence coupled with an absence of affirmative evidence of feigning is, as a matter of law, *not probative* of sanity. This is a conclusion of law that is well-founded in reason and empiricism.²⁴⁰ But *Payne* does not say that. *Payne* allows for such demeanor evidence to be probative of sanity but holds that *both* the experts' conclusions *and* some sufficiently long history of the defendant's mental illness are needed to overcome that demeanor evidence.²⁴¹ Thus, *Payne* joins *Barcroft* and *Myers* in calling *Galloway* into question with respect to whether demeanor evidence may have probative value of sanity. *Payne* just departs from *Barcroft* and *Myers* in how to assess the sufficiency of that

238. *Id.* (italics added; bold font removed).

239. *Id.* at 713.

240. Cf. James L. Knoll IV & Phillip J. Resnick, *Insanity Defense Evaluations: Toward a Model for Evidence-Based Practice*, OXFORD UNIV. PRESS 4–5 (Dec. 28, 2007) (recognizing that demeanor evidence from the time of the offense should be considered in forming the medical experts' conclusions), https://www.upstate.edu/psych/pdf/education/fellowships/insanity_defense.pdf [<https://perma.cc/K75J-JFH4>].

241. See *Payne v. State*, 144 N.E.3d 706 (Ind. 2020).

evidence with the defendant's medical history.

The *Payne* Court's reading of *Galloway* is problematic for another, but similar, reason. The defendant in *Payne* had nearly twenty years of medical records in support of his mental illness.²⁴² But the defendant in *Barcroft* had approximately five years of testimony—albeit, not in the form of medical records—in support of her “nonsensical” behavior, which the Court in *Barcroft* considered insufficient to require a NRBRI judgment.²⁴³ *Payne* thus appears to give a preferred status to those defendants whose life circumstances have enabled them to obtain professional medical treatment for some unspecified but significant period of time, even if that treatment was ultimately unsuccessful. Defendants who are no less mentally ill but whose life circumstances prevented them from accessing treatment, let alone prolonged treatment, would appear to be captured by the holding in *Barcroft* and unable to obtain the same relief obtained by the defendant in *Payne*.

Finally, while the defendant in *Galloway* had a long-standing history of mental illness, the Court's holding in *Galloway* was that there was no evidentiary conflict, *not* that appellate relief was justified based on the defendant's medical history.²⁴⁴ In reading *Galloway* in this way in *Payne*, the Court, as it had also done in *Myers*, limits *Galloway* to circumstances in which the defendant's mental illness is “well-documented,”²⁴⁵ even though that exact concern was part of the dialogue between our Court of Appeals and our Supreme Court leading up to *Galloway* and seemed to be addressed by the *Galloway* Court's conclusion that claims of temporary insanity are viable in Indiana.²⁴⁶ Further, *Payne* reads *Galloway* even more narrowly than the Court had done in *Myers* by expressly concluding that such evidence is *required* in order for “the probative value of demeanor evidence” to “dissolve[.]”²⁴⁷ That extremely narrow reading of *Galloway* casts doubt on the scope of *Galloway*'s standing as good law.

8. *Reconsidering Appellate Review of Rejected Insanity Defenses*

While the totality of the circumstances in any given case matters, so too does treating likes alike in the law. The body of NGBRI/GBMI law has become very disjointed, giving the appearance of inconsistent justice based on factors not supported by the reality of serious mental illnesses.

Indiana's insanity defense is, again, fundamentally about *the defendant's cognitive state*, specifically, his or her *ability to discern a normal moral code or society's common understanding of right from wrong, at the time the crime was*

242. *Id.* at 712–13.

243. *Barcroft v. State*, 111 N.E.3d 997, 1000, 1008 (Ind. 2018).

244. *See Galloway v. State*, 938 N.E.2d 699, 715 (Ind. 2010).

245. *Payne*, 144 N.E.3d at 712, 713.

246. *See Galloway*, 938 N.E.2d at 713; *Moler v. State*, 782 N.E.2d 454, 458–59 (Ind. Ct. App. 2003), *trans. denied*.

247. *Payne*, 144 N.E.3d at 712.

committed. But what does it mean to be able to discern a normal understanding of right from wrong when, in your own internal reality, you are Jesus Christ?²⁴⁸ What does it mean to be able to discern society's common understandings when, in your own internal reality, you and your family are being hunted by a foreign mafia that has infiltrated the highest levels of government?²⁴⁹ Do you know what a normal moral code is when, in your own internal reality, only you know the truth of numerous government misdeeds, government officials are trying to stop you from exposing them, and you are "dutybound" to bring attention to the issues by burning down covered bridges?²⁵⁰ And what does it mean to say that the *external manifestations* of those internal realities *disprove* an insanity defense *because* those external manifestations *appear rational* to those of us who *do* understand society's common morality?

The Court should restore *Galloway* to its best reading and extend it to its logical ends, namely, that nonconflicting expert conclusions establish a rebuttable presumption of insanity, and our fact-finders are not free to simply disregard that presumption by guessing as to the meaning of other evidence. Trained medical experts already rely on demeanor evidence and lay-witness evidence contemporaneous to the time of an offense to formulate their medical opinions regarding the defendant's cognitive state at the time of the offense.²⁵¹ They also already rely on the defendant's medical history to formulate their medical opinions and conclusions.²⁵²

A proper Venn Diagram showing the overlap between the *medically* probative value of such evidence and the *legally* probative value of it should be a single circle in the insanity context. Thus, demeanor evidence, the subjective impressions of lay-witnesses, and the defendant's medical history lose any probative value of sanity once the medical experts have relied on that information and formulated nonconflicting diagnoses of insanity and there is no affirmative evidence of feigning.

In other words, *Galloway* correctly demonstrates that demeanor evidence alone does not carry probative value of sanity once multiple medical experts have, without conflict, determined that a defendant was insane at the time of the crime committed.²⁵³ That same reasoning extends to lay-witness observations of the defendant's behaviors and the defendant's medical history. *Galloway* expressly and correctly recognizes that medical history may be wholly irrelevant in some circumstances.²⁵⁴ Likewise, the Court should disapprove of relying on

248. See *Galloway*, 938 N.E.2d at 704 (where the defendant suffered from a psychotic delusion that he was Jesus Christ and believed his actions were divinely mandated).

249. See *Barcroft v. State*, 111 N.E.3d 997, 1001 (Ind. 2018) (where the defendant experienced persecutory delusions involving an alleged foreign conspiracy targeting him and his family).

250. *Payne*, 144 N.E.3d at 713.

251. *Knoll & Resnick*, *supra* note 240.

252. *Id.* at 5 (recognizing that demeanor evidence from the time of the offense should be considered in forming the medical experts' conclusions).

253. See *supra* Part IV.D.5.

254. *Galloway v. State*, 938 N.E.2d 699, 714 (Ind. 2010).

the passage of time between an offense and a mental-health examination to discredit the examination. There must be some passage of time between an offense and the examination of the defendant.²⁵⁵ If that passage of time—which the Court relied on in both *Barany* and *Barcroft*—can invalidate nonconflicting expert opinions, Indiana may as well not have an insanity defense at all.²⁵⁶

Along with restoring and extending *Galloway*, the Court should overrule *Cate* and *Barany*, both of which were premised on demeanor evidence or lay-witness testimony without affirmative evidence of feigning illness to set aside the nonconflicting opinions of credible medical experts.²⁵⁷ Similarly, the Court should overrule *Myers* and *Payne* to the extent those opinions require a defendant's actions at the time of an offense to conform to a well-documented medical history in order to obtain the benefits of Indiana's insanity defense.²⁵⁸

Once a defendant has demonstrated a rebuttable presumption of insanity, to obtain a guilty or GBMI verdict the State must disprove the existence of insanity beyond a reasonable doubt.²⁵⁹ To allow our fact-finders to use evidence that trained medical experts will have already concluded lacks probative value of sanity to rebut those experts' conclusions bases a conclusion of sanity on a lay person's *assumptions* that *apparent* behavior was *rational* behavior and the medical experts were duped.²⁶⁰ Such a conclusion is not based on evidence of probative value but on the fact-finder's speculation as to the meaning of that evidence, and speculation is constitutionally insufficient to support a criminal conviction.²⁶¹ Further, and importantly, the risk that a lay fact-finder will engage in that speculation is heightened by the competency-restoration process, which, as noted earlier, often results in disguising a defendant's mental illness by having the defendant *appear* rational during trial.

The insanity statutes require evaluation of defendants by psychiatrists or psychologists for a reason, and our Supreme Court should reconsider its body of law here to implement our General Assembly's intent for that requirement. The *only* nonspeculative, probative evidence of the defendant's internal cognitive state at the time of an offense is the opinion of an expert trained in discerning that cognitive state; that cognitive state is what Indiana's insanity defense is all about.²⁶²

255. Knoll & Resnick, *supra* note 240, at 5.

256. *Barcroft v. State*, 111 N.E.3d 997, 1006-07 (Ind. 2018); *Barany v. State*, 658 N.E.2d 60, 64 (Ind. 1995).

257. *See supra* Part IV.D.2.

258. *See supra* Part IV.D.6-7.

259. *See, e.g., Adkins v. State*, 887 N.E.2d 934, 938 (Ind. 2008) (holding that, once a defendant places a mitigating or affirmative issue at issue, the State bears the burden of disproving that issue beyond a reasonable doubt).

260. As the Indiana Court of Appeals has long recognized in the context of medical malpractice claims: "An expert, who has the ability to apply principles of science to the facts, has the power to draw inferences from the facts which a lay witness or jury would be incompetent to draw." *Daub v. Daub*, 629 N.E.2d 873, 878 (Ind. Ct. App. 1994), *trans. denied*.

261. *See, e.g., Smith v. State*, 270 N.E.2d 743, 745 (Ind. 1971).

262. *See supra* Part D.1.

This is not to say that the State cannot rebut nonconflicting experts who support an insanity defense, but the rebuttal must establish a substantial reason that is beyond a reasonable doubt to not rely on the experts' nonconflicting opinions. By all means, let the State present affirmative evidence of a defendant's history of feigning mental illness or other medical information.²⁶³ Let the State affirmatively challenge the credibility of the experts.²⁶⁴ Let the State challenge the quality of the experts' assessments of the defendant.²⁶⁵ Let the State emphasize substantial inconsistencies between the experts' reports.²⁶⁶ Any or all of these are valid challenges to expert medical testimony and may reasonably support affirming the fact-finder's rejection of a rebuttable presumption under the insanity defense.

However, the Indiana Supreme Court should not allow nonconflicting and credible experts to come to a singular conclusion about the defendant's cognitive state at the time of an offense only to have a lay fact-finder shrug it off based on assumptions, guesses, or biases. Nor should the Court allow lay fact-finders and jurists to selectively choose and prefer evidence that may appear rational to those with normal cognitive states but has already been considered by medical experts to come to their conclusions on insanity, including demeanor and observation evidence contemporaneous to the offense as well as the defendant's medical history and how the defendant presents himself or herself at trial, as a basis to impeach those experts' conclusions. And the Court should not allow, as it did in *Payne*, for the meaningfulness of appellate review for some of our most vulnerable citizens to depend on a life history of access to medical care, especially in a state where access to that care is so hard to come by.

V. CONCLUSION

Hoosiers are suffering from a lack of available mental-health care in our communities. But Indiana's judiciary need not stand idly by in these times when it comes to serious mental illness among criminal defendants. The Indiana Supreme Court should amend the Indiana Criminal Rules to require judicial officers at initial hearings to administer the BJMHS. The Judicial Conference and other stakeholders should enable Indiana probation officers to become qualified mental-health specialists within their departments. Finally, the Indiana Supreme Court should revisit appellate review of rejected insanity defenses and hold that nonconflicting and credible expert testimony of insanity at the time of the crime establishes a rebuttable presumption of insanity.

263. *E.g.*, *Gambill v. State*, 675 N.E.2d 668, 672–73 (Ind. 1996).

264. *Cf.* *Galloway v. State*, 938 N.E.2d 699, 711 (Ind. 2010) (noting that the trial court, acting as the fact-finder, based its GBMI judgment not on the experts' testimony but on other evidence).

265. *See* *Barcroft v. State*, 111 N.E.3d 997, 1006–07 (Ind. 2018).

266. *See id.*

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NOTES

***PINING* FOR COAL ASH SOLUTIONS: HOW FEDERAL AND INDIANA LAW SHOULD REGULATE “BENEFICIAL USE” OF COAL ASH TO BETTER PROTECT HUMAN HEALTH AND THE ENVIRONMENT**

KARISA CANDREVA*

I. INTRODUCTION

Phyllis DaMota is known in her community as “the canary.” In April 2000, Phyllis purchased her first home in Town of Pines, Indiana, a small community just steps away from the Indiana Dunes. Shortly after moving in, Phyllis noticed a faint chemical-like smell coming from her water—almost “like walking into a beauty salon.” Phyllis contacted the Indiana Department of Environmental Management (hereinafter “IDEM”) to test her water. In May 2000, Phyllis’ water tested positive for benzene. Her neighbors then got their wells tested. The neighbors’ drinking water wells collectively tested positive for benzene, arsenic, lead, selenium, manganese, boron, and molybdenum; these toxic metals are all found in coal ash, the byproduct of burning coal. For the past twenty-five years, the small community of Town of Pines, Indiana, has faced devastating human health and environmental impacts from coal ash contamination.

This note argues how federal and Indiana law should regulate beneficial use of coal ash to better protect human health and the environment. Part I introduces coal ash and beneficial use of coal ash, defines the scope of coal ash in the United States, Midwest, and Indiana, and discusses the human health and environmental impacts of coal ash on the community of Town of Pines, Indiana. Part II discusses background information on federal and Indiana coal ash law and then explains the beneficial use regulatory gap that exists between federal law and Indiana law. Part III analyzes how both federal law and Indiana law should regulate beneficial use of coal ash to better protect human health and the environment.

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A. What Is Coal Ash?

Coal ash is a toxic, carcinogenic byproduct of burning coal.¹ There are four types of coal-burning residuals: (1) fly ash, (2) flue gas desulfurization sludge, (3) bottom ash, and (4) boiler slag.² These residuals are known as “coal ash” or “coal combustion residuals” (hereinafter “CCR”).³ Each type of residual has a unique composition, but all coal ash is made up of chemicals that are harmful to humans and the environment.⁴ These chemicals include aluminum, antimony, arsenic, benzene, boron, cadmium, chromium, lead, manganese, mercury, molybdenum, nickel, PM 2.5, selenium, thallium, vanadium, and zinc.⁵ Alone, each of these chemicals can have devastating effects on human health and the environment. Therefore, coal ash is extremely harmful to human health and the environment because the combination and concentration of these chemicals in one byproduct creates “a deadly brew of carcinogens, neurotoxins, and poisons.”⁶

Coal ash exposure to people and the environment results in harmful, lasting effects. Human health impacts include cancer of the liver, kidneys, lungs, bladder, or skin, birth defects, kidney disease, reproductive harm, and nervous system damage, especially in children.⁷ Environmental impacts include drinking water, groundwater, and surface water contamination, soil contamination, massive extirpation of fish and other aquatic life, bioaccumulation of toxins in the food chain, dust and air pollution, and radiation.⁸ Coal ash exposure to humans and the environment typically happen when owners or operators of coal ash units dispose or reuse coal ash improperly

1. Lisa Evans et al., *Coal Ash Primer*, EARTHJUSTICE 4 (2023), https://earthjustice.org/wp-content/uploads/coal-ash-primer_earthjustice_2023.pdf [<https://perma.cc/F9DA-YKBV>].

2. *Id.* at 5.

3. The terminology “coal ash,” “coal combustion residuals,” and “CCR” are interchangeable. All three terms refer to the byproduct of burning coal. This note uses the term “coal ash” colloquially, such as through description and analysis. This note uses the term “CCR” when referencing law or industry terms, such as the “2015 CCR Rule,” the “2024 CCR Rule,” “CCR piles,” “CCR management units,” or “CCR surface impoundments,” or otherwise if directly quoted.

4. Evans et al., *supra* note 1, at 5.

5. *Id.* at 7–9; *see also* Martha H. Keating & Lisa Gollin Evans, *Not in My Lifetime*, CLEAN AIR TASK FORCE 4–5 (2019), https://cdn.catf.us/wp-content/uploads/2019/10/21093534/Not_in_My_Lifetime.pdf?_gl=1*49dnq5*_gcl_au*MTg2Njc0MTQ2NS4xNzMwNzQyNjg5*_ga*R0ExLjEuNjMxNDUxMTAuMTczMDc0MjY4OQ..*_ga_88025VJ2M0*MTczMDc0MjY4OC4xLjEuMTczMDc0NTI4Mi4wLjAuMjMwNzU0MzI.*_fplc*Z2hkcGhPNEozZIRIJTJCT0dZeJgwWXVOOWxnSFklMkZRNxVWwKNibmhhaaDQ1ZVhLZUs0TDcweyUyQklLJTJGQjIEeFk0NjRR eEhvZjQ3J4VDk4U1p0WmpJVWYzSmslMkZTVWQwcnhUVEpMbEpnNUh1NmRtekR3bFpTcVIPZVpGeWtnSUFSDyUzRCUzRA [<https://perma.cc/8U7E-LZ8M>].

6. Evans et al., *supra* note 1.

7. *Id.* at 7–9.

8. *Id.* at 10–13.

or irresponsibly. Reuse of coal ash is known as “beneficial use.”⁹

B. What Is “Beneficial Use” of Coal Ash?

“Beneficial use” of coal ash is the process of reusing or recycling residuals into a usable form rather than disposing of the coal ash in a landfill or surface impoundment.¹⁰ The United States Environmental Protection Agency (hereinafter “EPA”) notes the “beneficial” aspects of reuse include environmental benefits, economic benefits, and product benefits.¹¹ However, not all beneficial use is the same. Two forms of beneficial use exist—encapsulated beneficial use and unencapsulated beneficial use.¹² Encapsulated beneficial use “binds the CCR into a solid matrix that minimizes their mobilization into the surrounding environment.”¹³ Examples of encapsulated beneficial use include binding the coal ash into concrete, cement, bricks, grout, plastics, rubber, and wallboard.¹⁴ Encapsulated uses are generally safer for human health and the environment than unencapsulated uses because the coal ash is in a bound form, making it less likely to leach into soil or groundwater.¹⁵ For example, the EPA conducted studies on the use of fly ash in concrete and the use of flue gas desulfurization sludge in wallboard and found that these uses do not pose greater risks to human health or the environment than the materials traditionally used in such applications.¹⁶

Alternatively, unencapsulated beneficial use is “a loose particulate, sludge, or other unbound form.”¹⁷ Examples of unencapsulated beneficial use include adding the coal ash into structural fill, roadways, agricultural uses, soil modification, and loose aggregate.¹⁸ Unencapsulated uses are generally less safe for human health and the environment than encapsulated uses because the coal ash is in an unbound form, making it more likely to leach into soil or

9. *Frequent Questions about the Beneficial Use of Coal Ash*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/coalash/frequent-questions-about-beneficial-use-coal-ash> [<https://perma.cc/4NPK-YLAZ>] (last updated Aug. 27, 2025).

10. *Id.*

11. *Coal Ash Basics*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/coalash/coal-ash-basics#04> [<https://perma.cc/LW9J-4QAS>] (last updated Aug. 27, 2025) (listing environmental benefits as “reduced greenhouse gas emissions, reduced need for disposing in landfills, and reduced use of other materials”; economic benefits as “reduced costs associated with [coal ash] disposal, increased revenue from the sale of [coal ash], and savings from using [coal ash] in place of other, more costly materials”; and product benefits as “improved strength, durability, and workability of materials”).

12. U.S. ENV’T PROT. AGENCY, *supra* note 9.

13. *Id.*

14. *Id.*

15. Evans et al., *supra* note 1, at 14.

16. *Coal Combustion Residual Beneficial Use Evaluation: Fly Ash Concrete and FGD Gypsum Wallboard*, U.S. ENV’T PROT. AGENCY (Feb. 2014), https://www.epa.gov/sites/default/files/2014-12/documents/ccr_bu_eval.pdf [<https://perma.cc/BQ5F-8UA8>].

17. U.S. ENV’T PROT. AGENCY, *supra* note 9.

18. *Id.*

groundwater.¹⁹ Risks of unencapsulated use include contamination of drinking water wells, creation of toxic fugitive dust, leaching of toxic trace elements into soil and groundwater, reduced crop growth, and crop absorption of higher concentrations of metals.²⁰

The EPA distinguishes both encapsulated beneficial use and unencapsulated beneficial use from disposal methods. Disposal methods include dumping coal ash into landfills or ash ponds, whereas beneficial use incorporates coal ash into products like concrete, bricks, wallboard, or fill. This differentiation is critical because federal and state law regulate disposal methods more stringently than beneficial use. Yet, in 2022, over half (sixty-two percent) of the coal ash produced in the United States was recycled as a beneficial use rather than disposed.²¹

C. Scope of Coal Ash in the United States, Midwest, and Indiana

Over the last century, U.S. coal plants have generated about five billion tons of coal ash.²² There are 746 coal ash units in forty-three states and Puerto Rico.²³ The Midwest houses many of these coal ash units for two main reasons: (1) coal plants are generally located near sources of water due to production needs, and the Midwest is home to the Great Lakes, and (2) the Midwest has historically had an abundance of coal deposits.²⁴ For example, Illinois has twenty-six coal plants, Indiana has twenty-four coal plants, Ohio has twenty-two coal plants, Kentucky has twenty coal plants, and Michigan has seventeen coal plants.²⁵

Indiana's economy and population heavily rely on coal production and consumption—Indiana is the eighth-largest coal-producing state and second-largest coal-consuming state.²⁶ In fact, while the United States' coal production

19. Evans et al., *supra* note 1, at 14–18.

20. *Id.* at 17–18.

21. Thomas H. Adams, *Coal Ash Recycling Rate Increased in 2022; Ash Harvesting Continued at Significant Volumes*, AM. COAL ASH ASS'N 1 (Dec. 27, 2023), <https://acaa-usa.org/wp-content/uploads/2023/12/News-Release-Coal-Ash-Production-and-Use-2022.pdf> [<https://perma.cc/WC6J-CKCN>].

22. *Coal Ash Solutions*, HOOSIER ENV'T COUNCIL, <https://www.hecweb.org/issues/environmental-health-justice/coal-ash/> [<https://perma.cc/DW6K-NY5L>] (last visited Oct. 11, 2025).

23. 40 C.F.R. § 257.53 (2024) (defining a coal ash unit as “any CCR landfill, CCR surface impoundment, or lateral expansion of a CCR landfill or CCR surface impoundment, or a combination of more than one of these units”); *Mapping the Coal Ash Contamination*, EARTHJUSTICE (Nov. 3, 2022), <https://earthjustice.org/feature/coal-ash-contaminated-sites-map> [<https://perma.cc/77LZ-SPLL>].

24. Steve Whittaker et al., *The Illinois Basin: The Geologic Gift that Keeps Giving*, ILL. STATE GEOLOGICAL SURV. (Apr. 4, 2022, 8:30 AM), <https://blogs.illinois.edu/view/8931/1168229593> [<https://perma.cc/C6PN-ZXNJ>].

25. *Where are Coal Ash Dump Sites?*, EARTHJUSTICE (May 3, 2023), <https://earthjustice.org/feature/coal-ash-map-sites-legacy-inactive-regulated> [<https://perma.cc/392V-K5RQ>].

26. *Indiana, Analysis*, U.S. ENERGY INFO. ADMIN., <https://www.eia.gov/states/IN/analysis> [<https://perma.cc/2T3V-BAFT>] (last updated Nov. 19, 2025).

decreased overall in 2023, Indiana's coal production actually increased by almost one percent, amounting to Indiana producing a total of 23.8 million tons of coal in 2023.²⁷ Most of Indiana's coal plants are found along Lake Michigan, the Ohio River, the Wabash River, and the White River.²⁸ Five plants are located in Northwest Indiana, impacting Lake Michigan and the Kankakee River.²⁹ Four plants are located in Western Indiana near the Illinois border, impacting the Wabash River.³⁰ Seven plants impact the White River and Patoka River in Southwest and Central Indiana.³¹ Two plants are located in Eastern Indiana near the Ohio border, impacting the Whitewater River.³² Six plants are located in Southern Indiana on the Kentucky border, impacting the Ohio River.³³

Concerningly, Indiana, with one hundred coal ash dumpsites, has the largest number of coal ash dumpsites than any other state.³⁴ These one hundred dumpsites are found all around the state, with about four million of Indiana's 6.6 million citizens living within thirty miles of a coal ash pond or landfill.³⁵ One site in particular, Yard 520 Landfill, has devastated a small town known as Town of Pines, Indiana.³⁶ Town of Pines is located in Northwest Indiana near the Lake Michigan shoreline, Indiana's greatest freshwater resource. Coal ash exposure in this community has resulted in contaminated soil, unsafe drinking water, and a myriad of health issues for residents.

D. Town of Pines, Indiana

Town of Pines, Indiana, is a small town of about 600 residents located on

27. *Annual Coal Report 2023*, U.S. ENERGY INFO. ADMIN. 2 (Oct. 2024), <https://www.eia.gov/coal/annual/pdf/acr.pdf> [<https://perma.cc/6KWZ-DDG5>].

28. *Toxic Coal Ash in Indiana*, CITIZENS ACTION COAL., <https://www.citact.org/campaign/toxic-coal-ash-indiana> [<https://perma.cc/R5GV-JLYN>] (last visited Nov. 22, 2024).

29. Indra Frank & Tim Maloney, *Our Waters at Risk*, HOOSIER ENV'T COUNCIL 15 (Nov. 2020), <https://www.hecweb.org/wp-content/uploads/2020/11/Our-Waters-at-Risk-Part-2.pdf> [<https://perma.cc/Y26H-H3BL>] (mapping the five plants that impact Lake Michigan and the Kankakee River as State Line, Bailly, Mitchell, Schahfer, and Michigan City).

30. *Id.* (mapping the four plants that impact the Wabash River as Cayuga, Wabash River, Dresser, and Merom).

31. *Id.* (mapping the seven plants that impact the White River and Patoka River as Gibson, Ratts, Petersburg, Edwardsport, Eagle Valley, Harding Street, and Noblesville).

32. *Id.* (mapping the two plants that impact the Whitewater River as Whitewater Valley and Tanner's Creek).

33. *Id.* (mapping the six plants that impact the Ohio River as AB Brown, Warrick, Culley, Rockport, Gallagher, and Clifty Creek).

34. *Toxic Coal Ash in Indiana: Addressing Coal Plants' Hazardous Legacy*, EARTHJUSTICE (May 3, 2023), <https://earthjustice.org/feature/coal-ash-states/indiana> [<https://perma.cc/VJ4S-R7HP>] (referring to archived information accessed via permalink).

35. IND. ENV'T REP. *In the Water*, at 27:19–27:28 (YouTube, Oct. 30, 2019), https://www.youtube.com/watch?v=_EwFL-jTDRs [<https://perma.cc/Q4SK-9JLQ>].

36. Sarah Bowman, *Who was Responsible for Harmful Pollution Left in Small Indiana Town After 'Cleanup' Done?*, INDYSTAR (May 23, 2024, 5:31 AM), <https://www.indystar.com/story/news/environment/2024/05/23/residents-of-small-indiana-town-face-risks-even-after-coal-ash-cleanup/73502047007/> [<https://perma.cc/NJ6A-A7HX>].

Indiana's Lake Michigan shoreline.³⁷ The town's moniker, "Door Step to Mount Baldy," references the 120-foot sand dune that is one of the landmarks and tourist destinations within Indiana's only national park, the Indiana Dunes National Park.³⁸ The Indiana Dunes National Park is the most ecologically diverse part of Indiana and the eighth most biologically diverse national park in the United States for vegetative species.³⁹ The park supports over 1,400 vascular plant species, over 350 bird species, around 71 species of fish, 41 mammal species, and 51 amphibian and reptile species.⁴⁰ These species thrive in the diverse habitats of the park including open beaches, sand dunes, grass covered dune ridges, dunes with woody shrub vegetation, pine-forested dunes, oak-forested dunes, oak savannas, prairies, marshes, and bogs.⁴¹ All of this biological diversity and ecological significance is at the "Door Step" of Town of Pines; however, the town has a very different environmental story to tell.

In the 1970s, Yard 520 Landfill opened in Town of Pines and began receiving coal ash from the Bailly and Michigan City Generating Stations, both owned by the Northern Indiana Public Service Company (hereinafter "NIPSCO").⁴² Yard 520 Landfill sits on top of the town's aquifer, only 300 feet from the nearest drinking water well.⁴³ Yard 520 Landfill has two separate areas, known as the South area and the North area.⁴⁴ The South area of the landfill was constructed with a liner, which helped protect coal ash contamination from leaching into the soil or groundwater.⁴⁵ However, the North area of the landfill was not constructed with a liner, which practically ensured coal ash contamination would leach into the soil and groundwater.⁴⁶ The South area stopped receiving waste in the early 2000s.⁴⁷ The North area stopped receiving waste in the mid-1980s.⁴⁸ Over the thirty years Yard 520 Landfill was receiving waste, NIPSCO ultimately dumped two billion pounds of coal ash into the Yard

37. *Town of Pines town, Indiana*, U.S. CENSUS BUREAU, https://data.census.gov/profile/Town_of_Pines_town_Indiana?g=160XX00US1876256 [<https://perma.cc/YBL8-QZ3W>] (last visited Nov. 22, 2024).

38. *Mount Baldy Restoration, Indiana Dunes National Park*, NAT'L PARK SERV., <https://www.nps.gov/indu/learn/nature/mount-baldy.htm> [<https://perma.cc/2EVM-DDMJ>] (last updated Oct. 24, 2023).

39. *Indiana Dunes National Park*, GLOB. ALL. OF NAT'L PARKS, <https://national-parks.org/united-states/indiana-dunes> [<https://perma.cc/CL9E-B5NV>] (last visited Nov. 22, 2024).

40. *Id.*

41. *Natural Features & Ecosystems, Indiana Dunes National Park*, NAT'L PARK SERV., <https://www.nps.gov/indu/learn/nature/naturalfeaturesandecosystems.htm> [<https://perma.cc/DW3Y-56PA>] (last updated Apr. 17, 2024).

42. Keating & Evans, *supra* note 5, at 5–6.

43. *Id.* at 6.

44. *Town of Pines Superfund Site, Record of Decision*, U.S. ENV'T PROT. AGENCY 5 (Sept. 2016), <https://semspub.epa.gov/work/05/508886.pdf> [<https://perma.cc/PSL4-MW5F>].

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

520 Landfill.⁴⁹ Yard 520 Landfill is an example of a coal ash disposal method, not a beneficial use.⁵⁰

In addition to NIPSCO dumping coal ash in Yard 520 Landfill, the Indiana Department of Health (hereinafter “IDOH”) assured residents that coal ash was a safe option to use as a filler for road beds and for low-lying areas—which dramatically exacerbated the coal ash issue in Town of Pines.⁵¹ Town of Pines was built around wetlands, areas in which soil is saturated with water, causing uneven and sunken land development over time.⁵² Thus, residents who had sinking backyards, front yards, and driveways welcomed a cheap fill option to better utilize their land for playground sets, gardens, landscaping, and roads. Using coal ash in this way is referred to as structural fill, construction fill, or residential fill.⁵³ Fill is an unencapsulated beneficial use, meaning the coal ash is reused in an unbound form which easily contaminates soil and groundwater.⁵⁴ Although the IDOH deemed using coal ash as fill safe in the 1970s, such use essentially spread the coal ash contamination around the town like wildfire—federal officials detected toxins and radiation from coal ash in residents’ yards, under main roads, and beneath the community playground.⁵⁵

In April 2000, Phyllis DaMota, a resident of Town of Pines, noticed a strange odor coming from her drinking water and called IDEM to test the water.⁵⁶ This call triggered IDEM to perform a series of drinking water tests from 2000–02 that revealed over 160 homes in Town of Pines had either contaminated drinking water wells or suspected contaminated drinking water wells.⁵⁷ The contaminants included benzene, arsenic, lead, selenium, manganese, boron, and molybdenum.⁵⁸ All of these contaminants are carcinogenic—and all of these contaminants can be found in coal ash. After IDEM discovered this vast coal ash contamination, residents came together and formed a committee known as “P.I.N.E.S.” (People In Need of Environmental Safety).⁵⁹ This grassroots committee formed “to ensure the town’s water was cleaned up and to keep residents aware of each step in the process.”⁶⁰ Such local advocacy continues to

49. Beth Edwards, *Northern Indiana Residents Doubt Outcome of Coal Ash Cleanup*, GREAT LAKES NOW (Apr. 25, 2022), <https://www.greatlakesnow.org/2022/04/indiana-residents-coal-ash-cleanup/> [https://perma.cc/PH8M-DXQJ].

50. See *infra* notes 163–65 and accompanying text.

51. IND. ENV’T REP., *supra* note 35, at 42:39–42:44.

52. *What is a Wetland?*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/wetlands/what-wetland> [https://perma.cc/N83B-4YM7] (last updated Apr. 7, 2025).

53. Edwards, *supra* note 49.

54. See *supra* notes 17–20 and accompanying text.

55. Sarah Bowman, *EPA: Cancer risk from coal ash higher than previously revealed. Could it be in your yard?*, INDYSTAR <https://www.indystar.com/story/news/environment/2024/02/20/cancer-risk-from-coal-ash-higher-than-thought-it-could-be-in-yards/71933973007/> [https://perma.cc/57DG-SFV6] (last updated Feb. 23, 2024, 4:49 PM).

56. Edwards, *supra* note 49.

57. Keating & Evans, *supra* note 5, at 4.

58. *Id.* at 4–5.

59. Edwards, *supra* note 49.

60. *Id.*

be instrumental in Town of Pines' fight for their town's cleanup through federal and state plans and settlements with the responsible contaminators.⁶¹

The Comprehensive Environmental Response, Compensation, and Liability Act (hereinafter "CERCLA") authorizes the EPA to clean up contaminated sites or force responsible parties to clean up contaminated sites.⁶² Such contaminated sites are known as "Superfund sites," and, through the Superfund Enforcement Program, the EPA finds responsible parties or potentially responsible parties to negotiate a cleanup plan.⁶³ In 2004, the EPA declared Town of Pines a contaminated site due to the coal ash contamination of the groundwater and soil.⁶⁴ The Town of Pines contaminated "site" includes the various properties throughout the town with contaminated groundwater and soil and the Yard 520 Landfill.⁶⁵ EPA determined NIPSCO, Brown, Inc., Ddalt Corp., and Bulk Transport were responsible for contaminating Town of Pines.⁶⁶ EPA did not place the Town of Pines site on the National Priorities List (hereinafter "NPL"), meaning the EPA took the "Superfund alternative approach" for the site.⁶⁷ While the EPA states the alternative approach "uses the same investigation and cleanup process and standards that are used for sites listed on the NPL," the alternative approach can result in the responsible parties having more discretion over the technical assistance services.⁶⁸ However, this increased discretion may be problematic if the technical assistance services preclude community participation; such participation is critical to ensuring community members are aware of any clean-up problems, discrepancies, setbacks, or progress. In 2022, the United States, on behalf of the EPA and IDEM, entered into a consent decree with NIPSCO for the remediation and removal of the contaminated soil within Town of Pines.⁶⁹ NIPSCO must pay around \$12 million for this clean up.⁷⁰

61. *'Do Your Job, EPA': Stories from the Frontlines of Coal Ash*, EARTHJUSTICE (Apr. 25, 2024), <https://earthjustice.org/feature/coal-ash-stories-epa-hearing> [https://perma.cc/STPS-6L6S].

62. *What is Superfund?*, U.S. ENV'T PROT. AGENCY, <https://www.epa.gov/superfund/what-superfund> [https://perma.cc/5V5E-E53F] (last updated Sept. 17, 2025).

63. *Superfund Enforcement*, U.S. ENV'T PROT. AGENCY, <https://www.epa.gov/enforcement/superfund-enforcement> [https://perma.cc/H2FT-YTFN] (last updated Jan. 16, 2025).

64. Bowman, *supra* note 36.

65. *Town of Pines Superfund Site, Record of Decision*, *supra* note 44, at 1.

66. *Superfund Site: Town of Pines Groundwater Plume, Town of Pines, IN*, U.S. ENV'T PROT. AGENCY, <https://cumulis.epa.gov/supercpad/cursites/csinfo.cfm?id=0508071> [https://perma.cc/WA74-Q48F] (last visited Jan. 30, 2025).

67. U.S. ENV'T PROT. AGENCY, *supra* note 44, at 1.

68. *Superfund Alternative Approach*, U.S. ENV'T PROT. AGENCY, <https://www.epa.gov/enforcement/superfund-alternative-approach> [https://perma.cc/9XDM-6K58] (last updated June 17, 2025).

69. Remedial Design/Remedial Action Consent Decree for Operable Unit 2 of the Town of Pines Superfund Site, *United States v. N. Ind. Pub. Serv. Co.*, 2022 U.S. Dist. LEXIS 163808 (N.D. Ind. 2022) (No. 2:22-cv-48).

70. Sarah Bowman, *Indiana Town was Built on Contaminated Coal Ash. Now, NIPSCO Must Pay \$12M to Clean it Up*, INDYSTAR (Mar. 10, 2022, 5:51 AM), <https://www.indystar.com/story/news/environment/2022/03/10/nipsco-paying-millions-clean-coal-ash-contaminated-indiana-town-pines/9410858002/> [https://perma.cc/J34A-B9HE].

The coal ash dumped within Town of Pines has had lasting, devastating effects to both human health and the environment. Many residents now suffer from different types of cancers and thyroid issues linked to the coal ash toxins found in their contaminated drinking water.⁷¹ Residents have been unable to depend on their wells for drinking water since the extent of the coal ash contamination was discovered in the early 2000s. Today, the majority of residents have been connected to the neighboring Michigan City's municipal water supply.⁷² However, some residents still rely on bottled water the EPA mandated NIPSCO to supply to them.⁷³ Some residents can no longer expect to sell their homes due to diminished property values, garden in their own backyards, allow their children and grandchildren to play outside, nor simply enjoy a glass of tap water. The fight in Town of Pines continues, most recently with the EPA's announcement of "a revised cleanup plan to lower levels for contaminants of concern at the Town of Pines Superfund alternative site."⁷⁴ Thus, Town of Pines residents currently, and foreseeably, face human health and environmental consequences from coal ash contamination.

Federal and state coal ash law failed Towns of Pines. The next section of this note explains the background of coal ash law at the federal level, the state level, and the beneficial use regulatory gap between federal and state law.

II. BACKGROUND

A. Federal Coal Ash Law

The federal government first developed coal ash regulations in 2015.⁷⁵ However, EPA's pre-2015 federal determinations of coal ash regulation, or lack thereof, has continuing consequences on current regulatory schemes. For one example, the EPA determined coal ash was to be regulated as non-hazardous solid waste rather than hazardous waste, resulting in coal ash authority housed under Subtitle D of the Resource Conservation and Recovery Act of 1976 (hereinafter "RCRA") rather than Subtitle C of RCRA which authorizes regulation of hazardous waste.⁷⁶ This section explains the dense statutory and

71. Bowman, *supra* note 55.

72. Edwards, *supra* note 49.

73. *Id.*

74. *EPA Updates Cleanup Plan for Town of Pines Superfund Alternative Site in Indiana*, U.S. ENV'T PROT. AGENCY, <https://www.epa.gov/newsreleases/epa-updates-cleanup-plan-town-pines-superfund-alternative-site-indiana> [<https://perma.cc/LJ5D-CRN2>] (last updated June 25, 2025).

75. *Legislative and Regulatory Timeline for Fossil Fuel Combustion Wastes*, U.S. ENV'T PROT. AGENCY, <https://www.epa.gov/coalash/legislative-and-regulatory-timeline-fossil-fuel-combustion-wastes> [<https://perma.cc/3MAL-V88J>] (last updated May 9, 2025); 40 C.F.R. §§ 257, 261 (2024).

76. See Brittany L. Daniels, Comment, *Caution: Hazards Ahead! How the EPA's Refusal to Classify Coal Ash as Hazardous Waste Fuels Environmental and Public Health Concerns*, 27 Vill. Env't. L. J. 93, 100 (2016).

regulatory background of federal coal ash law, as well as more recent federal coal ash case law.

1. Federal Statutes and Regulations

RCRA authorizes coal ash regulation on the federal level. Congress enacted RCRA “to address the increasing problems the nation faced from our growing volume of municipal and industrial waste,” and thus amended the mostly ineffectual Solid Waste Disposal Act of 1965.⁷⁷ RCRA was codified with the objective “to promote the protection of health and the environment and to conserve valuable material and energy resources.”⁷⁸ RCRA grants the EPA the authority to regulate hazardous and non-hazardous solid waste through “explicit, legally enforceable requirements.”⁷⁹ Subtitle C of RCRA regulates hazardous waste, and Subtitle D of RCRA regulates non-hazardous solid waste, including municipal waste and industrial waste.⁸⁰

In 1978, the EPA proposed the first standards for hazardous waste management under Subtitle C and deferred regulation of *special wastes* “until further study and assessment could be completed to determine their risk to human health and the environment.”⁸¹ Categories of *special waste* include cement kiln dust waste, crude oil and natural gas waste, fossil fuel combustion waste (including coal ash), and mining and mineral processing waste.⁸² At the time, these *special wastes* were thought to pose less of a risk to human health and the environment than the wastes initially regulated under Subtitle C as hazardous waste.⁸³

After the EPA deferred *special wastes* from regulation in 1978, Congress enacted the Solid Waste Disposal Act Amendments of 1980, including the Bevill Amendment which exempted fossil fuel combustion waste, among other *special wastes*, from regulation under Subtitle C “until further study and assessment of risk could be performed.”⁸⁴ After further study and assessment of risk was completed, the EPA made two regulatory determinations with respect to coal ash regulations under RCRA. First, in 1993, the EPA determined coal ash was “excluded from the definition of hazardous waste under RCRA,” and

77. *History of the Resource Conservation and Recovery Act (RCRA)*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/rcra/history-resource-conservation-and-recovery-act-rcra> [https://perma.cc/V33A-AA88] (last updated Jan. 22, 2026).

78. 42 U.S.C. § 6902(a) (2023).

79. *Resource Conservation and Recovery Act (RCRA) Overview*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/rcra/resource-conservation-and-recovery-act-rcra-overview> [https://perma.cc/ZJ52-X3H5] (last updated Sept. 11, 2024); see 40 C.F.R. §§ 239–282 (2024).

80. U.S. ENV’T PROT. AGENCY, *supra* note 79.

81. *Special Wastes*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/hw/special-wastes> [https://perma.cc/2BQX-YUNM] (last updated Mar. 20, 2025).

82. *Id.*

83. *Id.*

84. *Id.*; 42 U.S.C. § 6921(b)(3)(A)(i)–(iii) (2023).

thus was not subject to regulation under Subtitle C.⁸⁵ Second, in 2000, the EPA determined some coal ash, specifically coal ash disposed of in landfills, surface impoundments, and used as mine fill, was to be regulated under Subtitle D as non-hazardous waste.⁸⁶ The EPA also determined that beneficial use of coal ash did not warrant regulation, though acknowledged that about “one-quarter of all coal combustion wastes are diverted to beneficial uses.”⁸⁷ Accordingly, the EPA stated they “do not wish to place any unnecessary barriers on the beneficial use of fossil fuel combustion wastes so that they can be used in applications that conserve natural resources and reduce disposal costs.”⁸⁸

In 2010, the EPA proposed two options for regulating the disposal of coal ash.⁸⁹ The first option would reverse the Bevill Amendment and regulate coal ash under Subtitle C of RCRA as hazardous waste.⁹⁰ The second option would keep the Bevill Amendment in place and regulate coal ash under Subtitle D of RCRA as non-hazardous waste.⁹¹ Neither option, however, proposed to change the beneficial use exemption of coal ash regulation under the Bevill Amendment.⁹² After the proposal and a few published notices of data availability, the EPA signed a final rule regulating the disposal of coal ash in 2014, and the EPA published the final rule in the Federal Register in 2015.⁹³ Notably, the 2015 CCR Rule signifies the first regulation of coal ash in EPA history. The 2015 CCR Rule establishes the requirements for disposal of coal ash in landfills and surface impoundments under Subtitle D of RCRA, as non-hazardous waste.⁹⁴ Requirements for coal ash disposal under the 2015 CCR Rule include structural integrity requirements, groundwater monitoring and corrective action, location restrictions, liner design criteria, operating criteria, record keeping, notification, and internet posting requirements.⁹⁵ The 2015 CCR Rule only uses four criteria to regulate beneficial use.⁹⁶

Initially under RCRA, EPA only had the authority “to establish minimum

85. U.S. ENV'T PROT. AGENCY, *supra* note 75.

86. *Id.*

87. Notice of Regulatory Determination on Wastes from the Combustion of Fossil Fuels, 65 Fed. Reg. 32214 (May 22, 2000); *see* 40 C.F.R. § 261 (2024).

88. Notice of Regulatory Determination on Wastes from the Combustion of Fossil Fuels, 65 Fed. Reg. 32214 (May 22, 2000); *see* 40 C.F.R. § 261.

89. U.S. ENV'T PROT. AGENCY, *supra* note 75.

90. Hazardous and Solid Waste Management System; Identification and Listing of Special Wastes; Disposal of Coal Combustion Residuals from Electric Utilities, 75 Fed. Reg. 35128 (June 21, 2010) (to be codified at 40 C.F.R. pts. 257, 261, 264, 265, 268, 271, 302).

91. *Id.*

92. *Id.*

93. U.S. ENV'T PROT. AGENCY, *supra* note 75; *see also* 40 C.F.R. §§ 257, 261 (2015).

94. *Fact Sheet: Final Rule on Coal Combustion Residuals Generated by Electric Utilities*, U.S. ENV'T PROT. AGENCY (Dec. 2014), https://www.epa.gov/sites/default/files/2014-12/documents/factsheet_ccrfinal_2.pdf [<https://perma.cc/YX8T-45YT>].

95. *Id.* at 2–3.

96. *Id.*; *see infra* note 158 and accompanying text.

national criteria that apply to *facilities*.” (emphasis added).⁹⁷ Thus, Subtitle D, and subsequently the 2015 CCR Rule, was designed to be self-implementing.⁹⁸ However, the self-implementation regulatory scheme changed in 2016 when Congress passed the Water Infrastructure Improvements for the Nation (hereinafter “WIIN”) Act.⁹⁹ Section 2301 of the WIIN Act amended Section 4005 of RCRA, resulting in several changes: the EPA has the authority under RCRA to enforce the 2015 CCR Rule and permit provisions, the EPA must implement a coal ash permit program in Indian Country, the states can develop and implement a coal ash permit program with EPA approval, and the EPA must implement a coal ash permit program in states that do not have an approved permit program.¹⁰⁰ Essentially, the WIIN Act ensures all states have a coal ash permit program that is at least as protective as the federal coal ash regulations.

In May 2024, the EPA further expanded federal coal ash regulation with the finalization of the 2024 CCR Rule.¹⁰¹ The 2024 CCR Rule regulates legacy surface impoundments and CCR management units (hereinafter “CCRMUs”).¹⁰² Legacy surface impoundments contain “both CCR and liquids on or after October 19, 2015.”¹⁰³ Since these legacy units predate the 2015 CCR Rule that established coal ash disposal regulations, they are more likely to be unlined, unmonitored, prone to leaking and subsequent groundwater leaching, thus, more dangerous to human health and the environment.¹⁰⁴ CCRMUs include coal ash disposed in areas outside of previously regulated units, specifically meaning surface impoundments and landfills that closed prior to the 2015 CCR Rule and inactive landfills and piles.¹⁰⁵ For both legacy surface impoundments and CCRMUs, the 2024 CCR Rule establishes groundwater monitoring, corrective action, closure, and post closure care.¹⁰⁶

97. Hazardous and Solid Waste Management System; Disposal of Coal Combustion Residuals from Electric Utilities, 80 Fed. Reg. 21302, 21332 (Apr. 17, 2015) (to be codified at 40 C.F.R. pt. 257, 261).

98. See 40 C.F.R. §§ 257, 261.

99. *Permit Programs for Coal Combustion Residual Disposal Units*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/coalash/permit-programs-coal-combustion-residual-disposal-units> [https://perma.cc/252X-SUBW] (last updated Nov. 6, 2025).

100. *Id.*; but see H.R. 2396, 118th Cong., 1st Sess. (2023) (proposing to amend Section 4005(d) of the Solid Waste Disposal Act “to include any criteria necessary to protect human health and the environment,” including prohibiting open dumping of unencapsulated coal ash, among other provisions).

101. *Final Rule - Legacy Coal Combustion Residuals Surface Impoundments and CCR Management Units*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/coalash/final-rule-legacy-coal-combustion-residuals-surface-impoundments-and-ccr-management-units> [https://perma.cc/T8L8-TJVV] (last updated Dec. 19, 2025).

102. *Fact Sheet: Legacy Coal Combustion Residuals Surface Impoundments and CCR Management Units Final Rule*, U.S. ENV’T PROT. AGENCY (Apr. 2024), https://www.epa.gov/system/files/documents/2024-04/legacy_ccrmu_final_fact_sheet_april2024.pdf [https://perma.cc/A77Z-FPEQ].

103. 40 C.F.R. § 257.53 (2024).

104. U.S. ENV’T PROT. AGENCY, *supra* note 102, at 1.

105. *Id.*

106. *Id.*

Since the finalization of the 2024 CCR Rule, there have been several administrative updates and changes amidst industry pushbacks.¹⁰⁷ In November 2024, the EPA published a direct final rule and companion proposed rule which corrected minor technical errors and made clarifications to the 2024 CCR Rule.¹⁰⁸ EPA then published a second direct final rule and companion proposed rule in January 2025 for the same reasons.¹⁰⁹ The first direct final rule went into effect on February 6, 2025.¹¹⁰ Then on March 12, 2025, the EPA stated its priority is to encourage “state agencies to pursue oversight of coal ash management within their borders,” coupled with the EPA indicating a potential rewrite of the federal coal ash rule.¹¹¹ Soon after, on March 14, 2025, the second direct final rule was withdrawn because the EPA received adverse comment on it before the end of the comment period.¹¹² This means the EPA must respond to all comments received during the comment period as part of the final action taken on the proposed rule.¹¹³

Additionally, on July 22, 2025, the House Appropriations Committee approved an appropriations bill that disallows funding made available from the bill or any other act to “be used to implement, administer, or enforce” the 2024 CCR Rule.¹¹⁴ If approved by both the House and the Senate, this legislation would backstep the broadened regulatory scope of the EPA’s coal ash regulations, specifically concerning legacy surface impoundments and CCRMUs.¹¹⁵ On the same day, the EPA published another direct final rule and companion proposed rule to create “an additional option for certain owners and operators to comply with the Facility Evaluation Report (FER) Part 1 requirements and to extend compliance deadlines for the remaining CCRMU provisions.”¹¹⁶ Responding to public requests, the EPA held a public hearing for this proposed rule on September 12, 2025, and extended the comment period

107. Kari Lydersen, *Power Companies Pressure Trump EPA to Roll Back Rules on Toxic Coal Ash*, CANARY MEDIA (Jan. 29, 2025), <https://www.canarymedia.com/articles/policy-regulation/power-companies-pressure-trump-epa-to-roll-back-rules-on-toxic-coal-ash> [https://perma.cc/5X8X-EHZ8].

108. U.S. ENV’T PROT. AGENCY, *supra* note 101.

109. *Id.*

110. *Id.*

111. *EPA Announces Swift Actions on Coal Ash Program (Coal Combustion Residuals)*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/newsreleases/epa-announces-swift-actions-coal-ash-program-coal-combustion-residuals> [https://perma.cc/MLQ8-TEUA] (Mar. 12, 2025); *see also* Renee Sweany, *EPA and Governor’s Actions Affect Indiana’s Coal Ash Problems*, HOOSIER ENV’T COUNCIL (Mar. 14, 2025), <https://www.hecweb.org/2025/03/14/epa-and-governors-actions-affect-indianas-coal-ash-problems/> [https://perma.cc/38B3-ZV8N].

112. U.S. ENV’T PROT. AGENCY, *supra* note 101.

113. *Id.*

114. H.R. 4754, 119th Cong. § 464 (2025) (introduced but not enacted; subsequent FY 2026 appropriations legislation did not adopt the proposed reforms).

115. Maya Wilkins, *U.S. House Bill Expected to Change Coal Ash Regulations*, POST-TRIBUNE (July 23, 2025, 3:03 PM), <https://www.chicagotribune.com/2025/07/23/u-s-house-bill-expected-to-change-coal-ash-regulations/> [https://perma.cc/8UKZ-E6KG].

116. U.S. ENV’T PROT. AGENCY, *supra* note 101.

from the original date of August 21, 2025, to September 15, 2025.¹¹⁷ Given the many administrative updates, the final rule will likely not be effective until 2026, and thus coal ash regulation remains in flux.¹¹⁸ Concurrently, there has been recent federal case law regarding the regulation of coal ash.

2. Federal Case Law

There have been two recent, related cases important to the discussion on coal ash regulation. The first case favors broader coal ash regulation and catalyzed the 2024 CCR Rule promulgation.¹¹⁹ However, the second case directly challenges the 2024 CCR Rule due to its broadened regulatory scope.¹²⁰

In 2018, the D.C. Circuit Court decided *Util. Solid Waste Activities Grp. v. EPA*, the case that initiated the promulgation of the 2024 CCR Rule, which broadened EPA regulations of coal ash to include legacy surface impoundments and CCRMUs.¹²¹ In this case, environmental and industry petitioners challenged parts of the 2015 CCR Rule for either being too weak or too stringent, respectively.¹²² The court held in part that the EPA acted arbitrarily and capriciously and contrary to RCRA by exempting inactive surface impoundments at inactive power plants from regulation.¹²³ The court reasoned such impoundments pose a risk to human health and the environment.¹²⁴ Therefore, the court vacated the legacy surface impoundment regulatory exemption and remanded the issue to the EPA.¹²⁵ Ultimately, the EPA extended coal ash regulations to include both legacy surface impoundments and CCRMUs.¹²⁶ This ruling is significant because it favored broader coal ash regulation.

Subsequently, in *City Util. of Springfield v. EPA*, industry petitioners challenged the EPA's promulgation of the 2024 CCR Rule, claiming the rule is overly broad in attempting to regulate CCRMUs and thus filed a motion for

117. *Id.*

118. *See id.* (noting repeated withdrawals of direct final rules, reopened comment periods, technical corrections, and extensions of compliance deadlines for CCRMUs, delaying full regulatory implementation).

119. *See Util. Solid Waste Activities Grp. v. EPA*, 901 F.3d 414 (D.C. Cir. 2018).

120. *See City Utils. of Springfield v. EPA*, No. 24-1200, 2024 U.S. App. LEXIS 27788, at *8 (D.C. Cir. Nov. 1, 2024).

121. U.S. ENV'T PROT. AGENCY, *supra* note 102.

122. Frank & Maloney, *supra* note 29, at 4.

123. *Util. Solid Waste Activities Grp.*, 901 F.3d at 449.

124. Frank & Maloney, *supra* note 29, at 4.

125. U.S. ENV'T PROT. AGENCY, *supra* note 102, at 1.

126. *See supra* notes 101–06 and accompanying text.

stay.¹²⁷ On November 1, 2024, the court denied the motion for stay.¹²⁸ However, on August 11, 2025, the EPA requested that the court hold the petitions in abeyance until December 15, 2025, indicating that the EPA is reconsidering the 2024 CCR Rule on substantive grounds and thus needs to suspend the case for the meantime.¹²⁹ This case is important because it exemplifies how the industry is challenging the broader regulations of the 2024 CCR Rule and pushing back on more stringent coal ash regulation, and it shows how the EPA is responding to such challenges. Challenges to state level regulations echo these concerns as well.

B. Indiana Coal Ash Law

Indiana has adopted the federal coal ash regulations with very minor changes and exceptions.¹³⁰ This section explains the background of Indiana coal ash law including key statutes, regulations, legislation, and rulemaking and how Indiana law intertwines with federal law.

1. State Statutes and Regulations

After the passage of the 2015 CCR Rule, the Indiana Environmental Rules Board (hereinafter “IERB”) adopted an emergency rule to incorporate the federal regulations for CCR surface impoundments into the Indiana Administrative Code (hereinafter “IAC”).¹³¹ In December 2016, the IERB permanently incorporated the federal coal ash regulations into the IAC.¹³² The IERB adopted the federal regulations by reference, including the specific provisions relevant to beneficial use.¹³³

In addition to incorporating the federal coal ash regulations, Indiana, upon recommendation from the EPA after the finalization of the 2015 CCR Rule, also

127. *City Utils. of Springfield v. EPA*, No. 24-1200, 2024 U.S. App. LEXIS 27788, at *7 (D.C. Cir. Nov. 1, 2024); *see also City Utilities of Springfield, Missouri v. EPA*, U.S. CHAMBER OF COM. (Feb. 7, 2025), <https://www.uschamber.com/cases/energy-and-environment/city-utilities-of-springfield-missouri-v-epa> [<https://perma.cc/2QP5-67AB>].

128. *City Utils. of Springfield v. EPA*, No. 24-1200, 2024 U.S. App. LEXIS 27788, at *7 (D.C. Cir. Nov. 1, 2024).

129. Respondents’ Motion to Govern at 1, *City Utils. of Springfield v. EPA*, 2024 U.S. App. LEXIS 27788, No. 24-1200 (D.C. Cir. 2024).

130. *See* 329 IND. ADMIN. CODE 10 (2024); *see also Coal Combustion Residuals*, IND. DEP’T OF ENV’T MGMT., <https://www.in.gov/idem/waste/resources/permits-registrations-approvals-and-closures/coal-combustion-residuals/> [<https://perma.cc/NJL8-BG6Z>] (last visited Nov. 22, 2024).

131. IND. DEP’T OF ENV’T MGMT., *supra* note 130.

132. *Id.*

133. *Public Participation Response to Comments, Indiana Coal Combustion Residuals Part 256 Solid Waste Management Plan Amendment*, IND. DEP’T OF ENV’T MGMT. 2 (Feb. 23, 2017), https://www.in.gov/idem/waste/files/landfills_antique_history_ccr_plan_rtc.pdf [<https://perma.cc/C9D6-J5DQ>]; *see* 329 IND. ADMIN. CODE 10-9-1(b)-(c) (2024).

updated its Solid Waste Management Plan (hereinafter “SWMP”).¹³⁴ Before the 2015 CCR Rule was finalized, Indiana amended and submitted their SWMP to the EPA, and the EPA approved it in 1991.¹³⁵ Thus, the Indiana SWMP did not include regulation of coal ash landfills and surface impoundments, thereby requiring updates to accord with federal law. From April to June 2016, IDEM requested public comments on the draft amendment to the SWMP regarding coal ash management.¹³⁶ Topics of public comment included support for the incorporation of the federal coal ash regulations into Indiana’s rules, EPA changes to the federal rule, recommendations for Indiana coal ash rule development, evaluation of the effectiveness of the public participation program, and beneficial use.¹³⁷ Public comments on beneficial use differed between support for the lack of beneficial use regulation and support for a cautionary approach to beneficial use, allowing only “uses demonstrated to pose a minimal environmental risk which encapsulate the ash before its reuse.”¹³⁸ Regardless of any comments supporting more or less regulation, IDEM responded by stating, pursuant to House Enrolled Act 1230, the IERB would only approve a rule that incorporated the federal beneficial use regulation equivalently and consistently—nothing more, nothing less.¹³⁹ Thus, in February 2017, IDEM submitted the SWMP Amendment to the EPA for approval.¹⁴⁰ In March 2017, the EPA approved the SWMP Amendment conditioned “on Indiana completing a process to revise their CCR regulations to be consistent with the federal minimum CCR requirements.”¹⁴¹ Subsequently, the Indiana Code states only the applicable definitions, the rules the IERB shall adopt, and what IDEM shall do.¹⁴² Concerning beneficial use, the Indiana Code states the adopted rules may not regulate use of coal ash for antiskid material, manufacturing, structural fill, a base in road construction, and agricultural applications, among others.¹⁴³

In 2021, Senate Enrolled Act 271 required IDEM to establish a state permit program for coal ash under the WIIN Act, and subsequently required the IERB

134. U.S. ENV’T PROT. AGENCY, *supra* note 99 (referring to archived information accessed via permalink).

135. See Evan Bayh & Kathy Prosser, *Indiana Solid Waste Management Plan*, IND. DEP’T OF ENV’T MGMT. (1991), https://www.in.gov/idem/waste/files/landfills_antique_history_sw_plan_1991_vol_03a.pdf [<https://perma.cc/K5AK-CL3E>].

136. IND. DEP’T OF ENV’T MGMT., *supra* note 133, at 1.

137. *Id.* at 2–5.

138. *Id.* at 2.

139. *Id.*; see H.E.A. 1230, 120th Gen. Assemb., 1st Reg. Sess. (Ind. 2017).

140. See *Indiana Coal Combustion Residuals Part 256 Solid Waste Management Plan Amendment*, IND. DEP’T OF ENV’T MGMT. (Feb. 23, 2017), https://www.in.gov/idem/waste/files/landfills_antique_history_ccr_plan_amendment.pdf [<https://perma.cc/PWD2-8V2F>].

141. U.S. *State of Indiana Coal Combustion Residuals Solid Waste Management Plan Amendment Approval*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/coalash/us-state-indiana-coal-combustion-residuals-solid-waste-management-plan-amendment-approval> [<https://perma.cc/3576-WYEZ>] (last updated Oct. 23, 2025).

142. See IND. CODE § 13-19-3-3 (2024).

143. *Id.* at 3.1.

to adopt the rules for the state permit program.¹⁴⁴ However, in 2023, the Indiana legislature amended Indiana Code § 13-19-3-3 to prohibit “state standards for disposal of coal combustion residuals to be more stringent than federal standards.”¹⁴⁵ Under this law, the IERB “shall not impose a restriction or requirement that is not imposed by the federal CCR rule.”¹⁴⁶ This law is dispositive in understanding how beneficial use of coal ash can be regulated—if the federal government does not stringently regulate beneficial use of coal ash, neither can Indiana. Beyond this statute, Governor Mike Braun signed an executive order on March 12, 2025, stating that “Indiana is committed to promoting streamlined environmental policies consistent with federal policies” because “the existence of state environmental regulations that are more stringent than federal regulations” cause confusion, increase costs, and complicate industry compliance.¹⁴⁷ Thus, it is clear that Indiana’s legislative and executive branches are in favor of keeping Indiana’s regulatory scope consistent with the “baseline national standards.”¹⁴⁸

2. State Legislation and Rulemaking

While the Indiana legislature has introduced several bills over the past few years to regulate disposal and beneficial use of coal ash more stringently, none have passed. For example, Senate Bill 412, introduced in 2022, and Senate Bill 399, introduced in 2023, would create more stringent disposal and “closure in place” rules concerning floodplains, contact with groundwater, migration with aquifers, unstable areas, and seismic impact zones.¹⁴⁹ House Bill 1335, introduced in 2022, would require owners or operators of CCR surface impoundments or landfills in the flood zone or subject to closure to remove all coal ash to be put in an encapsulated beneficial use whenever possible.¹⁵⁰ House Bill 1190, introduced in 2023, would also require owners or operators of certain CCR surface impoundments to remove all coal ash and either transfer the coal ash for disposal or put the coal ash into an encapsulated beneficial use.¹⁵¹ House Bill 1404, introduced in 2024, would prohibit the beneficial use of coal ash in “structural fill” unless the coal ash is fully encapsulated, such as in cement or concrete.¹⁵²

To comply with the WIIN Act and Senate Enrolled Act 271, IDEM recently

144. S.E.A. 271, 122nd Gen. Assemb., 1st Reg. Sess. (Ind. 2021).

145. H.E.A. 1623, 123rd Gen. Assemb., 1st Reg. Sess. (Ind. 2023).

146. *Id.*

147. Ind. Exec. Order No. 25-38 (Mar. 12, 2025).

148. *Id.*; see Sweany, *supra* note 111 (stating “the EPA said it wanted to give more control over coal ash back to the states, while Governor Braun said that Indiana will follow federal requirements”).

149. S.B. 412, 122nd Gen. Assemb., 2nd Reg. Sess. (Ind. 2022); S.B. 399, 123rd Gen. Assemb., 1st Reg. Sess. (Ind. 2023).

150. H.B. 1335, 122nd Gen. Assemb., 2nd Reg. Sess. (Ind. 2022).

151. H.B. 1190, 123rd Gen. Assemb., 1st Reg. Sess. (Ind. 2023).

152. H.B. 1404, 123rd Gen. Assemb., 2nd Reg. Sess. (Ind. 2024).

drafted a state coal ash rule and permit program, which the IERB preliminarily adopted in December 2024.¹⁵³ Importantly, this rule does not include any beneficial use regulations beyond how beneficial use is regulated federally—the IERB is bound by the Indiana Code.¹⁵⁴ Thus, under current Indiana law, Indiana may only regulate beneficial use of coal ash to the same extent as federal law.

C. The Beneficial Use Regulatory Gap

The EPA has deemed the primary responsibility for beneficial use regulation remains with the states.¹⁵⁵ Therefore, federal coal ash regulations provide only minimum criteria; they do not preclude states from adopting more stringent regulations.¹⁵⁶ In fact, federal coal ash regulations require state permit programs to be “at least as protective as” EPA standards.¹⁵⁷ In other words, EPA coal ash regulations can be thought of as a floor that states must stand on, but individual states determine how high the ceiling goes.

Indiana adopted the federal coal ash regulations into the Indiana Code, which incorporates the federal beneficial use definition by reference. However, Indiana also codified a state prohibition on more stringent coal ash standards than federal coal ash standards. Therefore, a regulatory gap exists in Indiana regarding regulation of the beneficial use of coal ash. To put it simply, the EPA beneficial use regulations are the bare minimum—and, by passing a law containing no-more-stringent-than regulations, the Indiana legislature ensured the IERB cannot promulgate any regulations that would go beyond the EPA’s bare minimum regulations. This is problematic because the EPA’s regulatory scheme is designed to be a floor, not a ceiling.

EPA regulates coal ash based on how it is reused or disposed. There are three EPA-promulgated definitions important to such regulations: (1) “beneficial use,” (2) “CCR pile or pile,” and (3) “disposal.” To be regulated as a “beneficial use,” the coal ash must meet four specific criteria:

- (1) “the CCR must provide a functional benefit;” (2) “the CCR must substitute for the use of a virgin material, conserving natural resources that would otherwise need to be obtained through practices, such as extraction;” (3) “the use of the CCR must meet relevant product specifications, regulatory standards or design standards when available, and when such standards are not available, the CCR is not used in excess quantities; and” (4) “when unencapsulated use of CCR involving placement on the land of 12,400 tons or more in non-roadway applications, the user must demonstrate and keep records, and provide

153. Draft Rule, 329 IND. ADMIN. CODE 10 (preliminarily adopted Dec. 11, 2024).

154. IND. CODE § 13-19-3-3 (2024) (codifying the no-more-stringent-than state policy regarding CCR regulations).

155. U.S. ENV’T PROT. AGENCY, *supra* note 9.

156. U.S. ENV’T PROT. AGENCY, *supra* note 99.

157. *Id.*

such documentation upon request, that environmental releases to groundwater, surface water, soil and air are comparable to or lower than those from analogous products made without CCR, or that environmental releases to groundwater, surface water, soil and air will be at or below relevant regulatory and health-based benchmarks for human and ecological receptors during use.”¹⁵⁸

If these four criteria are met, the coal ash is considered a beneficial use and is not subject to further regulation under the federal coal ash rule. This regulatory exclusion dates back to the Bevill Amendment which excludes *special wastes*.¹⁵⁹ Although, if there is “a finding of imminent or substantial endangerment” regarding a specific circumstance, the EPA can take federal action under RCRA.¹⁶⁰

“CCR pile or pile” is defined as “any non-containerized accumulation of solid, non-flowing CCR that is placed on the land.”¹⁶¹ Off-site recycled coal ash is not considered a CCR pile.¹⁶² “Disposal” is defined as “the discharge, deposit, injection, dumping, spilling, leaking, or placing of any solid waste . . . into or on any land or water so that such solid waste, or constituent thereof, may enter the environment or be emitted into the air or discharged into any waters, including groundwaters.”¹⁶³ Disposal does not include the beneficial use of coal ash.¹⁶⁴ Disposal methods include landfills and surface impoundments or “ponds.”¹⁶⁵ Both of these disposal methods are regulated under the federal coal ash rule, and thus, are subjected to more stringent regulations than beneficial use. Therefore, regulations pursuant to these three categories—“beneficial use,” “CCR pile or pile,” and “disposal”—are somewhat ambiguous.

Beyond initiating the promulgation of the 2024 CCR Rule, *Util. Solid Waste Activities Grp. v. EPA* emphasizes the ambiguity of beneficial use regulation.¹⁶⁶ Industry petitioners asserted two claims against the EPA related to beneficial use regulation: (1) “the EPA arbitrarily regulated coal residuals piles of 12,400 or more tons,” and (2) “the EPA arbitrarily regulated on-site coal residuals destined for beneficial use.”¹⁶⁷ For both of these claims, the court granted the EPA’s voluntary remand without vacating the regulation, meaning the regulation stands, but the EPA must reconsider these two provisions in the

158. 40 C.F.R. § 257.53.

159. U.S. ENV’T PROT. AGENCY, *supra* note 9 (explaining that coal combustion residuals beneficially used are excluded from federal regulation as “special wastes” under the Bevill Amendment, absent a finding of imminent and substantial endangerment under RCRA); *see* U.S. ENV’T PROT. AGENCY, *supra* note 81.

160. *Id.*

161. 40 C.F.R. § 257.53.

162. *Id.*

163. *Id.*

164. *Id.*

165. Evans et al., *supra* note 1, at 14–15.

166. *See Util. Solid Waste Activities Grp. v. EPA*, 901 F.3d 414 (D.C. Cir. 2018).

167. *Id.* at 436.

meantime.¹⁶⁸

Subsequently in 2019, the EPA proposed changes to the 2015 CCR Rule concerning the exact same provisions that were at issue in *Util. Solid Waste Activities Grp. v. EPA*—beneficial use criteria and CCR piles.¹⁶⁹ One proposed change included replacing the 12,400-ton threshold under the beneficial use criteria with specific location-based criteria.¹⁷⁰ Using specific location-based criteria would establish additional criteria for where reused coal ash could be placed as fill, but as proposed, would eliminate numerical criteria. The additional criteria proposed included: “distance from the uppermost aquifer; placement in a wetland; placement in an unstable area; placement in a flood plain; distance from a fault area; and placement in a seismic zone.”¹⁷¹ This change remains pending. The other proposed change would have established a single approach for all temporary placement of unencapsulated coal ash on the land, “regardless of whether the pile is on-site or off-site, or destined for beneficial use or disposal.”¹⁷² As reasoning for this proposed change, the EPA referenced the RCRA definition of “disposal” which “closely mirrors” the RCRA definition of “CCR pile.”¹⁷³ EPA’s proposed approach would have regulated all CCR piles as “storage,” including the regulatory requirement to control releases of coal ash.¹⁷⁴ However, while the 2024 CCR Rule addressed this proposed change, the change was not finalized in the 2024 CCR Rule.

In an additional attempt to clarify the beneficial use regulatory gap, the EPA discussed public comments on beneficial use exemption with the promulgation of the 2024 CCR Rule. However, this discussion only explained what the 2015 CCR Rule regulates without making any changes or amendments. The clarifications regard the confusion of differentiating, and therefore regulating, CCRMUs, CCR piles, disposal, and beneficial use. While some commenters argued the regulation of CCRMUs “effectively revoked” the beneficial use exemption, the EPA disagreed.¹⁷⁵ The CCRMU definition encompasses CCR piles. CCR piles “placed directly on the land on-site of a utility” are not

168. *Id.* at 437.

169. *See id.* at 436–37; *Disposal of Coal Combustion Residuals from Electric Utilities Rulemakings*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/coalash/coal-ash-rule> [<https://perma.cc/YT7V-PMWZ>] (last updated Jan. 7, 2026).

170. Hazardous and Solid Waste Management System: Disposal of Coal Combustion Residuals from Electric Utilities; Enhancing Public Access to Information; Reconsideration of Beneficial Use Criteria and Piles, 84 Fed. Reg. 40353 (Aug. 14, 2019) (to be codified at 40 C.F.R. pt. 257).

171. *Id.*

172. U.S. ENV’T PROT. AGENCY, *supra* note 169.

173. Hazardous and Solid Waste Management System: Disposal of Coal Combustion Residuals from Electric Utilities; Enhancing Public Access to Information; Reconsideration of Beneficial Use Criteria and Piles, 84 Fed. Reg. 40353 (Aug. 14, 2019).

174. *Id.*

175. *See* Hazardous and Solid Waste Management System: Disposal of Coal Combustion Residuals From Electric Utilities; Legacy CCR Surface Impoundments, 89 Fed. Reg. 38950 (May 8, 2024).

beneficial uses.¹⁷⁶ Therefore, on-site CCR piles are regulated as a disposal method. For example, structural fill and coal ash placed below currently regulated CCR units on-site of a utility are not considered beneficial use and are regulated as disposal.¹⁷⁷ However, non-containerized coal ash that is placed directly on the land off-site of a utility and meets the beneficial use definition is not considered a CCR pile but is considered a beneficial use.¹⁷⁸ Thus, such off-site coal ash is not subject to the disposal regulations.¹⁷⁹

Despite these clarifications regarding beneficial use exemptions, regulatory loopholes remain. For example, in *Elec. Energy, Inc. v. EPA*, the EPA found the Ottumwa Generating Station's closure plan was not in compliance with the coal ash closure requirements.¹⁸⁰ Ottumwa placed additional coal ash in a closing surface impoundment, asserting that such placement was a "fill" and therefore a beneficial use exempt from regulation.¹⁸¹ However, the 2015 CCR Rule explicitly requires owners or operators to cease placing coal ash into closing surface impoundments. Therefore, such placement of coal ash was prohibited and not considered a beneficial use. Considering this case example and the tragedy of Town of Pines, federal and state law need to close the regulatory gaps regarding beneficial use of coal ash to better protect human health and the environment.

III. ANALYSIS: HOW SHOULD FEDERAL AND INDIANA LAW REGULATE BENEFICIAL USE OF COAL ASH TO BETTER PROTECT HUMAN HEALTH AND THE ENVIRONMENT?

There are many ways federal and Indiana law could regulate beneficial use of coal ash to better protect human health and the environment. This note suggests three ways federal law could regulate beneficial use of coal ash and three ways Indiana law could regulate beneficial use of coal ash to achieve this outcome. Federally, (1) the EPA should add location-based risk factors into the beneficial use criteria, (2) the EPA should require recordation for all unencapsulated beneficial use, and (3) the EPA should regulate unencapsulated beneficial use as a disposal method. In Indiana, (1) legislators should amend the Indiana Code to allow more stringent regulation, (2) the IERB should adopt state-specific beneficial use regulations into the state rule, and (3) the IDOH should prioritize coal ash contamination as a public health issue. While not all of these suggestions could be implemented simultaneously, they are possible options for implementing beneficial use regulation at the federal and state level that would better protect human health and the environment.

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.*

180. *Elec. Energy, Inc. v. EPA*, 106 F.4th 31, 38 (D.C. Cir. 2024).

181. *Id.* at 43.

*A. Federal Law**1. EPA Should Add Location-Based Risk Factors into the Beneficial Use Criteria*

Coal ash must only meet the four criteria promulgated by the EPA to be considered a “beneficial use,” and therefore to be within the regulatory gap. In summary, the four criteria are (1) functional benefit, (2) substitution of virgin material, (3) regulatory standards, and (4) 12,400 tons or more specifications.¹⁸² Notably, no overarching exception, caveat, or disclaimer exists within these four criteria on where reused coal ash can be placed. Therefore, there is no regulatory stop sign posted anywhere—reused coal ash can be placed in high-risk, high-exposure areas without regulatory consequences.¹⁸³ Town of Pines exemplifies this regulatory gap, as fill was placed in the roadbeds, under a playground, and in residents’ yards.

In 2019, the EPA proposed to replace the mass-based numerical value (criterion #4) with location-based criteria.¹⁸⁴ However, industry, environmentalists, and state governments alike disfavored this proposal. Industry claimed this proposal would be too burdensome.¹⁸⁵ State governments generally disfavor regulations that make coal ash reuse more burdensome.¹⁸⁶ Environmentalists claimed this proposal would create another regulatory loophole in which industry could use as much reused coal ash as they wanted to in non-risk areas.¹⁸⁷ To address this issue, location-based risk factors should be incorporated as an additional beneficial use criterion, not as a replacement of an existing criterion, such as the EPA proposed in 2019.

Incorporation of location-based risk factors would ensure that as part of the test to qualify as a beneficial use, the placement location must first be evaluated to ensure it is in fact a *beneficial* use. Examples of proposed location-based risk factors the EPA proposed in 2019 include “distance from the uppermost aquifer; placement in a wetland; placement in an unstable area; placement in a flood plain; distance from a fault area; and placement in a seismic zone.”¹⁸⁸ If the EPA

182. See 40 C.F.R. § 257.53.

183. See Hazardous and Solid Waste Management System: Disposal of Coal Combustion Residuals from Electric Utilities; Enhancing Public Access to Information; Reconsideration of Beneficial Use Criteria and Piles, 84 Fed. Reg. 40353 (Aug. 14, 2019) (to be codified at 40 C.F.R. pt. 257).

184. *Id.*

185. Tom Quinn, *Reuse can divert coal ash from landfills, but challenges remain*, ENERGY NEWS NETWORK (Aug. 31, 2022), <https://energynews.us/2022/08/31/the-solution-to-americas-colossal-coal-ash-problem/> [<https://perma.cc/59GF-TSQK>].

186. See *id.*

187. *Id.*

188. See Hazardous and Solid Waste Management System: Disposal of Coal Combustion Residuals from Electric Utilities; Enhancing Public Access to Information; Reconsideration of Beneficial Use Criteria and Piles, 84 Fed. Reg. 40353 (Aug. 14, 2019) (to be codified at 40 C.F.R. pt. 257).

required these factors to be evaluated before a reuse was deemed a *beneficial* use, it would provide a starting point for evaluating placement of coal ash more critically. To avoid industry exploitation of such factors, the factors should be considered along with the four beneficial use criteria promulgated by the EPA, as well as considerations for not only what the land is currently being used for, but what it may potentially be used for in the future. For example, adding location-based risk factors to the beneficial use criteria could have avoided what occurred in Town of Pines given coal ash was used as fill for wetlands and in a residential area; two factors that should be considered risks. Thus, as an additional consideration, incorporating risk factors into the beneficial use criteria would better protect human health and the environment.

2. EPA Should Require Recordation for All Unencapsulated Beneficial Use

The fourth criterion for beneficial use applies only when 12,400 tons or more of unencapsulated use of coal ash is placed on the land. If this numerical threshold is met, then the user must (1) “keep records” and (2) “provide such documentation upon request.”¹⁸⁹ Therefore, if this numerical threshold is not met, users do not need to keep records nor provide documentation on where unencapsulated coal ash was placed on the land. Arguably, however, this 12,400-ton-or-more threshold is arbitrary. The EPA originally promulgated the 12,400-ton-or-more threshold based on the 2010 Steam Electric Power Generating Effluent Guidelines Questionnaire, which indicated that the smallest size coal ash landfill met this threshold.¹⁹⁰ Essentially, the EPA promulgated this fourth criterion to ensure that large amounts of unencapsulated coal ash could not evade landfill regulations. However, industry called out the EPA for this threshold, claiming the EPA made a clerical error and that the correct threshold should actually be 74,800 tons or more.¹⁹¹ Given that the 12,400-ton-or-more threshold remains, industry would prefer to eliminate the fourth criterion all together.¹⁹²

Regardless of the threshold numerical value, the most important aspect to the fourth criterion should be applied to all unencapsulated use of coal ash—recordation. According to the Indy Star, “as many as 180 million tons of coal ash has made its way into structural fill all across the country since the 1980s,

189. 40 C.F.R. § 257.53.

190. Hazardous and Solid Waste Management System: Disposal of Coal Combustion Residuals from Electric Utilities; Enhancing Public Access to Information; Reconsideration of Beneficial Use Criteria and Piles, 84 Fed. Reg. 40353 (Aug. 14, 2019) (to be codified at 40 C.F.R. pt. 257).

191. *Id.*

192. *(Re)defining Beneficial Use?*, ASH AT WORK 8 (2024), https://acaa-usa.org/wp-content/uploads/2024/04/ASH-2024-1_f-web.pdf [<https://perma.cc/PXY6-7PNV>].

but few records exist on where it was used.”¹⁹³ This lack of recordation is problematic because of the potential negative human health and environmental impacts that coal ash exposure may cause. As a minimum standard, recordation would not limit industry or users from recycling coal ash as an unencapsulated use but rather would keep industry and users accountable for where and how they reuse such coal ash. Additionally, keeping records and providing documentation upon request would be instrumental for potential future clean-up efforts.

If communities do not know where coal ash is placed—regardless of how much was used—a situation akin to Town of Pines could occur. When the coal ash contamination crisis in Town of Pines first surfaced, community volunteers took to the streets—on their own time, with their own resources, and due to their own volition—to map out the coal ash contamination. Volunteers walked the entirety of the town with devices to measure radiation, so they would have a way of knowing where clean-up was most critical in the town. It should not take community volunteers to map out coal ash contamination. Considering the use of unencapsulated coal ash has such detrimental effects to human health and the environment, recordation is necessary, and the EPA should apply the standard to all unencapsulated uses regardless of the numerical threshold.

3. EPA Should Regulate Unencapsulated Beneficial Use as a Disposal Method

Considering the similar definitions and practicalities of “unencapsulated use,” “CCR piles,” and “disposal,” EPA should streamline the regulations by defining unencapsulated beneficial use as a disposal method. Unencapsulated coal ash is a loose, unbound form and is commonly utilized as fill for land, roadways, and other construction. Essentially, users take the loose and unbound coal ash and directly incorporate it into the land or road. Given this process, the disposal definition should apply, as the disposal definition under RCRA includes discharging, depositing, dumping, or placing of any solid waste into or on any land.¹⁹⁴

Additionally, not regulating unencapsulated beneficial use as a disposal method contributes to industry confusion and industry exploitation of loopholes on what constitutes a proper disposal method versus what constitutes a proper beneficial use.¹⁹⁵ The 2015 CCR Rule regulates surface impoundments and

193. Sarah Bowman, *Potentially harmful coal ash could be buried in your town. Here's what you need to know*, INDYSTAR (Feb. 20, 2024, 5:29 AM), <https://www.indystar.com/story/news/environment/2024/02/20/coal-ash-is-toxic-and-could-be-buried-all-around-us-what-that-means/72589114007/> [https://perma.cc/MDB6-DEZT].

194. See 40 C.F.R. § 257.53.

195. See *Elec. Energy, Inc. v. EPA*, 106 F.4th 31 (D.C. Cir. 2024) (rejecting industry arguments that placement of coal ash during closure qualified as “beneficial use” and reaffirming EPA’s repeated need to clarify the distinction between regulated disposal and exempt beneficial uses).

landfills by requiring structural integrity requirements, groundwater monitoring and corrective action, location restrictions, liner design criteria, operating criteria, record keeping, notification, and internet posting requirements. Because these regulatory requirements are applicable to unencapsulated beneficial use, the EPA should regulate unencapsulated beneficial use as a disposal method. Given unencapsulated beneficial use of coal ash is essentially “a backdoor means of coal ash disposal that avoids regulation,” regulating unencapsulated beneficial use of coal ash as a disposal method would better protect human health and the environment.¹⁹⁶

B. Indiana Law

1. Legislators Should Amend Indiana Code § 13-19-3-3 to Allow More Stringent Regulation of Coal Ash

When the Indiana legislature passed House Enrolled Act 1623 in 2017, Indiana prohibited state coal ash regulations from being more stringent than federal standards. In addition to this prohibition, the Indiana Code states that the IERB cannot impose rules not imposed by the federal coal ash rule.¹⁹⁷ Thus, the Indiana Code essentially ensures that as long as the EPA does not regulate beneficial use, neither can Indiana. This prohibition is especially problematic because the EPA has reserved beneficial use regulatory responsibility to the states—yet Indiana refuses to regulate beyond what the EPA has already regulated.

Public comments to IDEM’s draft CCR Part 256 SWMP Amendment in 2016 addressed how Indiana should regulate beneficial use.¹⁹⁸ One commenter supported amending the Indiana Code to allow the IERB “to adopt rules that support and promote the beneficial use of” coal ash.¹⁹⁹ Other commenters supported IDEM adopting “a precautionary approach to the regulation of beneficial use” by allowing only uses that “pose minimal environmental risk which encapsulate the ash before its reuse.”²⁰⁰ Additionally, public comments to IDEM’s draft coal ash rule in 2023 addressed how Indiana should regulate beneficial use.²⁰¹ Commenters argued that “beneficial uses of CCR should be limited to encapsulated uses only,” regardless of the federal definition which

196. Jeremy Richardson, Eric Dixon, & Ted Boettner, *Repairing the Damage: Cleaning Up Hazardous Coal Ash Can Create Jobs and Improve the Environment*, UNION OF CONCERNED SCIENTISTS 16, 28 (Sept. 2021), https://www.ucsusa.org/sites/default/files/2021-10/repairing-the-damage-report_2.pdf [<https://perma.cc/E7F7-CGHL>].

197. Ind. Code § 13-19-3-3 (2024).

198. See IND. DEP’T OF ENV’T MGMT., *supra* note 133.

199. *Id.* at 2.

200. *Id.*

201. IND. GEN. ASSEMB., SUMMARY/RESPONSE TO COMMENTS COAL COMBUSTION RESIDUALS, LSA DOC. NO. 21-458 (July 31, 2024).

includes both encapsulated and unencapsulated uses.²⁰² Therefore, Indiana stakeholders appear to support more stringent beneficial use regulation. While industry may benefit from a no-more-stringent-than policy, this same policy severely harms Indiana residents, like those in Town of Pines. In order to regulate beneficial use of coal ash beyond the federal criteria, Indiana would need to amend the Indiana Code to allow for the passage of more stringent state regulations than the federal coal ash rule.

2. IERB Should Adopt State-Specific Beneficial Use Regulations into the State Rule

Assuming the Indiana Code was amended to allow the IERB to adopt more stringent coal ash regulations than the minimal federal regulations, the IERB should adopt more stringent beneficial use regulations into the state rule, specifically to prohibit unencapsulated uses in residential areas.²⁰³ The state coal ash rule was preliminarily adopted on December 11, 2024, with only an incorporation of the federal definition of beneficial use.²⁰⁴ However, the federal beneficial use definition is not stringent enough to protect human health and the environment, especially considering residential areas in Indiana.

If Indiana prohibited unencapsulated beneficial use of coal ash in residential areas, Town of Pines could have avoided the severe consequences of NIPSCO, Brown, Inc., Ddalt Corp., and Bulk Transport's actions. While placing unencapsulated beneficial use anywhere may be dangerous for the environment, human health impacts significantly increase when such uses are in residential areas. For example, in Town of Pines residential fill was found under playgrounds, in backyards, and on the roads.²⁰⁵ Human health impacts included exposure to radiation, increased rates of cancer and thyroid issues, and drinking water contamination.²⁰⁶

In December 2023, 153 groups and 136 individuals, including thirty-one Indiana residents, signed a letter urging the EPA to prohibit the use of residential fill.²⁰⁷ The letter asked the EPA to do four specific things: (1) “quantify the full

202. *Id.*

203. See H.B. 1404, 123rd Gen. Assemb., 2nd Reg. Sess. (Ind. 2024) (proposing amendment of the Indiana Code to create a more stringent regulation regarding structural fill—“coal combustion residuals shall not be used as structural fill unless they are fully encapsulated in cement or concrete.”)

204. Draft Rule, 329 IND. ADMIN. CODE 10 (preliminarily adopted Dec. 11, 2024); see 40 C.F.R. § 257.53.

205. Bowman, *supra* note 55.

206. *Id.*

207. Rebecca Thiele, *Town of Pines residents sign letter urging EPA to ban using toxic coal ash as fill in construction*, WFYI INDIANAPOLIS (Dec. 14, 2023), <https://www.wfyi.org/news/articles/town-of-pines-residents-sign-letter-urging-epa-to-ban-using-toxic-coal-ash-as-fill-in-construction> [<https://perma.cc/5K4E-BHYX>]; see Jose Cora et al., *Re: New Data Support Urgent Need to Prevent Harm to Human Health from Use of Coal Ash as Structural Fill*, Docket ID No. EPA-HQ-OLEM-2020- 0107, EARTHJUSTICE 1 (Dec. 11, 2023), <https://earthjustice.org/wp-content/uploads/2023/12/community-letter-re-ccr-noda.pdf> [<https://perma.cc/VH5G-ET58>].

range of health risks posed by coal ash used as structural fill,” (2) “investigate areas where coal ash fill has been placed near residences and require cleanup,” (3) “initiate a rulemaking to prohibit the use of coal ash as structural fill,” and (4) “issue a public advisory recommending that coal ash fill in residential areas be immediately terminated pending a final rulemaking.”²⁰⁸ The letter referenced an EPA draft risk assessment which “found unacceptable cancer and non-cancer risks from exposure to arsenic and radioactivity from coal ash fill.”²⁰⁹ The letter also referenced the EPA draft Integrated Risk Information System Toxicological Review of Inorganic Arsenic which found “significantly heightened health risks from inorganic arsenic, one of the most common hazardous substances in coal ash and coal ash leachate.”²¹⁰ Although this letter was written to the EPA, therefore requesting federal changes, these requests can be reflected on the state-level as well. In fact, because the EPA reserves primary regulatory responsibility for the states, these changes would likely be legislated and implemented more effectively on a state-level, if Indiana decides to act.

3. IDOH Should Prioritize Coal Ash Contamination as a Public Health Issue

Considering the Indiana legislature precluded the IERB from adopting more stringent rules than the federal coal ash rules, regulating beneficial use of coal ash in Indiana proves challenging. However, one additional solution, beyond amending the current law, is for IDOH to prioritize coal ash contamination as a public health issue in Indiana. Human health issues linked to coal ash contamination include cancer, thyroid problems, reproductive harm, and nervous system damage.²¹¹ The EPA determines an unacceptable risk when environmental exposures cause cancer in one in 100,000 people.²¹² However, people living near a coal ash pond or landfill have a one in fifty chance of getting cancer—2,000 times EPA’s regulatory goals for unacceptable risks of cancer-causing environmental exposures.²¹³ Yet, IDOH does not consider illness due to drinking water contaminated by coal ash a reportable health issue.²¹⁴

IDOH does provide testing for private wells throughout the state, noting potential risks to clean water can come from industrial and hazardous wastes.²¹⁵ As discussed, coal ash is not regulated as hazardous waste. Additionally, IDOH lists the following risks under industrial and hazardous wastes: “factories and

208. Cora et al., *supra* note 207.

209. *Id.*

210. *Id.* at 2.

211. See Evans et al., *supra* note 1, at 7–9; see also Bowman, *supra* note 55.

212. IND. ENV’T REP., *supra* note 35, at 26:56–27:04.

213. *Id.* at 27:05–27:17; but see U.S. ENV’T PROT. AGENCY, REG. ID. NO. 2050-AE81, HUMAN AND ECOLOGICAL RISK ASSESSMENT OF COAL COMBUSTION RESIDUALS (Dec. 2014), (determining lower health risks exist).

214. IND. ENV’T REP., *supra* note 35, at 29:21–29:33.

215. *Well Water Quality and Testing*, IND. DEP’T OF HEALTH, <https://www.in.gov/health/eph/well-water-quality-and-testing/> [<https://perma.cc/W38C-ZP8C>] (last visited Jan. 31, 2025).

small businesses, gas stations, and dry cleaners; leaking underground tanks and piping; mining and construction by-products; chemical and petroleum production sites; and brownfields, abandoned industrial areas.”²¹⁶ Coal ash contamination is not explicitly named as a risk to well water contamination. Thus, Indiana residents are likely not as informed about potential coal ash contamination to their well water as they should be, just like the Town of Pines residents were not back in 2000.

Additionally, IDOH should perform health studies on known or suspected areas in which residential fill was used. Residents in Town of Pines requested such a health study, but the federal government denied them such, saying the town was too small for a study to be done.²¹⁷ Therefore, it is apparent if health studies are to be done on the small, impacted communities in Indiana, such studies will not be done by the federal government. With this, it is important to again note that the EPA has left the primary responsibility of beneficial use regulation to the states. Thus, IDOH should explicitly list coal ash contamination as a risk to well water and implement health studies as part of the state responsibility to regulate beneficial use of coal ash.

IV. CONCLUSION

In conclusion, current federal and state coal ash law is inadequate to protect human health and the environment. Coal ash is regulated under RCRA, the federal statute with an objective of protecting human health and the environment. Yet, beneficial use of coal ash is regulated at the federal level weakly and vaguely. Under Indiana law, the state cannot regulate beneficial use any more stringently than federal law, which is weak and vague. Therefore, to better protect human health and the environment, the EPA should add location-based risk factors into the beneficial use criteria, require recordation for all unencapsulated beneficial use, and regulate unencapsulated beneficial use as a disposal method. Indiana legislators should amend the Indiana Code to allow more stringent regulation, the IERB should incorporate state-specific beneficial use regulations into the state rule, and the IDOH should prioritize coal ash contamination as a public health issue. If federal and state legislators and regulators act to protect human health and the environment in such ways, another Town of Pines-like tragedy could be avoided.

216. *Id.*

217. Thiele, *supra* note 207.

HELP AGING HOOSIERS REMAIN IN THEIR HOMES: HOW INDIANA CAN PROVIDE BETTER PROTECTIONS TO BORROWERS OF REVERSE MORTGAGES

JILL GONTERMAN*

I. INTRODUCTION

With improved health care and a longer life expectancy, Americans are now on average living to be seventy-eight years old.¹ By 2034, older Americans, aged sixty-five and older, will outnumber children under the age of eighteen.² By 2025, the entire Indiana-based baby boomer generation will be sixty and over;³ the number of seniors in our community is continuing to grow.⁴ Many of these seniors prefer to age in place in their homes and communities, yet without additional funding or other ways for seniors to increase their income, this will be difficult.⁵ It is critical to have more safe options for seniors to safely age in place and not be displaced from their homes in their final years of life, and to do this, more tools and financial resources must be developed to help seniors age in place in their communities. One tool that could help seniors be more financially stable in their retirement years is a reverse mortgage.

The reverse mortgage has not lived up to Congress's intent of aiding seniors to age in place.⁶ Reverse mortgages have been a tool that seniors are wary of, because of deceptive sales tactics, lack of transparency about fees, high rates of default and foreclosures, and the general complexities.⁷ The Department of

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1. Aaron O'Neill, *Life Expectancy (from birth) in the United States, from 1860 to 2020*, STATISTA (Jul. 31, 2025), <https://www.statista.com/statistics/1040079/life-expectancy-united-states-all-time/> [<https://perma.cc/U9Q5-C4ZR>].

2. Jonathan Vespa, *The Graying of America: More Older Adults Than Kids by 2035*, U.S. CENSUS BUREAU (Oct. 8, 2019), <https://www.census.gov/library/stories/2018/03/graying-america.html> [<https://perma.cc/LS5E-7D4K>].

3. IND. FAM. & SOC. SERVS. ADMIN., INDIANA STATE PLAN ON AGING FEDERAL FISCAL YEARS 2023-2026, 3, 5 (2022), <https://www.in.gov/fssa/da/files/2023-2026-State-Plan-March-2022-Draft.pdf> [<https://perma.cc/Z46P-5HA5>].

4. *See id.* at 5.

5. *See* Michelle R. Davis, *Despite Pandemic, Percentages of Older Adults Who Want to Age in Place Stays Steady*, AARP (Nov. 21, 2022), <https://www.aarp.org/home-family/your-home/info-2021/home-and-community-preferences-survey.html> [<https://perma.cc/EV2B-6QMR>].

6. *Oversight of the Federal Housing Administration's Reverse Mortgage Program for Seniors: Hearing Before the Subcomm. on Ins., Hous. & Cmty. Opportunity of the H. Comm. on Fin. Servs.*, 112th Cong. 7 (2012) (statement of Peter H. Bell, President & CEO, Nat'l Reverse Mortg. Lenders Ass'n), <https://financialservices.house.gov/uploadedfiles/hhrg-112-ba04-wstate-pbell-20120509.pdf> [<https://perma.cc/CNE3-9DRN>] [hereinafter Bell].

7. *See* Debra Pogrud Stark et al., *Complex Decision Making and Cognitive Aging Call for Enhanced Protection of Seniors Contemplating Reverse Mortgages*, 46 ARIZ. ST. L.J. 299, 318–22 (2014); Jennifer Juergens, *Reverse Mortgage Complexity is Negatively Impacting Older*

Housing and Urban Development (HUD) has worked on addressing some of these consumer issues with reverse mortgages, but there is still room for improvement. Indiana should protect our seniors by creating more regulations for reverse mortgages because they are complex and difficult for seniors to understand. While this note primarily advocates for changes in Indiana, changes may also be beneficial at the Federal level. With increased safeguards and protections, a reverse mortgage could be a more useful tool for aging seniors.

The first part of this note will explain what a reverse mortgage is and identify how it could be useful for Indiana seniors. This portion of the note will discuss the economic strife for seniors, the current demographics of Indiana seniors, how the economic landscape creates barriers for older Hoosiers to safely age in place, and a comprehensive overview of the total financial cost of aging in place. The second section of this note will discuss the history and current regulations governing reverse mortgages, the gaps that make reverse mortgages not live up to their intended purpose, and the impacts of these shortcomings. The third section of this note will compare Indiana's current regulations against both Federal regulations and other states, and identify areas where Indiana falls short. The fourth section will summarize recommendations for Indiana to improve its borrower protections that would limit displacement of borrowers from their homes and create safeguards that allow seniors to age in place in their homes.

II. WHAT IS A REVERSE MORTGAGE AND HOW IT COULD HELP SENIORS

A. Reverse Mortgage Defined

Reverse mortgages are nonrecourse loans.⁸ There are three types of reverse mortgages available: the Home Equity Conversion Mortgage (HECM), the proprietary reverse mortgage, and the single-purpose reverse mortgage. The HECM differs from the other two types of reverse mortgages because it has different age requirements for borrowers, more flexible payment options, a maximum assessed home value, funds that can be used for any purpose, and it is federally insured by the Federal Housing Administration (FHA).⁹ This note

Americans, 6 HOU. L. REV. 209, 216–19 (2016); Sarah B. Mancini & Odette Williamson, *Reversing Course: Stemming the Tide of Reverse Mortgage Foreclosures Through Effective Servicing and Loss Mitigation*, 26 ELDER L.J. 85, 125 (2018).

8. *Nonrecourse loan*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/nonrecourse%20loan> [<https://perma.cc/D92F-G6XB>] (last visited Nov. 17, 2024) (explaining that a nonrecourse loan is one where “the lender agrees to accept the collateral security in lieu of repayment from the borrower . . . [even] if the value of the security falls below the amount of the loan”).

9. Michael G. Branson, 3 *Types of Reverse Mortgages Explained: Which One is Right for You?*, ALL REVERSE MORTGAGE, INC. (May 2, 2024), <https://reverse.mortgage/3-types-of-reverse-mortgages> [<https://perma.cc/5J7L-R9NX>] (discussing types of reverse mortgages. Proprietary

will focus on the HECM reverse mortgage because it is the most commonly used reverse mortgage and the only one insured through the FHA.¹⁰

The HECM was designed to allow lower-income, senior homeowners to access their home equity without having to sell their property or risk displacement.¹¹ The reverse mortgage is a tool that allows any homeowner who is sixty-two or older to borrow against the equity of their home while they still live in it.¹² The equity is paid to the borrower through either periodic lump sums, regular monthly payments, or a line of credit.¹³ One of the advantages to a reverse mortgage is that it does not require monthly payments to pay back the loan.¹⁴ A reverse mortgage becomes due and payable only after a triggering event, such as the borrower's death or moving out of the home.¹⁵

Because a reverse mortgage does not become due and payable until a specified event occurs, it differs from a home equity line of credit, which requires regular monthly payments.¹⁶ A reverse mortgage can be preferable to a home equity line of credit for individuals living on a fixed income, as they may be unable to afford monthly payments. For some seniors who still have a traditional mortgage, a reverse mortgage eliminates their monthly mortgage payment, which reduces their expenses and frees up funds during their retirement. This financial flexibility can be especially important as seniors' needs may increase with age. The extra funds available could help with home modifications, unexpected repairs, and the cost of in-home caregivers.

While a senior may be unable to leave their home to their heirs after taking out a reverse mortgage, they can enjoy greater financial independence and rely less on their loved ones in their later years. The ability to afford in-home care can ease the burden on family members from some caregiving responsibilities or allow the homeowner to compensate family members who provide assistance. Often, adult children reduce their work hours or leave their jobs to care for their aging parents, which lowers their earnings and, in turn, reduces their future

reverse mortgages are more often used for homeowners who have homes above the lending limits of the HECM and can assist borrowers as young as 55. Single-purpose reverse mortgages allow for a single lump sum to be paid to the homeowner for a specific purpose.).

10. *Home Equity Conversion Mortgages for Seniors*, U.S. DEP'T OF HOUS. AND URB. DEV., <https://www.hud.gov/hud-partners/single-family-hecmhome#close> [https://perma.cc/CCA5-59G5] (last visited Nov. 11, 2025).

11. Sarah Bolling Mancini, *Unmet Promise Reverse Mortgage Servicing Challenges and How to Preserve Housing Stability for Older Adults*, NAT'L CONSUMER L. CTR., 5 (2023), <https://www.nclc.org/wp-content/uploads/2023/02/RevMortgage-Rpt.pdf> [https://perma.cc/SX5N-ZKMZ].

12. *What is a Reverse Mortgage?*, CONSUMER FIN. PROT. BUREAU (Aug. 28, 2023), <https://www.consumerfinance.gov/ask-cfpb/what-is-a-reverse-mortgage-en-224/> [https://perma.cc/8A4H-9JK4].

13. *See* 24 C.F.R. § 206.13.

14. *See generally id.*

15. 24 C.F.R. § 206.27(c).

16. *HUD's Reverse Mortgage Insurance Program: Home Equity Conversion Mortgages*, CONG. RSCH. SERV. 1-2, (upd. Mar. 31, 2017), <https://www.congress.gov/crs-product/R44128> [https://perma.cc/CV2H-PGBB].

Social Security benefits when they become eligible—if those benefits are still available when they retire.¹⁷ Ultimately, the child’s ability to save for their own retirement becomes harder.

B. Economic Struggles of Seniors

The economic challenges seniors face from lack of income after ceasing to work emphasizes the need for more social tools, like reverse mortgages, available to help seniors attain financial stability. This lack of income has been an area of concern since before President Roosevelt’s implementation of the Social Security Act of 1935.¹⁸ The purpose of the Act, when enacted, was to provide older Americans with Social Security benefits to help reduce the economic insecurity they faced when they could no longer work.¹⁹ The Act intended to provide a source of financial support and serve as one leg of a “three-legged stool,” along with personal savings and retirement benefits and/or pensions.²⁰ But over the years, people’s retirement savings have decreased and companies have moved away from pensions and towards employer-sponsored retirement accounts.²¹ Seniors are also living longer and, as a result, drawing from Social Security benefits for a longer period than in previous generations.²²

With the decline in personal savings and the shift from pensions to employer-sponsored retirement accounts, many seniors now rely exclusively on their Social Security benefits.²³ Although Social Security includes annual cost-of-living adjustments (COLA), these increases are often insufficient to keep pace with inflation and rising medical costs.²⁴ The COLA increases can easily be offset by an increase in Medicare premium payments, which are deducted directly from a senior’s Social Security payment.²⁵ Moreover, seniors typically

17. *See Benefit Calculators*, SOC. SEC. ADMIN., <https://www.ssa.gov/OACT/ProgData/retirebenefit1.html> [<https://perma.cc/4MDZ-WBXS>] (last visited Feb. 10, 2025).

18. *Historical Background and Development of Social Security*, SOC. SEC. ADMIN., <https://www.ssa.gov/history/briefhistory3.html> [<https://perma.cc/7Y2U-BD8Y>] (last visited Sept. 1, 2024).

19. *Id.*

20. *Agency History*, SOC. SEC. ADMIN., <https://www.ssa.gov/history/stool.html> [<https://perma.cc/R3PL-CJ4X>] (last visited Nov. 11, 2025); Mancini, *supra* note 10, at 6.

21. *See generally* Alicia H. Munnell, Anthony Webb, & Francesca Golub-Sass, *Is There Really a Retirement Savings Crisis? An NRRI Analysis*, CTR. FOR RETIREMENT RSCH. AT BOS. COLL. 5-6 (2007), https://crr.bc.edu/wp-content/uploads/2007/07/ib_7-11-508.pdf [<https://perma.cc/YM8H-56YV>].

22. *See* O’Neill, *supra* note 1.

23. *New Report: 40% of Older Americans Rely Solely on Social Security for Retirement Income*, NAT’L INST. ON RETIREMENT SEC. (Jan. 13, 2020), <https://www.nirsonline.org/2020/01/new-report-40-of-older-americans-rely-solely-on-social-security-for-retirement-income/> [<https://perma.cc/QS6R-GAWT>].

24. Andy Markowitz, *How does Social Security calculate the COLA?*, AARP (Oct. 10, 2024), <https://www.aarp.org/retirement/social-security/questions-answers/social-security-calculate-cola.html> [<https://perma.cc/6S4Y-QPH9>].

25. *Id.*

spend about 25% of their Social Security benefits on medical expenses, including Medicare premiums and out-of-pocket costs.²⁶ Because medical expenses are rising faster than the general rate of inflation, the COLA increases often fail to cover seniors' full cost of living.²⁷

In Indiana, seniors aged sixty-five and older report the second-lowest median income of the state—\$51,468 annually—compared to those aged twenty-five to sixty-four.²⁸ In 2022, Indiana's Family and Social Service Administration (FSSA) conducted a Community Assessment Survey for Older Adults (CASOA) which showed that 48% of seniors have insufficient money to meet their daily expenses.²⁹

C. Financial Implications of Senior Housing

The shift in older Americans' income during retirement has had serious ramifications on senior housing by forcing many seniors to be “stuck in place,” rather than “aging in place.”³⁰ The combination of lower incomes and savings, along with the rising costs of goods, healthcare, and home-based support, has made it difficult for many seniors to age safely at home.³¹ A reverse mortgage may help seniors in Indiana who are income-poor due to reduced savings and retirement benefits, but are asset-rich because they own their homes.³² The equity they have accumulated over the years in their homes, which is typically available only after selling their property and moving out, could instead be a financial resource while they are still alive.³³ As of 2020, almost 81% of the sixty-five and older population in Indiana owned a home.³⁴ As of 2022, the

26. Melissa McInerney, Matthew S. Rutledge, & Sara Ellen King, *How Much Does Health Spending Eat Away at Retirement Income?*, CTR. FOR RETIREMENT RSCH. AT BOS. COLL. 1 (Aug. 2022).

27. Shameek Rakshit, et al., *How does medical inflation compare to inflation in the rest of the economy?*, PETERSON KFF (Aug. 2, 2024), <https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/> [https://perma.cc/KWN3-UN8K].

28. *Indiana Median Household Income by Age*, NEILSBERG (Aug. 9, 2024), <https://www.neilsberg.com/insights/indiana-median-household-income-by-age> [https://perma.cc/2NXZ-MEM2].

29. IND. FAM. & SOC. SERVS. ADMIN. *supra* note 3, at 10 (the Community Assessment Survey for Older Adults was conducted three times over the course of eight years (2013, 2017, and 2021) to gather data to compare responses).

30. Davis, *supra* note 5.

31. Munnell et al., *supra* note 21, at 6.

32. See Carolyn H. Sawyer, *Reverse Mortgages: An Innovative Tool for Elder Law Attorneys*, 26 STETSON L. REV. 617, 619 (1996).

33. *Id.*

34. *Forecasting State and National Trends in Household Formation and Homeownership: Indiana*, URB. INST., <https://www.urban.org/policy-centers/housing-finance-policy-center/projects/forecasting-state-and-national-trends-household-formation-and-homeownership/indiana> [https://perma.cc/84HN-Q5YN] (last visited Sept. 5, 2025).

median value of homes in Indiana was \$208,700.³⁵ It is projected by 2030, that 78% of the population aged sixty-five and older will own their home.³⁶

D. The High Cost of Care for Seniors

As of 2024, the annual cost of care for in-home services in Indiana ranged from \$73,216 to \$75,504 a year.³⁷ Some lower income seniors may qualify for Medicaid's Home and Community Based Services (HCBS) waiver, now known as Indiana PathWays for Aging Waiver ("PathWays"), to help cover these costs.³⁸ While PathWays is available for seniors who qualify, the current landscape of Pathways in Indiana makes it difficult for seniors to access it in a timely manner.³⁹ In the 2023-2024 budget, FSSA had a \$1 billion shortfall with most of the funding issues coming from the HCBS waiver.⁴⁰ Additionally, PathWays reached its maximum capacity for the available "slots" to eligible recipients.⁴¹ In response, FSSA implemented a waitlist for new recipients of PathWays⁴² without a timeframe for how long a person may be on the waitlist or guarantee someone on the waitlist will be able to access services.⁴³

The alternative for seniors who cannot access PathWays funding or afford to age in place due to the cost of in-home care is to move into a long-term care facility, where annual costs in Indiana range from \$101,835 to \$124,283 as of 2024.⁴⁴ For seniors who cannot pay these costs out of pocket, staying at skilled nursing facilities or Medicaid-certified facilities may be their only remaining

35. *Indiana*, CENSUS REP. (2022), <https://censusreporter.org/profiles/04000US18-indiana/> [https://perma.cc/VF76-AAS5].

36. URB. INST., *supra* note 34.

37. *Calculate the cost of long-term care near you*, CARESCOUT, <https://www.genworth.com/aging-and-you/finances/cost-of-care> [https://perma.cc/Y4AC-LA29] (last visited Oct. 15, 2025).

38. *Aged and Disabled Waiver*, IND. FAM. & SOC. SERVS. ADMIN., <https://www.in.gov/medicaid/members/home-and-community-based-services/aged-and-disabled-waiver/> [https://perma.cc/LB6H-BRVB] (last visited Feb. 20, 2025).

39. Abigail Ruhman, *FSSA creates waitlist for Aged and Disabled waiver. Advocates worry it creates a barrier to care*, IND. PUB. MEDIA (Apr. 8, 2024), <https://indianapublicmedia.org/news/fssa-creates-waitlist-for-aged-and-disabled-waiver-advocates-worry-it-creates-barrier-to-care.php> [https://perma.cc/5XD2-4Q46].

40. Brandon Smith, *Indiana Medicaid Program is \$1 billion more expensive after forecasting error*, LAKESHORE PUB. MEDIA (Dec. 19, 2023), <https://www.lakeshorepublicmedia.org/2023-12-19/indiana-medicaid-program-is-1-billion-more-expensive-after-forecasting-error> [https://perma.cc/V6QT-XLDF].

41. Ruhman, *supra* note 39.

42. *Id.*

43. *Aged and Disabled Waiver Waiting List: Frequently Asked Questions*, IND. FAM. AND SOC. SERV. ADMIN., 1, <https://www.in.gov/fssa/files/Aged-Disabled-Waiver-Waiting-List-FAQ.pdf> [https://perma.cc/M6D5-BE9L] (last visited Jan. 1, 2025).

44. CARESCOUT, *supra* note 37.

option.⁴⁵ However, this is far from ideal, as most seniors prefer to remain in their homes rather than move into a nursing home.⁴⁶ Furthermore, 20% of Indiana's Medicaid budget is going towards paying for nursing home care, and it is expected the enrollment population of nursing home care will grow about 5% from 2024 to 2026.⁴⁷ A reverse mortgage could allow seniors to pay for the costs of care in their home from the equity of their home. This would reduce some of the reliance on Medicaid's budget for skilled nursing facilities and leave more funding for in-home care services.

III. THE DEVELOPMENT OF REVERSE MORTGAGES AND THE CHALLENGES TO THEIR EFFECTIVENESS FOR SENIOR BORROWERS

A. The History of Reverse Mortgages

The first reverse mortgage was issued by a private bank in 1961.⁴⁸ The employee of the bank was looking for a way to help a widow in his hometown stay in her house after her husband died.⁴⁹ Over the next 20 years, the reverse mortgage product was studied by various groups, including a Professor of Mathematics from the University of California Los Angeles and the Wisconsin Board of Aging to explore its viability.⁵⁰ When the concept was presented to the federal government in 1980, it took another 9 years before the first FHA-insured reverse mortgage was issued.⁵¹

In 1987, Congress passed the National Housing Act of 1987, Section 225, which outlined the reverse mortgage program with oversight by HUD.⁵² Congress identified the purpose of this program as a way “[t]o meet the special needs of elderly homeowners by reducing the effect of the economic hardship caused by increasing costs of meeting health, housing, and subsistence needs”⁵³

In 1988, President Ronald Reagan signed the reverse mortgage bill into law, allowing FHA, through HUD, to have a fund that insures one of three types of

45. *Nursing Facilities*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html> [https://perma.cc/582T-YLDG] (last visited Feb. 8, 2025); see Alicia H. Munnell, *Nursing Homes Can't Meet the Care Needs of an Aging Population*, CTR. FOR RETIREMENT RSCH. AT BOS. COLL. 2 (Mar. 25, 2024), <https://ctr.bc.edu/wp-content/uploads/2024/03/Nursing-Homes-Cant-Meet-the-Care-Needs-of-an-Aging-Population-%E2%80%93-Center-for-Retirement-Research.pdf> [https://perma.cc/92AD-GWGK].

46. Davis, *supra* note 5.

47. 2024 MEDICAID FORECAST, IND. FAM. & SOC. SERVS. ADMIN. 13, 16 (2024) <https://www.in.gov/sba/files/December-2024-Medicaid-Forecast-FINAL.pdf> [https://perma.cc/S54J-E4RK].

48. Michael G. Branson, *History of the Reverse Mortgage – 1969 to Present Day Facts*, ALL REVERSE MORTG., INC. (Sept. 19, 2023), <https://reverse.mortgage/history> [https://perma.cc/K634-77V7].

49. *Id.*

50. Bell, *supra* note 6, at 3.

51. *Id.*

52. *Id.*

53. *Id.*

reverse mortgages—the HECM.⁵⁴ This insurance was a way to encourage lenders to provide reverse mortgages because it minimized their financial risk.⁵⁵ The insurance protects the lender if the home’s value is less than the loan amount when the loan becomes due, with the mortgage insurance paying the difference to the lender.⁵⁶ The insurance fund is paid by the borrowers of reverse mortgages as an initial and annual fee.⁵⁷

HUD created additional regulations from the 1990s through 2015 to reduce abuse and negative impacts of reverse mortgages. The first round of these regulations was passed throughout the 1990s, when Congress required reverse mortgage lenders to provide borrowers with thorough disclosures of costs and associated risks.⁵⁸ Then in 2001, HUD partnered with AARP to train and certify reverse mortgage counselors, so there would be a neutral person for potential borrowers to speak with to promote understanding about how a reverse mortgage works, the risks of reverse mortgages, and other options available to them.⁵⁹ In 2005, HECMs were able to be refinanced.⁶⁰ The last changes that were made to improve HECMs were made between 2010–2015, and were designed to: increase FHA’s mortgage insurance premiums to help FHA to continue to be able to cover the cost of unpaid reverse mortgage loans; implement a formal financial assessment of borrowers; and add non-borrowing spousal protections.⁶¹

B. Federal Regulations for Home Equity Conversion Mortgages (HECM)

All borrowers must meet certain requirements to be eligible for a HECM reverse mortgage all borrowers must meet certain requirements. To begin, borrowers must be at least 62 years old, and they must either own their home outright or have paid down a considerable amount of their existing mortgage.⁶² The home must be assessed under \$1,149,825⁶³ and serve as the borrower’s principal residence.⁶⁴ It must also meet the FHA maintenance and safety standards for habitability throughout the life of the loan,⁶⁵ remain current on property tax payments,⁶⁶ and be free of any outstanding unpaid obligation that

54. See 12 U.S.C. § 1715z-20; Branson, *supra* note 48.

55. See Bell, *supra* note 6, at 3–4.

56. See 24 C.F.R. § 206.103.

57. See 24 C.F.R. § 206.31; See *How the HECM Program Works*, U.S. DEP’T OF HOUS. AND URB. DEV., https://www.hud.gov/program_offices/housing/sfh/hecm/hecmabou [https://perma.cc/VX6Q-2J75] (last visited Feb. 8, 2025).

58. See 12 C.F.R. § 1026.19; see also Branson, *supra* note 48.

59. 24 C.F.R. § 206.41.

60. Branson, *supra* note 48.

61. *Id.*

62. U.S. DEP’T OF HOUS. AND URB. DEV., *supra* note 57.

63. *Id.*

64. 24 C.F.R. § 206.39.

65. 24 C.F.R. § 206.47.

66. 24 C.F.R. § 206.205.

could remove FHA's priority lien.⁶⁷

Unlike a home equity line of credit that has monthly payments, the borrower of an HECM does not make any monthly payments. Instead, the loan only becomes due when a triggering event occurs, such as: either the borrower or non-borrowing spouse passing away (whichever comes last); either the borrower or non-borrowing spouse no longer using the mortgaged property as their primary residence; the property is transferred; or default of another term of the loan agreement.⁶⁸

Because it is a nonrecourse loan, there is a risk to the lender that the price of the property may be less at the time of the triggering event than it was at the loan origination. FHA will insure those properties that qualify for a HECM.⁶⁹ This mortgage insurance is what makes the HECM the most utilized type of reverse mortgage.⁷⁰ The insurance will pay the lender the difference in the loan amount from the home's value when it is sold if the sale price is less than the loan amount.⁷¹ The insurance removes the risk of loss from the lender because it guarantees the lender will be repaid in full when the loan becomes due and payable, even if the property's value decreases from the initial valuation when the loan was executed. For the home to continue to qualify for the insurance throughout the life of the loan, the home must meet and maintain certain requirements.⁷² The lender may also be reimbursed for the loaned amount before a triggering event occurs if the loaned amount reaches 98% of the available loan.⁷³

The lender is entitled to assign the loan to the Federal Housing Commissioner ("Commissioner") when the borrower uses 98% of their loan balance.⁷⁴ This process can create issues for the borrower, as there is an incentive for lenders to assign their loans to the Commissioner because the lender can then get repayment on the loan without having to wait for a triggering event to occur.⁷⁵ While the Commissioner will manage the loan in the same manner as the lender, the only major difference is that the Commissioner has statutory authority to conduct fast, non-judicial foreclosures.⁷⁶ The Commissioner can enact this process when the loan becomes due and payable because of a triggering event. For example, if a triggering event is due to a borrower's default for missing a property tax payment, the Commissioner will

67. 24 C.F.R. § 206.32; 24 C.F.R. § 206.8(a).

68. 12 C.F.R. § 1026.33(a).

69. 12 U.S.C. § 1715z-20.

70. Branson, *supra* note 48.

71. CONG. RSCH. SERV., *supra* note 16, at 1, 9.

72. 24 C.F.R. § 206.47.

73. 24 C.F.R. § 206.107; Mancini, *supra* note 11, at 15 ("The Maximum Claim Amount is the maximum amount the FHA insurance can pay out on a claim, and is equal to the appraised value of the home when the loan is made, up to a ceiling set by FHA. . . . the lender is entitled to assign the loan to FHA and have its insurance claim paid in full.").

74. 24 C.F.R. § 206.107.

75. See Mancini, *supra* note 11, at 15.

76. 12 U.S.C. § 3751.

likely move to foreclose on the property, displacing the borrower without giving them an opportunity to mitigate the loss. The Commissioner's statutory authority to carry out the non-judicial authority supersedes state laws to the contrary.⁷⁷ However, lenders do not have this authority and must go through judicial foreclosure actions if the state requires it.

When a borrower is applying for an HECM, a HUD approved counselor must certify that the borrower and non-borrowing spouse have received counseling.⁷⁸ This requirement is meant to ensure that the homeowners understand the ramifications of taking a reverse mortgage and other options that may be available to them.⁷⁹ During this counseling, the borrower is informed of the different options they have to access the equity they are owed.⁸⁰ The options available to a borrower include single lump sum disbursements, a line of credit, regular monthly payments, or a combination of these options.⁸¹ The borrower can choose how to access their equity in a way that makes the most sense for their specific financial needs. If a borrower chooses to utilize a monthly payment amount, then the allowable monthly amount will be calculated based on the youngest homeowner and/or borrower of the loan.⁸² If there is a large age gap between the borrowers, or borrower and non-borrowing spouse, the amount that can be paid out may be significantly reduced because it will be based on the younger of the two. Additionally, the amount of equity that will be available for distribution will be reduced by the closing costs, fees, mortgage insurance premiums, servicing fees by the lender, and ongoing interest charges through the length of the reverse mortgage.⁸³ In some cases, if the home needs to be repaired to meet HUD standards, a borrower may also need to use the available equity to cover these costs. The total equity available to the borrower for disbursement will depend on various up-front costs that secure the loan.⁸⁴

The borrower's obligations throughout the life of the loan include payment of the property taxes, homeowners' insurance, ongoing property charges such as homeowners' association fees, and necessary repairs.⁸⁵ There is an option for these expenses to be paid by the lender through a Life Expectancy Set Aside ("LESA").⁸⁶ This is a voluntary option for some borrowers and mandatory for other borrowers depending on the outcomes of their financial assessment.⁸⁷

77. *Id.*

78. 24 C.F.R. § 206.41.

79. *Id.*

80. *Id.*

81. 24 C.F.R. § 206.13.

82. *Housing Counseling Handbook*, U.S. DEP'T OF HOUS. AND URB. DEV., 120 (Sept. 2023), <https://www.nrmలాonline.org/wp-content/uploads/2023/09/Updated-Housing-Counseling-Handbook-9-13-2023.pdf> [<https://perma.cc/S36X-TU8W>] [hereinafter U.S. DEP'T OF HOUS. AND URB. DEV.].

83. *See* 24 C.F.R. § 206.31.

84. CONG. RSCH. SERV., *supra* note 16, at 4.

85. 24 C.F.R. § 206.27.

86. 24 C.F.R. § 206.205.

87. *Id.*

In addition to the counseling requirement, a financial assessment is completed prior to approval of the loan to verify a borrower's credit standing, credit history, cash flow, and residual income.⁸⁸ A borrower may fail the financial assessment for several reasons, including, but not limited to, a poor credit rating, past failure to pay bills, or previous bankruptcy filings. Failing the financial assessment does not always disqualify the borrower from a reverse mortgage loan. Instead, the borrower would be required to do a LESA as part of the terms of the loan.⁸⁹ A LESA functions like an escrow account for mortgages, where funds from the equity of the home are set aside in an account to pay the property's homeowners' insurance and property taxes. A borrower who does pass the financial assessment may choose to opt into a LESA.⁹⁰ While this will reduce the amount of equity available to them over the life of the loan, it will lessen the possibility of default because of missed homeowners' insurance or property tax payments. However, if the amount in the LESA runs out, then the borrower must begin to make these payments to keep the loan from going into default.⁹¹ The decision whether to opt into a LESA is made at the time the loan originates, and it cannot be changed at any point in the future.⁹²

C. Past Issues, Solutions, and Success Stories of HECMs

Congress' goal with the reverse mortgage has been to help seniors access equity in their homes while they still live there so they can comfortably age in place.⁹³ Over time, issues with reverse mortgages have forced seniors out of their homes through foreclosures by HUD and lending companies.⁹⁴ Over the years, HUD has added more protections to limit these outcomes.⁹⁵ The next three subsections discuss an overview of these problems and the solutions.

1. Deceptive Sales Practices and Predatory Lending

The direst consequence for seniors who accept a reverse mortgage is losing their homes. Prior to the 1990's, lenders were taking advantage of seniors by not fully disclosing the costs and fees associated with reverse mortgages. Lenders were also making unfair or deceptive statements to borrowers,⁹⁶

88. 24 C.F.R. § 206.37; Carol M. Kopp, *Residual Income: What It Is, Types, and How to Make It*, INVESTOPEDIA (July 29, 2025), <https://www.investopedia.com/terms/r/residualincome.asp> [<https://perma.cc/JF7N-FBAD>] (Residual income is defined as available income after all debts and bills are paid).

89. 24 C.F.R. § 206.205.

90. *Id.*

91. *Id.*

92. *Id.*

93. Bell, *supra* note 6, at 3.

94. *See generally* Mancini, *supra* note 11, at 7-17.

95. *See* CONG. RSCH. SERV., *supra* note 16, at 19-20.

96. *See* Dan Latona, *Reversing Course: Strengthening Consumer Protections for Reverse Mortgages*, 23 ELDER L.J. 417, 429 (2016).

including that the death of a borrower would not trigger a foreclosure on a surviving non-borrowing spouse.⁹⁷ These deceptive and predatory practices are more egregious when considering the age of the borrower—seniors over the age of 62. Aggressive lenders can easily take advantage of the vulnerable population of seniors.⁹⁸ Some research has shown that seniors may suffer from cognitive risk factors that decrease their insight and awareness, making it more difficult for them to recognize fraud.⁹⁹

In the 1990's, the Truth in Lending Act was amended to implement the Home Ownership and Equity Protection Act of 1994 (HOEPA), which “imposed new disclosure requirements and substantive limitations” on reverse mortgage transactions.¹⁰⁰ Some of these requirements include, but are not limited to, disclosure of all fees payable by the consumer at or before the loan closing; all information on the reverse mortgage be made in writing and in a manner the consumer understands; and disclosures must be given at least three business days prior to finalizing the loan agreement.¹⁰¹

Unfortunately, the addition of these protections has not stopped lenders from using deceptive practices. In *People v. Butler*, a lender had his insurance license revoked because he did not disclose a material term of the agreement to eight reverse mortgage borrowers.¹⁰² The lender did not inform any of the borrowers of the service fee he charged (ranging from \$3,400–\$7,705) until after the loan was complete and the payment was due.¹⁰³ According to the Department of Insurance’s revocation order, the eight senior citizen borrowers would not have borrowed the reverse mortgage had they known of the service fee.¹⁰⁴ Disclosures of reverse mortgage service fees are mandatory under the Truth in Lending Act (TILA).¹⁰⁵

In *Wiseman v. First Mariner Bank*, a loan officer engaged in unfair or deceptive trade practices when he told the Wisemans false and misleading statements about reverse mortgages.¹⁰⁶ He claimed that Mrs. Wiseman, a non-borrowing spouse, would not be required to leave the home if Mr. Wiseman

97. See *Wiseman v. First Mariner Bank*, No. ELH-12-2423, 2013 U.S. Dist. LEXIS 136229 at *11 (D. Md. Sept. 23, 2013).

98. See Latona, *supra* note 96, at 430.

99. Karen Reimers M.D., *Why Are Older Adults More Vulnerable to Scams?*, PSYCHOLOGY TODAY (Sept. 18, 2023), <https://www.psychologytoday.com/us/blog/the-high-cost-of-forgetting/202309/why-are-older-adults-more-vulnerable-to-scams?> [<https://perma.cc/S6GY-CKWT>].

100. 12 C.F.R. §§ 1026.19, 1026.33; BD. OF GOVERNORS OF THE FED. RESRV. SYS., CONSUMER COMPLIANCE HANDBOOK: REGUL. Z TRUTH IN LENDING ACT, 1 (2017), https://www.federalreserve.gov/publications/supervision_cch.htm [<https://perma.cc/BJ89-SXRT>].

101. BD. OF GOVERNORS OF THE FED. RESRV. SYS., *supra* note 100, at 25–27.

102. *People v. Butler*, 212 Cal. App. 4th 404, 410 (2012).

103. *Id.*

104. *Id.*

105. 15 U.S.C. § 1648.

106. *Wiseman v. First Mariner Bank*, No. ELH-12-2423, 2013 U.S. Dist. LEXIS 136229 at *11 (D. Md. Sept. 23, 2013).

passed away before her.¹⁰⁷ Prior to obtaining the reverse mortgage, the Wisemans shared the property as tenants by the entirety with a right of survivorship, and both had equal rights in the property.¹⁰⁸ The loan officer specifically told both of the Wisemans that the property with the reverse mortgage would not be due for payment until they “both passed away or decided to sell or not to reside in their home any longer.”¹⁰⁹ The loan officer advised the couple that obtaining the reverse mortgage would require Mrs. Wiseman to convey her interest in the property to Mr. Wiseman by executing a life estate deed.¹¹⁰ He represented that this arrangement would ensure Mrs. Wiseman could remain in the home for the rest of her life if her husband passed away first.¹¹¹ Otherwise, the loan would become due and Mrs. Wiseman would not be able to continue living in their home.¹¹² Mr. Wiseman passed away before Mrs. Wiseman, and upon his death, First Mariner Bank said the loan was in default and moved to foreclose on the home where Mrs. Wiseman was still living.¹¹³ This case shed light on deceptive practices that lenders engage in to obtain reverse mortgages, and ultimately made HUD clarify protections for non-borrowing spouses.

2. HUD-Required Counseling

Reverse mortgages are complex and unlike other mortgage products available to consumers. Because of this complexity, as well as the costs, fees, and interest that accrue over the life of the loan, HUD requires every prospective borrower and non-borrowing spouse to receive financial counseling from a HUD-certified specialist before accepting a reverse mortgage.¹¹⁴ The prospective borrower must present the certificate of counseling completion to the lender before the loan can be finalized.¹¹⁵ The purpose of this regulation is to ensure that borrowers and non-borrowing spouses are aware of the costs, fees, and implications of obtaining a reverse mortgage, including less risky alternatives.¹¹⁶ Having adequate third-party counseling has been a staple of reverse mortgages since the program was rolled out in 1987.¹¹⁷

While the counseling requirement is a step towards fairness, proper

107. *Id.*

108. *Id.* at 8–9.

109. *Id.* at 10 (quoting Amended Complaint at ¶29, *Wiseman v. First Mariner Bank*, No. ELH-12-2423, 2013 U.S. Dist. LEXIS 136229 (D. Md. Sept. 23, 2013)).

110. *Id.* at 11.

111. *Id.*

112. *Id.*

113. *Id.* at 14.

114. 24 C.F.R. § 206.41.

115. *Id.*

116. See *Reverse Mortgages: A Discussion Guide*, CFPB, 1 (Aug. 2021), https://files.consumerfinance.gov/f/documents/cfpb_reverse-mortgage-discussion-guide.pdf [<https://perma.cc/V97X-4JY9>].

117. Bell, *supra* note 6.

counseling is largely dependent upon counselor assignment and adequacy of counseling services.¹¹⁸ To become a qualified HECM Counselor, all individuals must complete standardized training on HECM counseling standards and pass an exam administered by the FHA that is designed to test their knowledge of required HECM standards.¹¹⁹ HUD recommends that each counseling session with prospective borrowers and non-borrowing spouses take at least one hour, but some counselors have reported completing a session in less than fifteen minutes.¹²⁰ HUD allows for reimbursement of counseling on a case-by-case basis rather than pay-per-hour basis. The fee just cannot exceed “a level that is commensurate with the services provided [and] is reasonable and customary for the area.”¹²¹ This structure can incentivize some counselors to hold shorter sessions and require people to attend more sessions without accountability.

Currently, HUD does not have a way to determine if prospective borrowers are receiving quality counseling.¹²² HUD’s inability to track the information given at each counseling session creates inconsistencies for borrowers.¹²³ HUD requires each counselor to give a packet of information related to reverse mortgages to each prospective borrower and go over that information with them at the counseling session.¹²⁴ In a study conducted by the National Consumer Law Center (NCLC), advocates for borrowers who were in default of their reverse mortgage found that borrowers who defaulted because of missed property tax payments often defaulted because the borrower did not understand that they were responsible for paying these fees.¹²⁵

For many individuals that live in rural areas or do not have adequate transportation, face-to-face counseling may not be a feasible option. To ensure these individuals receive adequate counseling, HUD allows HECM counselors to conduct counseling sessions via telephone counseling.¹²⁶ While this is a beneficial alternative, it also creates concern as to whether prospective borrowers retain the necessary information in a phone session, especially considering the complexity of reverse mortgages and the counselor’s ability to gauge possible diminished capacity over the phone.¹²⁷ Counselors are supposed to assess legal capacity of prospective borrowers during the first intake

118. U.S. GOV’T ACCOUNTABILITY OFF., GAO-09-606, REVERSE MORTGAGES: PRODUCT COMPLEXITY AND CONSUMER PROTECTION ISSUES UNDERSCORE NEED FOR IMPROVED CONTROLS OVER COUNSELING BORROWERS, 30–33 (2009), <https://www.gao.gov/assets/gao-09-606.pdf> [<https://perma.cc/T9VN-SHTG>].

119. 24 C.F.R. § 206.304.

120. U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 118.

121. U.S. DEP’T OF HOUS. AND URB. DEV., *supra* note 82, at 83.

122. U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 118, at 31–32.

123. *Id.* at 30–33.

124. U.S. DEP’T OF HOUS. AND URB. DEV., *supra* note 82, at 43–44.

125. Mancini, *supra* note 11, at 31.

126. U.S. DEP’T OF HOUS. AND URB. DEV., *supra* note 82, at 103.

127. See Naomi Karp & Ryan Wilson, *Protecting Older Investors: The Challenge of Diminished Capacity*, AARP PUB. POL’Y INST., 17 (Nov. 2011), <https://financialservices.org/wp-content/uploads/2017/03/rr2011-04.pdf> [<https://perma.cc/KJ89-FNQ3>].

appointment by asking questions to ensure understanding throughout the counseling session.¹²⁸ To receive a certificate of completion, borrowers must be able to correctly answer a minimum of five out of ten questions asked during the session. The questions are chosen by the counselor from a bank of sixteen questions and are based on things a borrower should understand about their reverse mortgage.¹²⁹ Examples of questions a counselor may ask include: “When is the loan required to be repaid?”; “Which of the available options for receiving HECM proceeds are you interested in, and how does that option work?”; “What ongoing responsibilities will you have as a homeowner after obtaining a HECM?”; “What obligations must a surviving non-borrowing spouse maintain after the borrower’s passing?”; and “How are closing costs determined for a HECM for purchase?”¹³⁰ If the prospective borrower is unable to answer at least five of the questions correctly, the counselor may either invite them to do another counseling session, or ask if they would like to include someone else in a future session to assist them.¹³¹ A certificate of completion cannot be given until the borrower correctly answers at least five questions.¹³² There is no limit to the number of follow-up sessions a borrower may attend to try to meet this requirement, and the counselor has the discretion to determine how many sessions are necessary.¹³³

While HUD requires an individual complete counseling prior to being approved to receive a loan, HUD does not have the same requirements for follow-up counseling. HUD only requires the counselor to make reasonable efforts to contact the borrower within sixty days after the first counseling session to ask whether the loan has met the borrower’s needs and if they have any questions.¹³⁴ If the counselor does not make contact within three months of the initial counseling session, then the counselor may terminate the borrower’s file and refrain from attempting any more contacts.¹³⁵ A 2018 report by the Retirement Research Foundation analyzing post-default HECM counseling found “. . . that out of 162 HECM borrowers facing default or foreclosure, 70% were able to cure the default and remain in their homes with the help of experienced counselors.”¹³⁶ Improving the post-loan counseling requirement may help reduce the number of borrower defaults. A lot of information is given in the initial counseling session and borrowers may not know whether they have questions until after the reverse mortgage has been initiated. Having a counselor follow them through the process may help to clarify any misunderstandings or miscommunications.

128. U.S. DEP’T OF HOUS. AND URB. DEV., *supra* note 82, at 104, 112.

129. *Id.* at 111–14.

130. *Id.* at 113–14.

131. *Id.* at 114.

132. *Id.*

133. *Id.*

134. *Id.* at 116.

135. *Id.* at 33–34.

136. Mancini & Williamson, *supra* note 7, at 127.

3. Non-Borrowing Spouses

Until 2014, the death of a borrower or a borrower moving into a long-term care facility would trigger the repayment of the loan, even if a non-borrowing spouse was still using the mortgaged property as their primary residence.¹³⁷ The only way the non-borrowing spouse could stop the bank from foreclosing was repaying the loan within 120 days of the triggering event.¹³⁸ The high burden and difficulty of repayment led to non-borrowing spouses getting displaced from their homes.¹³⁹

Much litigation occurred to help non-borrowing spouses defer the loan throughout their lifetime. One of the most heavily litigated issues was the discrepancy between HUD's interpretation of a homeowner and Congress' definition of a homeowner.¹⁴⁰ HUD defined homeowner as "borrower," whereas Congress intended a more expansive definition to protect spouses of homeowners by encompassing both the borrower and non-borrowing spouse in the definition of "borrower."¹⁴¹ In *Bennet v. Donovan*, surviving non-borrowing spouse homeowners brought suit to enforce Congress's interpretation to avoid having their homes foreclosed after the triggering event of their spouses' death.¹⁴² The claimants asserted that HUD's definition of a homeowner as a "borrower" was unlawful and inconsistent with Congress's definition of homeowner, which encompassed both the borrower and the non-borrowing spouse from displacement.¹⁴³ The Appellate Court agreed that HUD's regulation was contrary to the statutory intent and suggested various steps HUD could take to correct the problem, including revising the definition to include the surviving spouse.¹⁴⁴

In 2014, HUD updated their definition of a "non-borrowing spouse" as:

- (i). . . [a] spouse of a HECM borrower at the time of the loan closing and remained the spouse of such HECM borrower for the duration of the HECM borrower's lifetime; (ii) [h]ave been properly disclosed to the mortgagee at origination and specifically named as an Eligible Non-Borrowing Spouse in the HECM mortgage and loan documents; (iii) Have occupied, and continue to occupy, the property securing the HECM as his or her principal residence; and (iv) Meet any other

137. Sam Brittingham, *Aging Out of Place: The Toll of Reverse Mortgages and How to Fix the Program*, 29 ELDER L.J. 149, 166 (2021).

138. *Id.* at 164-65.

139. *Id.* at 165.

140. *Bennett v. Donovan*, 703 F.3d 582, 586 (2013).

141. *Id.*; 12 U.S.C. § 1715z-20(j); 24 C.F.R. § 206.27(c).

142. *Bennet v. Donovan*, 703 F.3d at 586.

143. *Id.*; 12 U.S.C. § 1715z-20(j); 24 C.F.R. § 206.27(c).

144. *Bennet v. Donovan*, 703 F.3d at 586 (HUD explained the regulation came out of a concern that "[a] homeowner, after taking out a reverse mortgage, marries a spouse — particularly a young spouse — and thereby significantly increases a lender's risk.").

requirements as the Commissioner may prescribe by Federal Register notice for comment.¹⁴⁵

HUD further clarified its regulations to allow for HECM loan payments to be deferred after the borrower's death or departure from the home, provided that the non-borrowing spouse lived in the home when the reverse mortgage originated and continues to use it as their primary residence.¹⁴⁶ To defer the loan balance, the non-borrowing spouse must notify the lender within a specified time of the triggering event.¹⁴⁷ This rule also requires the non-borrowing spouse to establish legal ownership of the home within 90 days of their borrower spouse leaving the home or dying.¹⁴⁸ Additionally, the non-borrowing spouse must continue to fulfill the requirements of the loan terms, such as paying the property taxes, maintaining homeowners' insurance, completing necessary repairs to maintain the home at the standard set forth by FHA, and maintaining the property as their principal residence.¹⁴⁹

It is important to note that the amount of equity available to the borrowing spouse is calculated based on the age of the youngest homeowner, and any remaining equity in the home after the borrower's death cannot be accessed by the non-borrowing spouse unless they refinance the reverse mortgage.¹⁵⁰ This includes money that was set aside under a LESA to pay for taxes on the property, as no LESA funds will be disbursed to the mortgagor, estate, or non-borrowing spouse.¹⁵¹ Because a borrower must have a certain amount of equity in the home to refinance a reverse mortgage, the equity remaining after the death of the borrowing spouse may not be enough for the non-borrowing spouse to refinance.¹⁵²

Both the eligible or ineligible non-borrowing spouse and the borrowing spouse are required to go through HUD-approved counseling.¹⁵³ However, the financial assessment is only required for the borrower, not the non-borrowing spouse.¹⁵⁴ Issues may arise when the borrower passes away and the non-borrowing spouse must take over the mandatory payments for the home. With the loss of their spouse's income, they may no longer be able to afford the rising cost of their property taxes and homeowner's insurance, which may cause the non-borrowing spouse to default on the loan and lose their home through

145. 24 C.F.R. § 206.55(c)(1).

146. 24 C.F.R. § 206.55(a); U.S. DEP'T OF HOUS. AND URB. DEV., MORTGAGEE LETTER 2014-07, at 3, 5 (Apr. 25, 2014), <https://www.hud.gov/sites/documents/14-07ml.pdf> [<https://perma.cc/85HN-3AYT>].

147. Brittingham, *supra* note 137, at 166.

148. 24 C.F.R. § 206.55(d).

149. 24 C.F.R. § 206.41(b)(2).

150. U.S. DEP'T OF HOUS. AND URB. DEV., *supra* note 82, at 120–121, 139.

151. *Id.* at 139.

152. *Id.* at 123.

153. 24 C.F.R. § 206.41.

154. 24 C.F.R. § 206.37(b)(1).

foreclosure.

D. Reasons for Foreclosures

Even with the changes and increased regulations from the 1990s through 2015, borrowers still face issues with reverse mortgages. Although the goal of reverse mortgages is to assist older Americans with aging in place, the foreclosure rate with reverse mortgages is still quite high even with the regulations mentioned above.¹⁵⁵ However, in many circumstances, foreclosures can be prevented or mitigated.¹⁵⁶

1. Property Charge Defaults and Limited Loss Mitigation

Many seniors end up defaulting on their loans because they cannot afford to keep paying their property taxes or home insurance premiums due to the rising costs and their low incomes. According to the NCLC, as of April 2021, roughly 27,000 HECM borrowers were in default because of missed property tax payments.¹⁵⁷ At the time a borrower takes out a reverse mortgage, they can afford their property taxes, but they cannot continue to pay them with their rates increasing over time. Some borrowers inability to keep up with increased taxes on their limited income leads to a default, which is another triggering event that makes the full amount of their loans due and payable.¹⁵⁸ A lender may pay a missed property tax or insurance premium with the borrower's equity if they have some, but under certain conditions, may still proceed with foreclosure if the missed payments indicate financial insolvency.

For lenders to maintain mortgage insurance on the loans, they must meet certain FHA guidelines, including the home being up to date on property taxes, being in good repair, and the loan being in good standing.¹⁵⁹ The fear of losing the mortgage insurance has pushed lenders to foreclose in lieu of other loss mitigation options.¹⁶⁰ For example, if the balance of the loan is at 98%, but the borrower is in default for missed property tax payments, the lender cannot assign the loan to HUD for repayment.¹⁶¹ Instead, they can attempt to mitigate the loss or move forward with a foreclosure.¹⁶² If the amount paid on the sale of the house is less than the loan amount, lender may apply for reimbursement of the difference from HUD.¹⁶³ Offering a repayment plan to a borrower in lieu of foreclosure creates a risk to the lender because if the borrower remains in

155. Mancini, *supra* note 11, at 7-8.

156. *See id.* at 9-15.

157. *Id.* at 10.

158. *See id.* at 9-10, 31.

159. Mancini & Williamson, *supra* note 7, at 92.

160. *Id.* at 122.

161. Mancini, *supra* note 11, at 32.

162. *Id.*

163. *Id.*

default, and the total due on the loan surpasses the maximum amount of the original loan, the lender will only be reimbursed the original loan amount.¹⁶⁴

While there is an option for borrowers to utilize a LESA to allow the lender to pay for property taxes and insurance premiums, this option may not be ideal; there are more fees and charges applied to the loan if a lender has the responsibility for paying these recurring charges.¹⁶⁵ This option will reduce the amount of equity available to a borrower, and it is not guaranteed that there will be enough equity to continue paying the fees through the life of the loan.¹⁶⁶ Depending on the life of the loan, this may not leave much equity for the borrower to use throughout the loan. Furthermore, if the equity runs out before the life of the loan, then the responsibility for these charges goes back to the borrower until the loan becomes due and payable.¹⁶⁷ If a borrower elects this option, they cannot modify this decision before the end of the loan term.¹⁶⁸

Given the issues discussed above with reverse mortgages, HUD should mandate loss mitigation between lenders and borrowers. According to research done by the NCLC, “[o]nly about a quarter of reverse mortgage borrowers in default on property charges have obtained any form of loss mitigation.”¹⁶⁹ The NCLC and advocates for borrowers of reverse mortgages conducted a survey analyzing reverse mortgages and found that, with proper financial counseling and budgeting, 78% of borrowers maintained their housing after being assisted by a professional when the borrower was in default and offered a repayment plan by a lender.¹⁷⁰ In this survey, advocates reported factors contributing to borrower default on property charges included paying overpriced insurance; not getting all property tax exemptions; memory or cognitive impairments; financial hardship (loss of income or increased expenses); or lack of understanding at loan origination about the requirements to pay property taxes and insurance.¹⁷¹ Loss mitigation can help to cure defaults and allow borrowers to remain in their homes.

2. *False Claims of Non-Occupancy*

To qualify for a reverse mortgage, a borrower must use their home as their principal place of residence throughout the year; otherwise, the loan will

164. *Id.*

165. 24 C.F.R. § 206.205(a)(2).

166. *See* 24 C.F.R. § 206.205.

167. *Id.*

168. 24 C.F.R. § 206.205(d).

169. Mancini, *supra* note 11, at 10.

170. *Id.* at 30, 36 (reporting that participating advocates who provide services to HECM borrowers totaled 45 individuals; 37 self-identified as legal service attorneys; 4 self-identified as HUD-certified housing counselors; and the remaining 4 self-identified as a private attorney, a nonprofit attorney, a consumer advocates, and a nonprofit provider of technical assistance).

171. *Id.* at 31.

become due and payable.¹⁷² The sole way that borrowers certify they still live in the home is through a notice in the mail sent by the lender.¹⁷³ Borrowers have the option of designating an alternative contact person in case the lender cannot verify from the borrower that the home is still their principal residence.¹⁷⁴

Besides mailing the certification letter to verify the borrower's residence before commencing a foreclosure action, there are no extra steps a lender must take.¹⁷⁵ The lender does not have to confirm the borrower received the letter, make multiple attempts to reach the borrower, try to call the borrower, or give the borrower a certain amount of time to respond to the letter.¹⁷⁶ Mancini and Williamson advocate for additional policy changes, with the letter as a first attempt, and if there is no response, requiring the lender to call the borrower.¹⁷⁷ If this still does not get a response, Mancini and Williamson propose requiring the lender to attempt at least two in-person contacts before initiating a foreclosure.¹⁷⁸ This author offers another proposal for reform is that lenders should also send the letter via certified mail, so the borrower or non-borrowing spouse must sign for it. This process would also signal the letter's importance.

Borrowers may forget to return the certification letter for many reasons. For example, a borrower may be hospitalized during the time the letter is mailed and miss sending it back, or a borrower may not know the importance of the letter, so it ends up in a junk mail pile. When this occurs, the lender should take reasonable steps to determine if the borrower still lives in the home before taking immediate action.¹⁷⁹ Taking immediate action when the letter is not returned results in unnecessary costs for both the lender and borrower; the lender incurs costs to initiate the foreclosure, and the borrower incurs costs trying to stop it because of the mistake.

Neither HUD nor Indiana agencies account for circumstances where a borrower may not be in the home for a brief period but still considers the home to be their principal residence. For example, if a borrower is hospitalized for a month and then spends sixty days in a rehabilitation facility, they may miss the certification letter sent by the lender. Even if they plan to return home after their rehabilitation, their lender may promptly file a foreclosure action in court due to the failure to respond. Other states have included more detailed language to encompass incidents like these and protect the borrower from default when they are ill but may return home.¹⁸⁰

Missouri and Utah are two states that provide more flexibility in circumstances of temporary absences; Missouri allows for a temporary absence

172. 24 C.F.R. § 206.39.

173. Mancini & Williamson, *supra* note 7, at 125; 24 C.F.R. § 206.211.

174. 24 C.F.R. § 206.211.

175. *See* Mancini & Williamson, *supra* note 7, at 125.

176. *Id.*

177. Mancini & Williamson, *supra* note 7, at 125.

178. *Id.*

179. Mancini, *supra* note 11, at 14.

180. *See* N.C. GEN. STAT. § 53-267 (2024); § 443.903(6)(a) R.S.Mo. (2024).

of the home up to sixty days, or more than sixty days but less than six months, without the loan becoming “due and payable so long as the borrower has taken prior action to secure the home in a satisfactory manner.”¹⁸¹ Utah specifies that a borrower does not maintain the property as their primary residence if they fail to occupy it for more than twelve months and no other borrower remains in the house.¹⁸² These provisions go further in describing when a property is no longer considered a borrower’s principal residence. Having this type of detail ensures both borrowers and lenders have the same expectation when there is a claim of non-occupancy triggering an event of default.

IV. WHERE INDIANA STANDS COMPARED TO FEDERAL REGULATIONS AND OTHER STATES

A. Indiana’s Current Regulations for Reverse Mortgages and Issues to Consider

Indiana’s regulations mirror the regulations created by HUD and leave the same gaps for Indiana senior borrowers. Indiana has two statutes specific to reverse mortgages.¹⁸³ One statute broadly defines a reverse mortgage as “a mortgage loan that: (1) provides periodic payments to the borrower based on . . . equity in the real estate securing the loan . . . and (2) becomes due either: (A) at a specified date; or (B) on the occurrence of a specified event. . .”¹⁸⁴ Like the federal statute, Indiana also requires the home used for the reverse mortgage loan to be the borrower’s principal residence.¹⁸⁵ The second Indiana statute outlines that a potential borrower and their non-borrowing or ineligible non-borrowing spouse, must complete HUD-approved counseling.¹⁸⁶

1. Indiana’s Counseling Requirement

Under the HUD guidelines, a borrower may receive counseling from a certified counselor within a reasonable distance from their location and should be available for in-person counseling if desired, and if not, then it can be done over the phone.¹⁸⁷ In Indiana, there is only one certified HUD counselor.¹⁸⁸ If this person is unavailable, then a borrower will have to receive counseling over the phone from someone outside of Indiana who may or may not provide them

181. § 443.903(6)(a) R.S.Mo. (2024).

182. UTAH CODE ANN. § 57-28-102 (2024).

183. IND. CODE ANN. § 28-15-11-9 (2024); IND. CODE ANN. § 24-4.4-2-503 (2024).

184. IND. CODE ANN. § 28-15-11-9 (2024).

185. IND. CODE ANN. § 24-9-2-9 (2024).

186. IND. CODE ANN. § 24-4.4-2-503 (2024).

187. U.S. DEP’T OF HOUS. AND URB. DEV., *supra* note 82, at 42, 50.

188. *Housing Counseling Services*, U.S. DEP’T. OF HOUS. AND URB. DEV., https://answers.hud.gov/housingcounseling/s/?language=en_US [<https://perma.cc/5QLE-YQU7>] (last visited Nov. 12, 2025).

with accurate information.¹⁸⁹ Given that seniors are more likely to have diminished capacity in comparison to other age groups, it is important to consider whether phone counseling is a sufficient alternative for relaying the complexities and possible financial implications of reverse mortgages.¹⁹⁰ It may be a more useful alternative to mandate counseling sessions that cannot be conducted in-person be done over video, where a counselor can easily see if the applicant is confused or having difficulty understanding; however, the borrower might not have the ability, knowledge, and technology to navigate a video session.

2. Indiana's Statute for Settlement Conferences in Lieu of Foreclosure Actions

Indiana offers additional protections for first-lien mortgage holders, including borrowers of reverse mortgages, that allow the borrower to request a settlement conference when a lender files a foreclosure action.¹⁹¹ While lenders are not mandated to hold a settlement conference before going forward with a foreclosure action, borrowers have the ability to request a settlement conference with the court upon receiving a notice of foreclosure from a lender.¹⁹² Requesting a conference may be a way to cure a default and stay the foreclosure proceedings to remain in their homes. Often, the reasons for foreclosure are fixable and can be corrected with proper communication between the lender and borrower.¹⁹³

3. Indiana's Property Tax Exemptions for Seniors

Because many defaults occur due to a borrower's failure to pay property taxes, Indiana has assistance programs that may be helpful to certain seniors.¹⁹⁴ While these exemptions are not specific to seniors with reverse mortgages, they are an available resource that may allow some seniors to budget better for their property taxes and know if they can afford them for years ahead. Indiana has a circuit breaker tax that prevents property taxes from increasing more than 2% per year for qualified senior homeowners.¹⁹⁵ To qualify for this tax benefit, seniors must be at least sixty-five years old, have an annual income below \$30,000 for single filers or below \$40,000 for joint filers, and qualify for a

189. U.S. DEP'T. OF HOUS. AND URB. DEV., *supra* note 83, at 42, 50.

190. Karp & Wilson, *supra* note 127, at 17.

191. IND. CODE ANN. § 32-30-10.5-10 (2024).

192. IND. CODE ANN. § 32-30-10.5-8 (2024).

193. *See, e.g.,* Mancini, *supra* note 11, at 13-14.

194. *Housing Assistance for Seniors in Indiana (2025 Guide)*, GRANTS FOR SENIORS (Aug. 19, 2025), <https://grantsforseniors.org/housing-assistance-for-seniors-in-indiana/> [<https://perma.cc/V6S5-7GJP>] (lists property tax programs seniors may qualify for).

195. IND. CODE ANN. § 6-1.1-20.6-7.5 (2024).

homestead exemption credit for their property.¹⁹⁶ In response to the COVID-19 pandemic, and as part of the American Rescue Plan Act of 2021, the Indiana Homeowners Assistance Fund was created with federal funding to assist eligible homeowners with payment of housing-related costs, including property taxes and homeowners insurance.¹⁹⁷ Funding for this program is no longer available to homeowners, but it could be something to reconsider reinstating in the future. To save money, the funds could be limited to seniors with reverse mortgages who have received notification of a foreclosure for failure to pay property taxes or homeowners insurance.¹⁹⁸

B. How Other States Are Making Reverse Mortgages a Safer Tool to Help Their Seniors Age in Place

1. Property Tax Relief Programs and Property Tax Freezes for Seniors

The District of Columbia Housing Finance Agency provides financial assistance to qualified senior District homeowners for delinquent property taxes, homeowners' insurance, and HOA/Condo fees that put the homeowners at risk for foreclosure through their Reverse Mortgage Insurance & Tax Payment Program (ReMIT).¹⁹⁹ The program provides assistance to qualified homeowners who have received legal notice of default on their reverse mortgage loan because of a failure to pay property taxes or homeowners insurance premiums.²⁰⁰ If the borrower and lender have entered into a repayment agreement but the borrower can show financial difficulty, then the ReMIT program will help them pay off the past due amount.²⁰¹ This program allows for funding up to \$40,000 in the form of a zero-interest nonrecourse loan.²⁰² To qualify, a homeowner's income must not exceed \$77,450.²⁰³ This program was originally created during COVID-19 and then was reinstated in 2024 after the initial pilot program from 2019–2021 ended.²⁰⁴

Other states have different types of property tax relief programs or property tax freezes for seniors that can help them maintain the cost of their property

196. IND. CODE ANN. § 6-1.1-20.6-8.5 (2024).

197. *Indiana's Homeowner Assistance Fund (IHAF)*, IND. FORECLOSURE PREVENTION NETWORK, <https://www.877gethope.org/ihaf-servicers> [<https://perma.cc/EJ7K-BJB3>] (last visited Nov. 11, 2024); *Indiana Homeowner Assistance Fund Mortgage Assistance Program*, IND. HOUS. AND CMTY. DEV. AUTH., 2, <https://home.treasury.gov/system/files/136/HAFP-0085-Indiana-SubmittedPlanNarrative.pdf> [<https://perma.cc/94D9-V8HQ>] (last visited Feb. 9, 2025).

198. *ReMIT*, D.C. HOUS. FIN. AGENCY, <https://dchfa.org/homeownership/remit/> [<https://perma.cc/M6JY-BRZA>] (last visited Sept. 28, 2024).

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. D.C. CODE § 42-2703.07a (2024).

taxes on fixed incomes. These programs were not created for the purpose of assisting seniors who have reverse mortgages like the D.C. ReMit program, but they can still aid seniors with reverse mortgages. So, while property tax freeze programs provide tax benefits by preventing the eligible senior homeowner's property from increasing in value and allow a borrower to project if they have the income to continue paying taxes through the life of the loan, state property tax relief programs reduce property taxes for seniors to lessen their property tax burden.²⁰⁵

For example, South Dakota offers two separate relief programs for homeowner seniors who are at least seventy-years old.²⁰⁶ These programs delay the payment of property taxes.²⁰⁷ Program 1 has eligibility based on age and home value and Program 2 is an annual application with eligibility based on age, income, and other factors.²⁰⁸ These programs have been implemented because "state officials understand that many elderly and disabled South Dakotans live on fixed incomes and may have difficulty meeting their property tax obligations."²⁰⁹ Programs like these can help reduce the likelihood that seniors will lose their homes because they cannot afford the annual increase in their property taxes.

Additionally, Washington state's Property Tax Freeze is available for eligible seniors based on age and income. The income must fall within a certain percentage of the median income in the county of their primary residence.²¹⁰ The statute places a freeze on the property's assessed value at the date the applicant first qualifies or January 1, 1995, whichever is later.²¹¹

2. States with Reverse Mortgage Acts

Illinois, Missouri, North Carolina, South Carolina, Utah, and Washington have adopted Reverse Mortgage Acts to codify and expand HUD's regulations.²¹² Washington, Utah, and Colorado are three of the top 10 states

205. Nathan Justice, *3 Best Senior Citizen Property Tax Relief Programs*, SENIOR STRONG (Nov. 10, 2024), <https://www.seniorstrong.org/3-best-senior-citizen-property-tax-relief-programs/> [<https://perma.cc/SNV2-AC56>].

206. *Homestead Exemption Programs*, S.D. Dep't of Revenue (Dec. 2024), <https://dor.sd.gov/media/5lrpvndw/homestead-exemption-brochure.pdf> [<https://perma.cc/EZ4F-PS3W>].

207. *Id.*

208. *Id.*

209. *Id.*

210. WASH. REV. CODE § 84-36-383 (2024); *Property Tax Exemption for Senior Citizens and People with Disabilities*, Wash. State Dep't of Revenue, 1–2 (Sept. 23, 2024), https://dor.wa.gov/sites/default/files/2022-02/PTExemption_Senior.pdf [<https://perma.cc/8LQC-QCJQ>].

211. WASH. ADMIN. CODE § 458-16A-140(7).

212. 765 ILL. COMP. STAT. §§ 945, 1–35 (2024); MO. REV. STAT. §§ 443.901–12 (2024); N.C. GEN. STAT. §§ 53-255–74 (2024); S.C. CODE ANN. §§ 29-4-10–60 (2024); UTAH CODE ANN. §§ 57-28-201–08 (2024); and WASH. REV. CODE ANN. §§ 31.04.500–906 (2024).

with the highest reverse mortgage consumers.²¹³ While the Reverse Mortgage Acts have some variation, most include a more robust description of reverse mortgages, responsibilities of lenders, responsibilities of borrowers, and definitions of default on the part of the lender and borrower.²¹⁴ The Reverse Mortgage Acts benefit both borrowers and lenders by detailing various guidelines that ensure both parties are aware of their rights and obligations with reverse mortgages.

North Carolina has codified regulations that provide more robust sanctions than standard HUD guidelines against a lender that fails to properly service a reverse mortgage loan to meet their contracted obligations.²¹⁵ HUD's current sanctions for lenders who fail to make timely payments or who do not follow through on their servicing responsibilities are limited to the lender's loss of insurance, debarment, and limited denial of participation as a HUD mortgagee.²¹⁶ North Carolina's statute specifies that when a lender defaults and does not make payments to the borrower, "the lender shall forfeit any right to collect interest or service charges under the contract. The lender's right to recovery at loan maturity shall be limited to the outstanding balance as of the date of default."²¹⁷ Further, North Carolina further allows its Commissioner to act against a lender and allows for the borrower to have remedies through civil actions.²¹⁸

Utah is another state that has expanded the borrower's cooling off period after signing the loan from HUD's required three to five days.²¹⁹ The cooling-off period gives the borrower the ability to rescind the loan without any penalty. Because reverse mortgages are complex, having some additional time to weigh their advantages and disadvantages is important. The additional time in the cooling-off period gives borrowers some space to think and ensure this is the best decision based on their circumstances and may also give borrowers time to discuss this decision with potential heirs so that there are fewer surprises when the borrower passes away.

3. State-Run Reverse Mortgage Programs

Montana is the only state that has its own state-administered Reverse

213. Am. Advisors Grp., *California Tops List of Most Popular States for Reverse Mortgages According to AAG*, PR NEWswire (Jul. 20, 2021), <https://www.prnewswire.com/news-releases/california-tops-list-of-most-popular-states-for-reverse-mortgages-according-to-aag-301336951.html> [https://perma.cc/8MGT-RF3X].

214. S.C. CODE ANN. §§ 29-4-10–60 (2024); N.C. GEN. STAT. §§ 53-255–74 (2024); MO. REV. STAT. §§ 443.901–12 (2024); 765 ILL. COMP. STAT. §§ 945, 1–35 (2024); UTAH CODE ANN. §§ 57-28-201–08 (2024); and WASH. REV. CODE ANN. §§ 31.04.500–906 (2024).

215. See N.C. GEN. STAT. § 53-266 (2024).

216. 24 C.F.R. § 206.201.

217. N.C. GEN. STAT. § 53-266 (2024).

218. *Id.* at § 53-271 (2024).

219. UTAH CODE ANN. § 57-28-207 (2024).

Annuity Mortgage (“RAM”) program. The RAM program is available to qualifying Montana senior residents.²²⁰ The RAM program is not an FHA-insured HECM program, but is instead, provides for the Montana Department of Commerce to manage the loans.²²¹ In 1989, the RAM program was created by the Montana State Legislature when it was noticed that elderly homeowners had difficulty remaining in their homes with rising costs, inflation, and their lower fixed incomes.²²² Since its inception, the RAM program has issued 240 loans with an average monthly payment of \$540 a month.²²³

The qualifications for the RAM program have some similarities and some differences to the FHA-insured HECM loans. First, the Montana Board of Housing is the first lien holder on the home.²²⁴ Second, both loans require financial counseling before they can obtain a loan, but the counseling for the RAM program is done through Montana’s Aging Services Network.²²⁵ The RAM counselor continues to be a liaison between the borrower and Montana Housing staff throughout the loan process.²²⁶ Third, to qualify for Montana’s program, borrowers must be at least 68 years old and meet certain income limits.²²⁷ In certain circumstances, seniors who have high medical costs and are over the income limits, may deduct their verifiable and recurring medical costs from their income to qualify for the program.²²⁸ Fourth, the loan terms are for ten years.²²⁹ A borrower may continue to live in their home after ten years if it is still their principal place of residence. The interest will continue to accrue on their loan until it is paid.²³⁰ A downside of the RAM program is that some seniors may outlive the life of the loan or exhaust the equity in their homes, leaving them without additional income.²³¹ Fifth, the RAM program has a minimum and maximum loan amount available based on 80% of the

220. MONT. CODE ANN. § 90-6-502 (2024); *Reverse Annuity Mortgages*, MONT. DEP’T. COM., <https://commerce.mt.gov/Housing/Homeownership/Reverse-Annuity-Mortgages> [https://perma.cc/5UKD-27R7] (last visited Sept. 28, 2024).

221. *See Reverse Annuity Mortgage Loan Program Helps Montana Seniors Stay in Their Homes*, MONT. DEP’T COM. (Nov. 4, 2024), <https://commerce.mt.gov/News/newsletter-articles/Reverse-Annuity-Mortgage-Loan-Program-Helps-Montana-Seniors-Stay-in-their-Homes#:~:text=The%20Montana%20Board%20of%20Housing%2C%20administratively%20attached%20to,maintain%20financial%20flexibility%20while%20remaining%20in%20their%20home> [https://perma.cc/6ZNL-6Z5N].

222. Chris Clow, *Why Montana Is More Heavily Promoting Its State-Run Reverse Mortgage Program*, HOUSINGWIRE (Aug. 19, 2024), <https://www.housingwire.com/articles/why-montana-is-more-heavily-promoting-its-state-run-reverse-mortgage-program/> [https://perma.cc/6EL7-V7Y3].

223. MONT. DEP’T COM., *supra* note 221.

224. *Id.*

225. *Id.*

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

homeowner's equity.²³² Borrowers can access funds through a lump sum payment up to \$10,000 or monthly payments.²³³ Lastly, the RAM program offers Montana seniors a low-interest rate that does not have additional fees for the administration or servicing of the loan.²³⁴

V. SUMMARY OF RECOMMENDATIONS FOR THE INDIANA CODE

While Indiana does have some statutory protections for reverse mortgage borrowers, there is still room for growth. First, Indiana should create more robust regulations to the counseling requirement of its current statute. This can be accomplished by creating a method to track the information provided in counseling sessions to Indiana borrowers and requiring borrowers and non-borrowing spouses to answer seven, rather than five of the ten questions correctly. Ensuring borrowers fully understand a reverse mortgage and its impact will help to reduce default and negative outcomes. Additionally, this tool will help Indiana know if counselors are familiar with Indiana's tax exemptions and if the counselors are giving adequate counseling to prospective borrowers.

Second, Indiana should also find ways to increase the number of HUD-certified counselors. With more local counselors, more seniors will have access to counseling sessions. Because the counselor must go through a lot of paperwork with the prospective borrower, it is best if both the counselor and prospective borrower are in the same location while going over this paperwork together. If a face-to-face session is not possible, the next best option is to utilize video chats, and phone counseling as a last resort. The ability for counselors to see the person they are counseling can help them determine if the borrower understands and has the mental capacity to understand this complex tool. Additionally, the counselor is more likely to know of Indiana's tax exemptions and programs that the prospective borrower may be eligible for.

Third, Indiana should require mandatory follow-up meetings with counselors after loan execution. While HUD creates an obligation for counselors to be available after the application process to answer applicant questions, it is not mandatory to have a follow-up meeting. Many seniors have questions about why the loan balance is so high, why their loan is assigned to FHA, or other issues. Requiring a counseling session six to twelve months after the start of the loan would be beneficial. This may, in turn, help reduce the rate of defaults and foreclosures since the counselor can verify that the borrower understands the terms of the loan and can help troubleshoot any issues. The problem with the current structure is that the initial counseling session takes place before the terms of the loan are executed. Because the counselor can only talk in general terms, having a mandatory follow-up session allows for more information to be given that is specific to the borrower.

232. *Id.*

233. *Id.*

234. MONT. DEP'T COM., *supra* note 221.

Fourth, the borrower and eligible non-borrowing spouse should both be financially assessed prior to loan execution. Because one spouse will pass away before the other, it is important to consider if one spouse alone can continue to meet the financial requirements to keep the loan from going into default while they continue to live in the home. The non-borrowing spouse will not be able to access any leftover equity in the house without refinancing the reverse mortgage; thus, there is a risk that they will not have their spouse's assistance to help cover the cost of property taxes or insurance, which may impact their ability to continue to meet financial obligations. For the borrower and non-borrower to plan properly, they should have information that will help them determine if it is likely the non-borrowing spouse will be able continue to make required payments.

Fifth, Indiana should expand its circuit breaker tax by making a tiered system that allows more seniors to qualify for tax benefits. This includes adding tiers based on income ranges that correlate with a cap on property tax increases. For example, a single senior with an income from \$33,654 to \$40,654 would be eligible for a cap that would prevent their property tax from increasing more than 3%.²³⁵ This expansion could lessen the financial burden on seniors and help them accurately project their property taxes.

An alternative for extending the circuit breaker tax would be for Indiana to create a property tax freeze for seniors within a certain income limit. If loss of revenue from property tax is a concern, then a property tax freeze for borrowers of reverse mortgages may lessen the occurrence of borrowers and non-borrowing spouses defaulting because they have been better able to project their annual property tax charges. Indiana could become a second lien holder on the property to later recoup the difference between the borrower's payment and the actual amount due. FHA regulations allow homeowners to have a second lien on the property, so long as FHA has priority and remains the first lien holder.²³⁶ Because these options could cause the county or city to lose revenue, an alternative to consider is reinstating Indiana's Homeowner Assistance Fund while mirroring the requirements of D.C.'s ReMit program. By taking this route, the money paid out by the state would be limited because only seniors with reverse mortgages, who have received a letter of foreclosure because of a missed property tax payment, would be eligible.

Sixth, Indiana should allow borrowers to make a change to their LESA election later or to end a LESA if they opted in at the loan's origination. A borrower may not want to set aside so much of their equity in a LESA in the beginning because they do not know how much they will need to pay for

235. Daniel Shackle, *Over 65 Circuit Breaker Income Threshold Calculation for Pay 2025*, Ind. Dep't of Loc. Gov't Fin., 1 (May 24, 2024), <https://www.in.gov/dlgf/files/2024-memos/240524-Shackle-Memo-Over-65-Circuit-Breaker-Income-Threshold-Calculation-for-Pay-2025.pdf> [<https://perma.cc/UBM9-GEFV>] (providing an overview of the 2025 threshold to cap a property tax increase at 2% is \$33,653.52 for a single senior).

236. 24 C.F.R. § 206.8.

expenses over time or how much to set aside that will still allow them to cover other costs in the future. Greater flexibility with the LESA, especially later in the life of the reverse mortgage when a borrower's mental capacity or physical capacity is declining, would be helpful in preventing default due to missed property tax and homeowners' insurance payments.

Seventh, Indiana should amend their statutes to specify when a borrower can claim their residence as their primary residence after an extended absence. Hospitalizations and follow-up care should be included as exceptions that allow the borrower to retain their primary residence after an extended absence. Moreover, Indiana should require additional efforts from lenders to track certification letters sent to borrowers, including sending these letters by certified mail. Indiana may also mandate alternative means of contact, such as requiring a certified letter to include alternative contacts or requiring additional attempts at contacting the borrower either by phone or in-person prior to initiating a foreclosure. An increase in methods to attempt contact will increase the likelihood that a borrower or alternative contact will be able to respond, and a needless foreclosure action will be avoided.

This note also recommends updating the Indiana Code to include adding sanctions against lenders who default. Sanctions could include the lender being unable to collect interest, charging service fees, and only being able to recover the amount of the loan at the date of the default when the loan matures. Currently, borrowers can file a complaint with the Attorney General's office or HUD, but they do not have a remedy for damages. Indiana should add a private right of action for borrowers to seek monetary damages against lenders who default.

Lastly, borrowers should be allowed an extended cooling-off period. The cooling-off period after closing allows a borrower to rescind the reverse mortgage loan without any negative implications. This extension is recommended because it gives the borrower some additional time to process the decision and make sure it is the best choice for them. These loans are complex and will have implications on the borrower, possible non-borrowing spouse, and heirs.

VI. CONCLUSION

Reverse mortgages play an important role for seniors who are income poor but asset rich. Because Indiana's senior population will make up nearly 19% of all Hoosiers by 2025, a number that will only continue to grow, it is necessary to find more tools to help them age in place. Most seniors want to be able to spend their remaining years in their homes and communities. A reverse mortgage would allow these senior homeowners to access money from the equity in their home while they still live there. The payments from the reverse mortgage loan could help them cover additional expenses, including healthcare costs, which they could not otherwise afford. Because this loan is not due and

payable until a specified event like death, it would also reduce the senior homeowner's monthly costs if they were still paying off their homes by getting rid of their mortgage payments.

While HUD has regulations in place for reverse mortgages, there is still room for Indiana to increase protections, as other states have done, and make reverse mortgages a valuable option for aging Hoosiers. The recommendations made in this note would help to increase borrower protections, increase lender accountability by providing oversight to lenders, and ensure conformity with best practices. Moreover, the protections recommended should help seniors remain in their homes for as long as they choose, and not have their homes placed in foreclosure because of mistakes, miscommunications, or lack of ability to cure the default. With greater protections, the reverse mortgage could live up to its original purpose of meeting the special needs of the elderly and allowing them to live their final years of life with dignity and comfort in their homes.

The proposed increased protections may lead more older Hoosiers to utilize the reverse mortgage tool, which could relieve some of the financial burden of their cost of care from Indiana's Medicaid system. It is important to note that reverse mortgages are only one tool in the toolbox for helping seniors age in place. These reverse mortgages will not be a tool that makes sense for every senior homeowner, but greater protections should be added for those seniors who can benefit from a reverse mortgage.

THE BIG \$35 QUESTION: HOW MUCH IS COURT APPOINTED GUARDIANSHIP REALLY WORTH?

MORGAN SEAGRAVE*

I. INTRODUCTION

A. Potential for Abuses

Despite the growing need for guardianships evidenced by the societal issues in the next section, an emerging awareness of the pitfalls of poor guardianship has developed in recent years.

The 2021 social media frenzy concerning the high-profile guardianship and conservatorship cases involving Britney Spears, artist Peter Max, and “America’s Top 40” host Casey Kasem and movies such as *I Care a Lot*, helped to significantly bolster public awareness and discussion about outdated practices in the guardianship system. They’ve also drawn attention to a dangerously burdened system that can put the lives in the hands of others with little or no evidence of necessity and then fails to guard against abuse, theft, and neglect.¹

In spite of greater attention being called to issues surrounding guardianship, a recent topic of discussion has been how little guardianship data there is,² considering there are approximately 1.3 million guardianship or conservatorship cases open in the U.S. at any given time.³ There is a lack of centralized data at both the national and state level. This makes it difficult to discern information about those under guardianship as well as the status of many guardianships considering most states do not have a registry or database.⁴ While there is little

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1. Elizabeth Moran, *2021 Guardianship Legislation: Highlights and Trends Effectuating Improved Processes and Outcomes in U.S. Guardianship Systems*, A.B.A. (Mar. 14, 2022), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-43/bifocal-forty-three-four/2021-guardianship-trends/ [https://perma.cc/GQ8H-BY2Q]; see also LAWRENCE A. FROLIK & ALISON BARNES, *ELDER LAW: CASES AND MATERIALS* 404 (6th ed. 2015) (“Unless the court oversees the guardian’s activities, there is opportunity for poor decision making, financial abuse, theft, self-dealing, making inappropriate gifts and a general failure to carry out the responsibilities of a guardian.”).

2. See In re Ord. Establishing the Ind. Guardianship Oversight Task Force, No. 24S-MS-00399, 2024 Ind. LEXIS 704, at *2 (Ind. 2024) (“In recent years, it has become clear that further research on issues surrounding guardianship can help Indiana create a more effective system of oversight and supervision by aligning resources and designing a system that is easy to navigate and ensures justice is fairly administered.”).

3. Moran, *supra* note 1.

4. Kristin Hamre & Derek Nord, *Guardianship: Synthesizing the Data*, IND. INST. DISABILITY AND CMTY. 1 (2023), <https://iidec.indiana.edu/doc/resources/IIDC-Issue-Briefs/IIDC-Issue-Brief->

statistical data, poor guardianship practices have been the subject of investigative journalism. Specifically noted in a Bloomberg Law series, there is no national standard to limit the number of cases that guardians can take on at a time, which places a lot of pressure on the limited programs that are able to provide this service.⁵ For example, Debra Woods is a solo practitioner in Greenwood, Indiana, who maintains a caseload of over 200 guardianships at a time and claims “she must maintain that caseload to earn a good living.”⁶ This practice does not violate any rules or laws in Indiana related to guardian responsibilities.⁷ Not only is this a failure in oversight⁸ and legal standards to ensure proper care, it is also a failure of incentive. With proper oversight, beyond that currently imposed by court systems across the United States, increasing the Medicaid reimbursement for guardianship fees will incentivize maintaining a reasonable caseload while disincentivizing fraud and/or abuse.

The reason that guardians or guardianship programs have such a high caseload, aside from the overwhelming demand, is that a portion of their income is derived from the \$35 per month per person Medicaid allowance that caps their fees.⁹ Debra Woods notes that if there were a higher guardianship fee, she would simply hire individuals to assist her in providing guardian services.¹⁰ But until then, the current fee structure under Medicaid necessitates her caseload of 200-plus guardianships.¹¹ Woods is not alone. Legal experts have identified caseloads that high in California, Florida, and Michigan as well.¹² One wonders how guardianships can effectively be maintained when the court-appointed guardian has only so much time. It borders on malpractice and does a disservice to guardianships across the country. Legal experts and practitioners surveyed have opined that the proper number of guardianships that any one guardian can effectively maintain at a time is somewhere between 10 and 30—nowhere near 200.¹³ A guardian could make a decent living at the low rate of \$35 per month

on-Guardianship-2.pdf [https://perma.cc/QLC6-CAVJ]; *Beyond Guardianship: Toward Alternatives that Promote Greater Self-Determination*, NAT’L COUNCIL ON DISABILITY 65 (Mar. 22, 2018), <https://www.ncd.gov/assets/uploads/docs/ncd-guardianship-report-accessible.pdf> [https://perma.cc/E5TD-HVXS]. (“Many courts and states do not know the number of adults under guardianship in their jurisdiction, let alone the demographics.”).

5. See Ronnie Greene, *420 Cases, One Guardian: System Runs Amok on Just \$35 a Month*, BL (Mar. 8, 2023), <https://news.bloomberglaw.com/us-law-week/420-cases-one-guardian-system-runs-amok-on-just-35-a-month> [https://perma.cc/XAF5-V2HW].

6. *Id.* (also noting that Woods has taken on over 420 guardianship clients since 2016); *About Us: What We Do*, CARE FIRST INC., <https://www.carefirstincbrownsburg.com/about> [https://perma.cc/Y9U6-64RS] (last visited Nov. 20, 2025).

7. Greene, *supra* note 5.

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

per guardianship,¹⁴ but that only encourages one to take on too much and lower the value of their services. Moreover, some of the care facilities that the incapacitated individuals reside in may be all over the state that a guardian practices in, making it significantly more difficult for a guardian to engage in oversight and caretaking abilities because of travel and time constraints.¹⁵

In fact, a case handled by Debra Woods has received judicial scrutiny by at least one judge, who was “disturbed” with Woods’ inattention to one guardianship in particular and “blew a fuse” at her negligence in taking a protected person¹⁶ to cancer treatment during the COVID-19 pandemic.¹⁷ “As Woods’ caseload grew, court records show, items sometimes did slip through the cracks. Woods failed to file a required status report in one case and faced a possible contempt citation. The judge in another case said a client’s final accounting was unacceptable. In a third case, Woods hadn’t notified all kin that their relative was under guardianship.”¹⁸ This kind of inattentiveness is inevitable with such a high caseload. One family member of a protected person frustratedly called Woods’ guardianship a “sham” and noted that Debra Woods did not invest much time in her mother’s care, only visiting once every six months.¹⁹

It is no secret that many nonprofits struggle with fundraising and producing revenue. Woods’ case provides a clear example of how a nonprofit guardianship organization can struggle to produce enough income when the fees for their services are so low. Without those fees, it puts more pressure on fundraising. And when these organizations do attempt to get their name out and obtain funding, it generally costs money, which takes away from their resources that could be used to pay staff and acquire talent in an extremely burdened field that is desperate for help. Debra Woods conceded that she would hire staff if she had the resources. Unless parties begin making substantial gifts to organizations/guardians who are similarly situated, the law must change or they will be forced to cut costs and overburden themselves to keep their heads above water. Nonprofits like guardianship organizations provide a public good²⁰ that aids in the care of the growing population of the United States that is deemed incapacitated due to mental illness, mental infirmity due to age, or inability to

14. *Id.* (noting that at the current rate, a guardian with “215 active cases at \$35 per month would earn \$90,300 a year”).

15. *Id.*

16. Throughout this Note, the terms “client” and “protected person(s)” are used interchangeably in reference to individuals under guardianship. Some jurisdictions also use the terms “ward” or “conservatee.” See FROLIK & BARNES, *supra* note 1, at 353.

17. Greene, *supra* note 5.

18. *Id.*

19. Binghui Huang, ‘It’s a Sham’: Spouses, Families Raise Alarm on Adult Protection Laws, INDYSTAR (Mar. 21, 2024), <https://www.indystar.com/story/news/local/2024/03/21/guardianship-systems-flaws-raise-concerns-among-families-advocates/72399037007/> [<https://perma.cc/U6TD-BZV2>].

20. JAMES J. FISHMAN ET AL., NONPROFIT ORGANIZATIONS: CASES AND MATERIALS 33 (6th ed. 2021).

care for oneself for myriad other reasons. However, this does not mean that the law should not seek to redress the vast discrepancy between guardianship fees currently in the State of Indiana and reasonable compensation for these services.

The Center for At-Risk Elders (CARE), at least in 2017, had approximately 140 indigent, incapacitated individuals residing in Central Indiana under their guardianship.²¹ With a larger staff, care and the tasks associated with guardianship overall do not fall through the cracks. While a larger staff is better-equipped to handle a higher case load of guardianships than a one-man-band like Debra Woods, Volunteer Advocates for Seniors and Incapacitated Adults (VASIA) programs will likely always have a need for more staff because the work is complex and is still difficult even with a full staff. Larger programs—those with greater recognition and funding—are better equipped than a solo guardianship or organization of small size to handle high caseloads. This is common sense. When an organization is stretched thin and does not have the resources necessary for a large clientele, there is a degree of inattention. The client suffers as a result of insufficient oversight, handling of assets, care, housing, etc.

Part of the problem could be the lack of binding standards on guardians, although standards have been proposed by the National Guardianship Association. To that point, guardianship as a field has been inconsistent in its training and expectations across the country.²² “Training requirements for new guardians range from no training required for new guardians (e.g., Indiana) to completion of a defined training program (e.g., Illinois).”²³ The Indiana Supreme Court has recently formed a guardianship task force to address this deficiency and tasked the group with reporting findings and recommendations on best practices, future programming, policies, and procedures to improve Indiana’s guardianship system.²⁴

B. Silver Wave/Tsunami

There is currently a growing proportion of elderly individuals in the United States. By 2030, one-fifth of the United States population will be made up of individuals age 65 years and older.²⁵ “People aged 65 and older account for

21. *Testimony Before the Senate Family and Children Services Committee on Senate Bill 396 Regarding Guardian Reimbursement and Medicaid Eligibility*, 120th Gen. Assemb., 1st Reg. Sess. (Ind. Jan. 23, 2017) (statement of Ken Bennett, Senior Counsel, Center for At-Risk Elders) (video of Jan. 23, 2017, 10:00 a.m. meeting, accessible via committee webpage), https://iga.in.gov/session/2017/video/committee_family_and_children/ [https://perma.cc/S3TZ-GPMJ] [hereinafter *Testimony*].

22. Hamre & Nord, *supra* note 4.

23. *Id.*; 20 ILL. COMP. STAT. 3955/1 (2024).

24. *In re Ord. Establishing the Ind. Guardianship Oversight Task Force*, No. 24S-MS-00399, 2024 Ind. LEXIS 704 (Ind. 2024).

25. ‘Silver Tsunami’ And Other Terms That Can Irk The Over-65 Set, NPR (May 19, 2014, 3:23 AM), <https://www.npr.org/2014/05/19/313133555/silver-tsunami-and-other-terms-that-can-irk-the-over-65-set> [https://perma.cc/36RV-HLBK].

more than one-third (35%) of U.S. health care spending.”²⁶ As this population grows, it is logical that states will expend more resources in caring for this older population through the combination of Medicare and Medicaid, especially given the fact that the two often work hand-in-hand.²⁷ Medicaid represents nearly one-fifth of money spent on healthcare in the United States.²⁸ With this growing population of elderly, those who are low income, and those who have mental illnesses/disabilities, state budgets are unavoidably going to be strained. A larger portion of states’ populations are going to fit within the parameters of eligibility for Medicaid. Consequently, a larger amount of money in state budgets—which may not affect the proportion of the budget—will have to be allocated for the care of these individuals.

Further, it has been widely recognized that there is what has been dubbed a “mental health crisis” throughout the world, but especially in the United States. “It is estimated that one in five U.S. adults live with a mental illness (59.3 million in 2022; 23.1% of the U.S. adult population).”²⁹ This trend was recognized before the COVID-19 pandemic but has been exacerbated by pandemic-related effects.³⁰ Importantly, some recognized mental illnesses qualify an individual for Medicaid coverage. “People with behavioral health needs, especially those with serious mental illness, may . . . qualify for Medicaid based on having a disability.”³¹ In 2022, there were 15.4 million adults with a serious mental illness,³² or 6% of the adult population in the United States.³³ In many states where one has a mental illness that makes them eligible for Supplemental Security Income (SSI), they are automatically eligible for Medicaid.³⁴ As of 2011, 50% of adults and 47% of children eligible for

26. Deborah Wince-Smith, *Bracing for the Silver Tsunami*, FORBES (Feb. 28, 2022), <https://www.forbes.com/sites/deborahwince-smith/2022/02/25/bracing-for-the-silver-tsunami/> [https://perma.cc/T5C2-C79J].

27. This is evidenced by the purpose for the creation of the two programs—namely, an aging population with too little resources to pay for their own care.

28. Elizabeth Williams et al., *Medicaid Enrollment & Spending Growth: FY 2024 & 2025*, KAISER FAM. FOUND. (Oct. 23, 2024), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2024-2025/> [https://perma.cc/M6TX-FVNN].

29. *Mental Illness*, NAT’L INST. MENTAL HEALTH (Sep. 2024), <https://www.nimh.nih.gov/health/statistics/mental-illness> [https://perma.cc/7RCQ-Z4PM].

30. *Protecting the Nation’s Mental Health*, CDC (Aug. 8, 2024), <https://www.cdc.gov/mental-health/about/what-cdc-is-doing.html> [https://perma.cc/9TJZ-85SN].

31. Julia Zur et al., *Medicaid’s Role in Financing Behavioral Health Services for Low-Income Individuals*, KFF (June 29, 2017), <https://www.kff.org/mental-health/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/> [https://perma.cc/UX6Z-9GEZ].

32. *Mental Illness*, *supra* note 29. (serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities; the burden of mental illnesses is particularly concentrated among those who experience disability due to SMI).

33. *Id.*

34. Zur et al., *supra* note 31.

Medicaid based on having a disability had a behavioral health diagnosis.³⁵ While Medicaid typically does not lay out the specific mental illnesses it will cover, conditions such as bipolar disorder and schizoaffective disorder have rendered individuals Medicaid-eligible in states such as Arizona and Virginia.³⁶ For comparison sake, Indiana at least lists the specific mental disorders that render an individual eligible for Social Security.³⁷ Additionally, Medicaid coverage can be more comprehensive than private insurance coverage for behavioral health services, “such as case management, individual and group therapy, detoxification, and medication management, in addition to psychiatric hospital visits.”³⁸ Without Medicaid, one with a mental health diagnosis would likely have significant difficulty in paying for their care unless they are financially well-off. Medicaid expenditures for those with mental illnesses are high due to this group’s additional health needs. In comparison to enrollees without mental illnesses, those with behavioral health issues are more likely to have “comorbid chronic physical conditions” and lower overall health.³⁹ Although those with behavioral health conditions account for only 20% of the Medicaid population, they are responsible for about half of Medicaid spending.⁴⁰ Said differently, Medicaid spends about four times more on those with mental health diagnoses than those without said diagnoses.⁴¹

The number of individuals throughout the country with some form of recognized mental illness or mental health diagnosis is rapidly growing. A large portion of individuals with this diagnosis rely heavily on Medicaid for mental health and physical health treatment compared to those without such a diagnosis. Considering the financial burden on states and the widely reported issues related to addressing the mental health crisis, guardianships are needed more than ever to coordinate mental health care for those eligible for Medicaid. Guardians, properly carrying out their duties, will help to alleviate the issues states are dealing with related to the mental health crisis and potentially help reduce the “negative publicity” surrounding the care of the lower-income individuals and marginalized groups.

C. Thesis and Roadmap

Guardianship services are severely underfunded in Indiana for protected persons whose care is covered by Medicaid. The Indiana General Assembly should balance their budgetary constraints with the substantial need for quality

35. *Id.*

36. *Id.*

37. *Disability Evaluation Under Social Security*, SOCIAL SEC. ADMIN., <https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm> [https://perma.cc/K94W-DMC2] (last visited Nov. 20, 2025).

38. Zur et al., *supra* note 31.

39. *Id.*

40. *Id.*

41. *Id.*

care for the growing elderly and incapacitated population. Specifically, the General Assembly should target a “goldilocks” rate of \$100 per month reimbursement by Medicaid, which would be the median of the current rate of \$35 per month per person and the \$175 rate that was proposed in 2017. This can serve as a cap or limit, with the understanding that guardianship services for those not eligible for Medicaid, or otherwise possessing sufficient resources, are to be assessed under a reasonable compensation framework. The increased compensation structure through Medicaid could also be limited in its applicability to VASIA programs with certified guardians. Additionally, the Indiana Guardianship Task Force should recommend a caseload they feel is appropriate for any one practitioner or organization and adopt “reasonable compensation” criteria. This would incentivize entry into the guardianship profession, more diligent work, and better health and financial outcomes for incapacitated individuals. Further, these steps remedy the failings of different professional ethics rules in prohibiting poor guardianship practices. Finally, the current grants to VASIA programs in place in Indiana should potentially be replaced with a higher reimbursement rate for guardians across Indiana.

First, this Note discusses what a guardianship is, the need and reasons for guardianship, and the typical duties of a guardian. This includes a look at guardianships in the State of Indiana and common practices of Indiana guardianship organizations. Second, this Note explains the history and role of Medicaid in aiding the growing elderly or incapacitated population in paying for care, including guardianship fees. Next, it lays out the standards utilized by other jurisdictions. Then, it explores Indiana’s current guardianship fee statute and attempts to change it. Finally, the different approaches are analyzed, and solutions are proposed involving raising the fixed fee for guardianship services, reasonable compensation, and fee standards established by different professional associations.

II. BACKGROUND

A. What Is a Guardianship?

Guardianship organizations and VASIA organizations serve an important role in our society. The ability to establish a guardianship arises from the State’s *parens patriae* power, which “obligates the state to care for the vulnerable and the less fortunate.”⁴² Guardianships are established in order to manage the care needs of an individual who has been deemed incapacitated and incapable of taking care of themselves or providing informed consent.⁴³ This includes persons of any age, but about 80% of guardianships are in place for individuals

42. FROLIK & BARNES, *supra* note 1, at 351 (quoting *In the Matter of the Guardianship of Hedin*, 528 N.W.2d 567 (Iowa 1995)).

43. *Id.* at 453.

aged 60 and older.⁴⁴ Under Indiana law, one is incapacitated if they are partially or completely unable to manage their property, care for themselves, or both.⁴⁵ This can be the result of mental illness, physical illness, habitual drunkenness, excessive use of drugs, or fraud, duress, or undue influence by others.⁴⁶ So, a guardianship may be established regardless of whether an individual has a mental illness or infirmity. It involves filing a petition for guardianship as a result of being notified by a party or observing that one cannot care for themselves. Importantly, a guardian can be an individual or an entity.⁴⁷

Guardianship usually entails arranging appropriate medical care for the protected person or individual under guardianship as well as managing their assets as a fiduciary. In Indiana, a guardian's duties include being responsible for an incapacitated person's care, custody, and property.⁴⁸ Specifically, this involves identifying what care services are necessary for the individual, handling their finances in a fiduciary manner, applying for appropriate public benefits to ensure their needs are met, monitoring the quality of their care and services, and advocating for quality of life in the least restrictive environment.⁴⁹ In other words, guardianships include: guardian of the person, guardian of the estate, and guardian of the person and estate.⁵⁰

Depending on your status as guardian, you might be able to do things like receive the protected person's money and apply those funds towards their living arrangements, personal effects, medical care, education or other services. You also might be able to invest the person's money, pay people who care for them, delegate responsibilities, select their place of living, arrange for their medical care, protect their personal property, enter into contracts on their behalf, and provide consent.⁵¹

Guardians should be "sufficiently acquainted" with incapacitated individuals' capabilities, limitations, and needs and are to report to the court on

44. *Id.* at 349

45. *Incapacity and Guardianship in the Hoosier State*, HAWKINS ELDER LAW (Jan. 20, 2021), <https://www.hawkinselderlaw.com/incapacity-and-guardianship-in-the-hoosier-state/> [https://perma.cc/CKX8-HMF3].

46. *Id.*

47. Hamre & Nord, *supra* note 4.

48. *See* Greene, *supra* note 5.

49. *Testimony*, *supra* note 21 (statement of Ken Bennett, Senior Counsel, Center for At-Risk Elders); *see* Hamre & Nord, *supra* note 4 (many individuals who qualify for guardianship or who are under guardianship simultaneously qualify for public benefits through Social Security Disability, Medicare, Medicaid, etc.; some have noted that nearly 60% of young adults with intellectual and developmental disabilities between the ages 18-22 that receive funded supports are under guardianship).

50. *Incapacity and Guardianship in the Hoosier State*, *supra* note 45.

51. *Id.*

their physical or mental well-being.⁵² A VASIA program “provides trained and supervised volunteers to serve as court-appointed limited guardians to assist this vulnerable population and the courts in decision-making regarding these critical needs.”⁵³

In 2013, the Indiana General Assembly established the Adult Guardianship Office under the purview of Indiana Supreme Court.⁵⁴ This Adult Guardianship Office provides general resources for courts on issues related to adult guardianship and administers funding for VASIA programs throughout the state.⁵⁵ In 2023, the Office “awarded \$1.3 million in matching funding to 20 volunteer-based guardianship programs, serving 52 counties” throughout the State of Indiana.⁵⁶ The programs assist over 800 incapacitated adults who do not have family or others who are suitable to provide care for them.⁵⁷ While the programs vary in size, there is a shortage in terms of being able to take care of the individuals who need guardianship, considering how many counties are unrepresented in the funding mentioned above. Not only that, but there are far more individuals in need than staff available to serve as their guardians. In some cases, this leads to individuals and programs taking on too many clients.⁵⁸

Some nonprofits receive referrals from hospitals to potentially take on new clients/protected persons under guardianship.⁵⁹ CARE, for example, receives referrals from three hospital systems to help fund their work through subscription grant agreements.⁶⁰ CARE also receives referrals from Adult

52. Greene, *supra* note 5.

53. *Volunteer Advocates for Seniors and Incapacitated Adults*, FRANCISCAN HEALTH, <https://www.franciscanhealth.org/patient-resources/programs-and-support/vasia> [https://perma.cc/T47Q-4JTF] (last visited Nov. 20, 2025).

54. *Adult Guardianship*, IN.GOV, <https://www.in.gov/courts/iocs/adult-guardianship/> [https://perma.cc/8PJJ-6UZ9] (last visited Nov. 19, 2024).

55. *Id.* It also administers a guardianship registry that provides the public with non-confidential information like the name of the protected person, the name of the guardian, whether the guardianship case is active, and the county issuing the guardianship. It serves as a vital tool for different entities frequently engaging with protected person—such as law enforcement, hospitals, banks, and government agencies—to know whether the person is under guardianship and who needs to be contacted on behalf of the protected person. “It is also an important tool for courts, tracking the number and types of guardianships filed in each jurisdiction.”

56. *Id.*

57. *Id.*

58. *See* Greene, *supra* note 5.

59. *See* Marion County LR49-PR00-413.2, available at <https://www.in.gov/courts/files/marion-local-rules.pdf> [https://perma.cc/37CD-E8KN] (last visited Jan. 31, 2025) (this is often done because the Marion County, Indiana Local Rules require that one seeking guardianship provide the court with a physician’s report attesting that the one sought to be placed under guardianship is incapacitated); *see also About Us: Referral Partnerships*, CARE FIRST INC., <https://www.carefirstincbrownburg.com/about> [https://perma.cc/Y9U6-64RS] (last visited Nov. 20, 2025) (noting that referrals are received from hospitals, nursing homes, group homes, agencies, and families in need).

60. *Testimony*, *supra* note 21 (statement of Ken Bennett, Senior Counsel, Center for At-Risk Elders).

Protective Services (APS) in Marion County.⁶¹ Importantly, Indiana does not have a “public guardianship” program where the State provides guardianship services to those in need; instead, Indiana focuses on the development and utilization of volunteer guardianship programs referred to as VASIA programs under Indiana Code § 29-3-8.5.⁶² Although the State does not have a government entity that carries out guardianships, it funds some guardianship services carried out by nonprofit organizations—though, as this Note points out, inadequately.

B. Medicaid

Central to guardianship services is the method of compensation they receive, which largely comes from Medicaid. Medicaid is one of the most prevalent examples of cooperative federalism. In the 1960s, under the administration of Lyndon Johnson, Medicare and Medicaid were created in order to pay the increasing costs of medical care for a growing class of individuals who were impoverished and could not afford to pay.⁶³ Elderly individuals made up a large portion of this population.⁶⁴ “Medicaid and the Children’s Health Insurance Program (CHIP),” specifically, “cover more than 87 million people, about 24 percent of the U.S. population.”⁶⁵ Medicaid was built on federal foundation but allows substantial leeway in terms of policy choices within the federal statutory structure; this is what is known as cooperative federalism, where the federal government provides an overarching regulatory scheme, but states may implement many of their own policies.⁶⁶ In this scenario, each state’s Medicaid laws may look different.⁶⁷ States that accept federal money, however, must comply with certain mandatory provisions that must be included in their Medicaid plan, mostly having to do with covering costs for low-income people.⁶⁸ This welfare-based perspective has contributed to the limitations of Medicaid as only applying to the “deserving poor” and has thus limited eligibility due to negative connotations surrounding the idea of providing “handouts.”⁶⁹

“Medicaid is a jointly funded program operated by individual states and the federal government that provides medical and financial assistance to low-income persons (many who are seniors) who are unable to fund their medical care. The program is structured on a voluntary, opt-in basis in that states may

61. *Id.*

62. *Id.*; see also IND. CODE § 29-3-8.5 (2020).

63. NICOLE HUBERFELD ET AL., THE LAW OF AMERICAN HEALTH CARE 54–55 (3d ed. 2023).

64. *Id.*

65. *Id.* at 105.

66. *Id.* at 106.

67. *Id.*; Moran, *supra* note 1.

68. HUBERFELD ET AL., *supra* note 63, at 106.

69. *Id.* at 107.

elect, but are not required, to participate.”⁷⁰ States that opt in must create and develop their own state Medicaid Plan for approval by the federal government.⁷¹ The plan must comply with the Medicaid Act and regulations proposed by the Secretary of the Department of Health and Human Services.⁷² The regulations typically define “income” as property which can be applied directly, or by sale or conversion, to meet basic needs, such as food, shelter, and medical expenses.⁷³ “The federal Medicaid statute mandates the provision of a ‘personal needs allowance’ in the state program by providing that a state plan will not receive federal approval unless certain deductions or ‘allowances’ are allowed to be taken from a recipient’s monthly income, including a ‘personal needs’ allowance.”⁷⁴

Each state has a Medicaid program of its own that provides money to be set aside. Otherwise, any income they have over a certain amount—which varies state by state—must be used to pay for their care. Individuals are required to contribute all of their available income and assets to pay for the costs of any nursing facility they live in, while the state pays the difference between the recipient’s available income and the cost of their care.⁷⁵

C. Other States’ Approaches to Guardianship Fees

It is worth noting that in many cases, guardians are eligible to receive fees for their services from protected persons with the ability to pay. “In some states, fees are based on a percentage of the total assets. In others, the fees must be reasonable with reference to the work done and the size of the estate. Many courts limit fees to hourly rates that are relatively low in relation to a typical hourly rate for an attorney.”⁷⁶ Within the last few years, a few states have proposed legislation regarding guardianship fees.⁷⁷ Illinois has proposed that guardianships be entitled to “reasonable and appropriate compensation for guardianship duties.”⁷⁸ All fees must be reviewed and approved by a court in a petition for fees.⁷⁹ Illinois SB 80 lays out factors to be considered by the court in awarding guardianship fees, yet it does not provide a specific amount that the fees may not exceed per month.⁸⁰ These factors include:

70. Brien M. Penn, *The Maryland Survey: 2000-2001*, 61 MD. L. REV. 795, 940 (2002).

71. *Id.*

72. *Id.*

73. *Id.* at 941–942.

74. *Id.* at 942.

75. *Id.* at 941.

76. FROLIK & BARNES, *supra* note 1, at 361.

77. Comm’n on Law & Aging, *Guardianship Reform: 2021 Adult Guardianship Legislation Summary*, AM. BAR ASS’N 1 (2021), https://www.americanbar.org/content/dam/aba/administrative/law_aging/2021-guardianship-leg-summry.pdf [<https://perma.cc/TKU9-T77V>].

78. S.B. 80, 102nd Gen. Assemb. (Ill. 2021), <https://www.ilga.gov/legislation/102/SB/PDF/10200SB0080.pdf> [<https://perma.cc/8LZZ-JXFT>].

79. *Id.* at 26.

80. *Id.* at 25–26.

- (1) the powers and duties assigned to the guardian by the court;
- (2) the necessity of any services provided;
- (3) the time required, the degree of difficulty, and the experience needed to complete the task;
- (4) the needs of the ward and the costs of alternatives; and
- (5) other facts and circumstances material to the best interests of the ward or his or her estate.⁸¹

Florida acted similarly.⁸² Additionally, Delaware SB 85 allows for guardianship fees in accordance with standards established by the State Guardianship Commission and approved by the Chancery Court.⁸³

Advocacy work is not considered reasonable compensation for guardianship fee purposes.⁸⁴ In *Lamb*, the guardians, the Hardmans, requested guardianship fees of \$225 per month for two of their wards for guardian services and \$150 per month for “special advocacy fees” in their triennial guardian’s reports.⁸⁵ The Washington Department of Social and Health Services (DSHS) filed an objection to the Hardmans’ requested guardian fees arguing that Washington law limits routine guardian fees to \$175 per month and lobbying and community activism are not within the definition of permissible “extraordinary fees.”⁸⁶ DSHS noted that any increase in guardian fees, which are paid prior to a client’s participation in cost of care (similar to Indiana), reduces the amount otherwise available to reimburse the State for care.⁸⁷ This is the same argument against increasing the allowable fee in Indiana.

Maryland courts have rejected the idea of guardianship “commissions” or fees being considered part of one’s personal needs allowance in a Medicaid set-off.⁸⁸ The Maryland Court of Appeals held in *Department of Health and Mental Hygiene v. Campbell* that guardianship commissions and legal fees were not the kind of “personal needs” expenses contemplated by Code of Maryland Administrative Regulations (COMAR) § 10.09.24.10D.⁸⁹ The *Campbell* court further held that the \$40 per month allowance for personal needs was meant to cover essential items like those used to maintain one’s hygiene as is implied by

81. *Id.* at 26 (importantly, the compensation awarded through this fee petition comes from the guardianship estate; in other words, this is the case when an individual has the ability to pay a private guardian, so Medicaid is not paying the fees; otherwise, it is likely that the public guardian would care for the protected person).

82. FLA. STAT. § 744.108 (2025).

83. AM. BAR ASS’N, *supra* note 77, at 8.

84. *In re Guardianship of Lamb*, 265 P.3d 876, 885 (Wash. 2011).

85. *Id.* at 880.

86. *Id.* at 880–81; WASH. ADMIN. CODE § 388-79A-010 (2018).

87. *In re Guardianship of Lamb*, 265 P.3d at 881.

88. Penn, *supra* note 70, at 936; Dep’t of Health and Mental Hygiene v. *Campbell*, 771 A.2d 1051, 1058–59 (Md. App. Ct. 2001).

89. Penn, *supra* note 70, at 936; *Campbell*, 771 A.2d at 1059; MD. CODE REGS. 10.09.24.10(D).

the small amount permitted.⁹⁰

New Jersey takes a different approach by allowing a certain percentage of one's income to be used for the provision of a private guardian. Specifically, New Jersey law mandates that an adult under guardianship contribute 75% of his or her disposable monthly income towards the cost of their care.⁹¹ "Further, as much as six percent of his total gross annual income may be used toward a guardianship fee."⁹² However, this expense is not permitted where guardianship is provided through the Bureau of Guardianship Services (court appointed and government provided).⁹³ Alaska similarly follows a sliding scale approach, where fees range from \$40 per month for a ward with assets less than \$10,000 to \$145 per month if the ward has more than \$100,000 in assets.⁹⁴

Some courts hold that it is a mandatory requirement that a guardian must confer a benefit to a protected person to be entitled to guardianship fees in statutes on the subject.⁹⁵ Nevada has no such strict requirement; rather, Nevada Revised Statutes § 159.344 employs permissive language—"may"—to invite courts to consider any benefit to the protected person.⁹⁶

Likewise, Washington D.C. has a statute addressing guardianship of infants that serves as a comparable example. The D.C. statute provides for reasonable compensation for guardianship services, but provides that the guardian's commission is not to exceed 5% of the property of the estate collected, if and when disbursed.⁹⁷ Once again, certain states appear to favor the reasonable compensation approach while preferring to set a limit on what the reasonable compensation should be. It stems from a policy grounded in the notion that a guardian's fees should be determined on a case-by-case basis, disregarding the excess costs created by a court having the duty to determine what reasonable compensation entails. Washington D.C. courts have held the reasonable compensation determination "must be based upon (1) the character of the services rendered, (2) the amount of time spent, (3) the size of the estate administered, and (4) the benefits that accrued to the estate as a result of the

90. Penn, *supra* note 70, at 948; *Campbell*, 771 A.2d at 1059.

91. *In re P.A.*, No. A-5521-16T2, 2019 N.J. Super. Unpub. LEXIS 128, at *2 (N.J. Super. Ct. App. Div. 2019); N.J. ADMIN. CODE § 10:46D-3.1(a), (b) (2024) ("Total monthly net income less personal needs allowance (PNA) and, where documented, a plan to achieve self-support (PASS) = disposable monthly income.").

92. *See* N.J. ADMIN. CODE § 10:46D-3.1(f) (2024).

93. *Id.*

94. Catherine Seal & Spencer Crona, *Standards for Guardian Fees*, 2012 UTAH L. REV. 1575, 1607 (2012).

95. *See e.g., In re Guardianship of Sleeth*, 244 P.3d 1169, 1174 (Ariz. Ct. App. 2010) ("We cannot agree that the legislature intended that courts overlook whether an attorney's or a fiduciary's services produced any value or benefit to the protected person."); *In re Guardianship of Ansley*, 94 So. 3d 711, 713 (Fla. Dist. Ct. App. 2012) (requiring courts to consider benefits conferred despite the statute's failure to list such benefits as a factor in an enumerated list of factors to support guardianship fees).

96. *In re Jones*, 2021 Nev. App. Unpub. LEXIS 601, at *7-8 (Nev. Ct. App. 2021); *see* NEV. REV. STAT. § 159.344(5) (2024) (providing factors for consideration).

97. D.C. CODE § 21-143 (2026); *Mitchell v. Ensor*, 412 F.2d 155, 160 (D.C. Cir. 1969).

services.”⁹⁸

Indiana’s neighbor state, Illinois, has a different approach. Illinois’s approach towards guardianships involves a state-run organization devoted to guardianships called the Office of State Guardian (OSG).⁹⁹ Within the Illinois Administrative Code, the OSG is permitted to receive \$250 per month per guardianship for guardianship of the person.¹⁰⁰ For guardianship of the estate, guardians are entitled to a monthly fee of \$300 when the individual under guardianship has an estate of \$24,999 and below in liquid assets.¹⁰¹ For an estate of \$25,000 and above, the guardian is entitled to “[u]sual, customary and reasonable fees, for public or appointed guardians in the county where the case is filed.”¹⁰² Additionally, the schedule for fees associated with the assessment of a one-time case opening fee for guardianship of the person, estate, or both are: \$500, \$750, and \$1,000, respectively.¹⁰³ Similarly, the assessment of a guardianship petitioning fee is \$500.¹⁰⁴ Although, these figures are just a one-time fee, they are significantly greater than the \$35 per month allowable through Medicaid under the Indiana Administrative Code (as opposed to individuals with resources that are under the reasonable fees standard).¹⁰⁵ More importantly, the monthly fees under the Illinois Administrative Code are significantly greater than those allowed under the Indiana Administrative Code. As are the typical fees offered by the New Mexico Office of Guardianship to contracted guardianship organizations, which may be approximately \$325 per month per client served,¹⁰⁶ and Texas’ Medicaid reimbursement, which allows compensation for guardians up to \$175 per month per client.¹⁰⁷

D. Indiana Statute

Indiana law regarding guardianship fees reimbursed through Medicaid has gone unchanged over several years. It does not provide a reasonable compensation framework and is not tied to any percentage of the protected person’s assets or estate.¹⁰⁸ First, Indiana law provides that individuals eligible for Medicaid who

98. *Ensor*, 412 F.2d at 160.

99. ILL. ADM. CODE tit. 59, § 301.10 (2020); *see also* S.B. 80, 102nd Gen. Assemb. (Ill. 2021), <https://www.ilga.gov/legislation/102/SB/PDF/10200SB0080.pdf> [<https://perma.cc/8LZZ-JXFT>].

100. ILL. ADM. CODE tit. 59, § 301.60 (2020).

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. 405 IND. ADMIN. CODE 2-1.1-7(b)(3) (2025).

106. Ronnie Greene & Holly Barker, *Guardians’ Dark Side: Lax Rules Open the Vulnerable to Abuse*, BL (Mar. 6, 2023), <https://news.bloomberglaw.com/us-law-week/guardians-dark-side-lax-rules-open-the-vulnerable-to-abuse> [<https://perma.cc/SVQ7-ZKLT>].

107. Bruce P. Bower, *Access to Justice*, 74 TEX. BAR J. 732, 733 (2011).

108. *See* 405 IND. ADMIN. CODE 2-1.1-7(b)(3) (2025); *cf.* Seal & Crona, *supra* note 94, at 1608–09.

are not living at home and are receiving care at a hospital or nursing facility are granted a personal allowance of \$52 per month that may be exempt from income eligibility consideration.¹⁰⁹ Under 405 Indiana Administrative Code 2-1.1-7, an institutionalized individual under guardianship may have an amount not exceeding \$35 per month set aside from their income to pay guardianship fees.¹¹⁰ This scenario applies to individuals who are considered very poor and government benefits are typically their only source of income.¹¹¹ It is categorized as “increased personal needs,” an amount in addition to the \$52 set-aside for the individual under guardianship to do with as they please.¹¹² The administrative code provision relating to guardianship fees addresses how income is to be dealt with after an individual is determined to be eligible for Medicaid. It addresses income that is to be paid from the eligible individual’s income to the institution that they are residing in.¹¹³ The procedures prescribed by the code instruct that in determining how much income is to be paid to the institution: first, establish total income not excluded by federal statute; then, subtract the personal needs allowance; and then, subtract the guardianship fees, health insurance premiums, necessary care not covered by the state plan, and taxes owed.¹¹⁴

Medicaid is the party that handles the payment of guardianship fees because of the protected person’s inability to pay. This is why they are typically under guardianship in the first place; they cannot coordinate their own medical care due to an incapacity and many do not have the financial means to pay for their care, let alone a guardian. Just because one is able to pay does not mean that a VASIA program will not act as guardian. If the protected person does have sufficient resources, guardianship organizations are entitled to request reasonable guardianship fees for their services, essentially at a cost, to be determined by a court. If a protected person has family or friends who are willing to care for them and/or they have the means necessary to pay for their own care, guardianship organizations largely do not get involved because there is not as great a need. Instead, the sad reality is that many individuals that these organizations take on as clients do not have loved ones who are present or adequately suited to care for them and the protected person has hardly any assets. Moreover, some have bad actors in their lives looking to take advantage

109. IND. CODE ANN. § 12-15-7-2 (2025).

110. 405 IND. ADMIN. CODE 2-1.1-7 (2025); *Testimony*, *supra* note 21 (statement of Ken Bennett, Senior Counsel, Center for At-Risk Elders) (currently, any guardian for a Medicaid nursing home resident is only allowed to be paid \$35 per month for their services (citing Indiana Health Coverage Program Policy Manual § 3455.15.10); notably, this has been the reimbursement level since adopted in 2014 in the Administrative Code).

111. *See* 405 IND. ADMIN. CODE 2-1.1-5(g) (2025).

112. 405 IND. ADMIN. CODE 2-1.1-7(b)(3) (2025); *see also* IND. CODE ANN. § 12-15-7-2 (2025) (categorizing the allowance as “increased personal needs,” a separate allowance from the \$52 monthly set-aside and in addition to the \$52 reserved for the individual under guardianship to use as they choose).

113. 405 IND. ADMIN. CODE 2-1.1-7(b) (2025).

114. *Id.*

of them and exploit their financial resources. This is why hospitals typically work with guardianship organizations to try to arrange care—if for no other reason than to open up a bed for a paying customer—for those who do not appear to have loved ones or the ability to pay. It also serves the purpose of reducing the hospital’s liability so that they are not performing illegal discharges of individuals without capacity.

III. ANALYSIS AND SOLUTIONS

A. Attempts to Change Indiana Law

In 2017 a Senate Bill was proposed in the Indiana General Assembly in an attempt to increase the funding for guardianship organizations via Medicaid reimbursements.¹¹⁵ This bill would have increased the Medicaid reimbursement for guardianship fees from \$35 per month to an amount not to exceed \$175 per month.¹¹⁶ The Indiana State Senate attempted to recognize the great need for funding among nonprofit guardianship programs by increasing one source of income. Beyond that, an increase in the Medicaid reimbursement would allow these programs to be compensated fairly for the vital work they do, which would allow them to hire more staff and take on more clients, as there is a growing need for guardianship assistance.¹¹⁷ In response to the proposed legislation, the Office of Fiscal and Management Analysis composed a Fiscal Impact Statement that acknowledged that there is no known data indicating how many individuals who are Medicaid-eligible and living in institutions have court appointed guardians, including how many of those guardians are paid fees through Medicaid.¹¹⁸ But it did note that the proposed legislation would increase the state’s fiscal responsibility (because it receives matching federal Medicaid funds) by \$48.17, or a total of \$60.22 per month per protected person.¹¹⁹

In his testimony before the General Assembly, Ken Bennett of CARE noted that “empirical studies have shown that access to trained guardians tends to decrease the overall costs to the medical system [including Medicare and Medicaid] by ensuring preventative care and services are provided, as well as improving compliance with post-acute discharge orders, thus decreasing

115. See S.B. 396, 120th Gen. Assemb., 1st Reg. Sess. (Ind. 2017), <https://iga.in.gov/pdf-documents/120/2017/senate/bills/SB0396/SB0396.04.COMH.pdf> [<https://perma.cc/S8SA-6B6D>].

116. *Id.*

117. *In re* Ord. Establishing the Ind. Guardianship Oversight Task Force, No. 24S-MS-00399, 2024 Ind. LEXIS 704, at *1 (Ind. 2024) (“Each year, the number of vulnerable Hoosiers requiring guardianship or other caretaking services continues to rise. Caring for these individuals by coming together and creating a better system is both crucial and timely.”).

118. Fiscal Impact Statement from Office of Fiscal Mgmt. and Analysis on Guardian Reimbursement and Medicaid Eligibility (Mar. 24, 2017), <https://iga.in.gov/pdf-documents/120/2017/senate/bills/SB0396/fiscal-notes/SB0396.04.COMH.FN001.pdf> [<https://perma.cc/Z6AD-U768>] [hereinafter Fiscal Impact Statement]

119. *Id.* at 2.

unnecessary readmissions.”¹²⁰ Bennett also argued the passage of Senate Bill No. 396, and increased guardianship fees more generally, would significantly expand access to guardianship services for Indiana’s incapacitated adults in need, reasonably compensate guardians for their work, improve the quality of guardianship services by encouraging greater professionalism, and help to reduce the overall costs to Indiana’s Medicaid program.¹²¹

Increasing guardianship fees would also be proportional to the size of a guardianship program. Currently, as stated previously, there were 20 VASIA programs in the State of Indiana that received grants worth a combined \$1.3 million from the Indiana Supreme Court subdivision.¹²² Hypothetically, if the 20 VASIA programs were to each get approximately \$65,000 through a grant from the State were instead allowed to be reimbursed \$100 per client per month for a year, and the 20 organizations each had an average of 54 clients, this would be approximately the same amount of money as what they are receiving via the grant from the State. Under this increased fee reimbursement hypothetical, it would cost the State \$1.296 million dollars per year, whereas the current system costs the State \$1.3 million dollars per year, apart from the excluded income from the \$35 set-aside currently in place paid by the State.¹²³ Additionally, when considering the costs of employing staff within a guardianship organization, \$65,000 does not even cover one employee taking into consideration salary and benefits, even with a modest salary common of a nonprofit. Larger VASIA programs could bring in greater guardianship fees more commensurate with the number of clients they take on and appropriately fund their activities. The Indiana Adult Guardianship Office uses a number of factors for distributions of matching grants as opposed to splitting evenly among counties and programs, but increasing the reimbursement rate through Medicaid on a fee-for-service basis would be a more rational approach.¹²⁴

Unfortunately, there is no data indicating how many individuals receive the

120. *Testimony, supra* note 21 (statement of Ken Bennett, Senior Counsel, Center for At-Risk Elders); *Who’s Overseeing the Overseers? A Report on the State of Adult Guardianship in Indiana*, IND. ADULT GUARDIANSHIP STATE TASK FORCE 29 (Feb. 2012), <https://www.in.gov/courts/iocs/files/ad-guard-2012-full-report.pdf> [<https://perma.cc/9AFY-QVSL>].

121. *Testimony, supra* note 21 (statement of Ken Bennett, Senior Counsel, Center for At-Risk Elders); see also *Public Guardianship Saves Money*, WASH. STATE, <https://www.courts.wa.gov/content/publicUpload/Office%20of%20Public%20Guardianship%20-%20About%20Us/OPG%20Saves%20Lives.pdf> [<https://perma.cc/7EW9-DYSP>] (last visited Feb. 23, 2025) (noting that guardianships promote preventative care that reduces the “revolving door” of ER visits) (presumably, the reduced ER visits would lower costs to the state through Medicaid and would not result in hospitals attempting to recoup this money by increased costs to the wider patient population).

122. IN.GOV, *supra* note 54 (referring to archived information accessed via permalink).

123. See *id.* (it is unclear whether and how much this amount may vary depending on the number of VASIA programs and money available for grants).

124. See IND. SUP. CT., ADULT GUARDIANSHIP OFF., CHECKLIST FOR 2023 VASIA APPLICATION, <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.in.gov%2Fcourts%2Fiocs%2Ffiles%2Fvasia-checklist-instructions.docx> [<https://perma.cc/Q8EG-DS8J>] (last visited Nov. 20, 2025).

\$35 per person per month for guardianship fees, and thus it is unclear was the current fiscal impact is on a larger scale when combined with the grants to the twenty guardianship organizations.¹²⁵ But, even if the fiscal impact is greater under a statutory scheme with a larger reimbursement than \$35, the health outcomes would be greatly improved by the increased utilization of guardianship organization with expertise and experience who can properly handle a protected person's assets and coordinate appropriate medical care. What is clearer is that if a single guardian is working with what is considered a reasonable caseload—say, twenty clients—then for Medicaid recipients the guardian would be paid \$35 per month for each of those twenty clients for 12 months, totaling \$8,400 per year. It is clear why individuals like Debra Woods have to take on so many clients. If the number was increased to \$100 per month, this would at least help support staff more than the current reimbursement.

Such a low number makes it very difficult for a guardianship organization to provide the much-needed care for a large population with no loved ones or very few assets. Even a well-run organization cannot survive on the current reimbursement. Moreover, what gets lost in the criticism of Debra Woods is that she uses an hourly rate of \$35 per hour for clients who do have the ability to pay,¹²⁶ a number likely far lower than her colleagues in the field.¹²⁷ Charging such a low fee for those who can pay actually reduces the government's financial burden for guardianship-related expenses!¹²⁸ Expecting practitioners to charge such a low amount for protected persons who can pay, like Debra Woods, is asking too much and would further dissuade talented individuals from the practice. Instead, the State should incentivize taking on guardianships with Medicaid paying the bills by bringing the reimbursement at least slightly closer to parity with what those with the ability to pay are charged.

B. Establish a Higher Reimbursement Rate Per Month

One solution to this problem is to increase the reimbursement rates, as the legislature has already attempted to do. However, lawmakers may have balked at the proposition because the increase was so large, raising concerns about fiscal impact and long-term stability. Some states set a fixed monthly allowance

125. Fiscal Impact Statement, *supra* note 118, at 1; *see* Greene, *supra* note 5.

126. Greene, *supra* note 5.

127. *See e.g.*, Greene & Barker, *supra* note 106 (stating that one New Mexico guardianship organization charged private clients with greater financial means \$950 per month).

128. This is because, theoretically, charging a lower hourly rate for guardianship services not paid through Medicaid makes it possible for those with fewer assets and/or lower income to pay for the services themselves. This means lower costs for the State. Such a public service should not be met with shifting the burden to practitioners to take significant pay cuts. After all, the market does not appear to be competing for rates this low, for the most part. *See generally* Ronnie Greene & Holly Barker, *Peter Max's Bare Ledgers Show Guardianships Drain Even the Rich*, BL (Mar. 9, 2023), <https://news.bloomberg.com/us-law-week/peter-maxs-bare-ledgers-show-guardianships-drain-even-the-rich> [<https://perma.cc/9V3E-HCCG>] (on file with author).

for guardianship fees, like Indiana, that established a uniform amount that can be deducted or disregarded regardless of the actual cost of services. An important consideration is looking at Indiana's sister state of Illinois' approach, which is similar to our own. The difference between the two states is that guardianship solely over the person in Illinois entitles the guardian to an amount approximately seven times greater than in Indiana. While Indiana need not adopt a statutory scheme as drastic in terms of the increase in fees, if Indiana prefers to stay with a fixed rate, it could find a middle ground between the Illinois example and what it currently is—\$35. It may not be ideal for keeping the budget low, but it is more commensurate with the value of services and more adequately compensates for much needed work.

Guardianship fees may go largely unnoticed because many of these cases are handled by the probate courts and do not receive much attention or public notoriety.¹²⁹ Debra Woods thinks that \$100 per month is a reasonable number.¹³⁰ This is the number that the legislature in Alaska has adopted for the maximum guardianship fee allowable under Medicaid.¹³¹ As previously stated, the Indiana General Assembly has attempted, without success, to pass legislation increasing the Medicaid reimbursement for guardianship fees to \$175 per month. One approach could be to meet in the middle at \$100 dollars instead of going as high as was suggested in SB 396. This would hopefully appease lawmakers and keep costs down, which is certainly always a concern of the legislature as they conduct a fiscal impact assessment with proposed bills. In fact, that is likely one of the reasons that the legislation has remained the same for the past few decades—an attempt at controlling costs.

One method of making this approach more palatable to the General Assembly would be to limit the organizations that can receive this fixed amount set-aside. Efforts to focus the increased amount of \$175, or an amount a little below that number, on certain organizations could increase the likelihood of the bill being passed into law. The concern in the past was the fiscal impact. Current proposals seem poised to achieve what the 2017 proposed Senate Bill could not by making the increased cap available to only VASIA programs and/or certified guardians in Indiana in hopes of reducing the fiscal impact on the State budget. This would help alleviate the concerns raised before, after the bill had passed unanimously through the Committee on Family and Children's Services but died in the Appropriations Committee. The current Indiana Administrative Code—specifically 405 Indiana Administrative Code 2-1.1-7—allows court ordered guardianship fees paid to an institutionalized Medicaid applicant or their legal guardian.¹³² This makes the fee available to individuals and groups that may not be recognized VASIA programs. Increasing the fees only for VASIA programs is appropriate given their level of expertise in the area and

129. Greene, *supra* note 5.

130. *Id.*

131. ALASKA ADMIN. CODE tit. 7, § 100.558(f)(6) (2025).

132. 405 IND. ADMIN. CODE 2-1.1-7 (2025).

still limits the costs for the State. It could be further limited to only certified guardians.¹³³

C. Reasonable Compensation

Many jurisdictions, such as Wisconsin, allow courts to determine the fees that a guardian is entitled to for their work on a case-by-case basis, but provide some guidelines for what is to be considered.¹³⁴ Indiana similarly allows for reasonable compensation for guardianship services, for those who are able to pay, by petitioning the court.¹³⁵ These are different than the Medicaid set-aside of \$35 for those who are unable to pay for guardianship services. These factors include: reasonableness of services rendered; fair market value of the services rendered; conflict of interest of the guardian; availability of another to provide the services; the value and/or nature of the ward's assets and income; whether the ward's basic needs are being met; and the hourly or other rate proposed by the guardian for their services.¹³⁶ Further, "[t]he amount of the compensation may be determined on an hourly basis, as a monthly stipend, or on any other basis that the court determines is reasonable under the circumstances."¹³⁷ Not surprisingly, what goes along with these conditions is that the court must approve of the guardianship fees or compensation. What is different between this statutory scheme and that of Indiana currently is that Wisconsin law leaves the door open for a court to determine that guardianship services might be less some months than others as opposed to a flat rate—instead, it is variable. Notably, the Wisconsin statute does not award compensation via reimbursement through Medicaid.¹³⁸

Besides adopting similar approaches as other states in determining reasonable compensation, Indiana law could attempt to incorporate similar factors to attorney fee standards for determining what is a reasonable fee for legal services. In that context, the factors to be considered are: time and labor required (novelty or difficulty of issue), work load outside of that particular client, customary fee for those type of services in the particular locale, the amount involved and results obtained, time limitations imposed by the circumstances, nature and length of relationship with client, experience and ability of lawyer, and whether the fee is fixed or contingent.¹³⁹ These factors are

133. Greene, *supra* note 5 (currently, there is no certification requirement to be a guardian in the State of Indiana).

134. WIS. STAT. § 54.72(1)(c) (2025).

135. *See* IND. CODE ANN. § 29-3-9-3 (2024) ("A guardian is entitled to reasonable compensation for services as guardian and to reimbursement for reasonable expenditures made in good faith on behalf of the protected person.").

136. WIS. STAT. § 54.72(1)(b) (2025).

137. WIS. STAT. § 54.72(1)(c) (2025).

138. *See* WIS. STAT. § 54.72 (2025).

139. MODEL RULES OF PRO. CONDUCT r. 1.5 (A.B.A. 2020), https://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_5_fees/ [<https://perma.cc/9PEX-6E7S>].

quite similar to those evaluated by courts making a guardianship fee determination in other jurisdictions. Most of them are relevant in the guardianship context as well. In light of the Debra Woods case study, evaluating one's caseload would appear to be an important factor to consider, if not just increasing the flat rate by explicit law. Fees ordinarily charged in similar situations would seemingly be common sense and without much disagreement. The amount of assets involved with the client and the case can make the work more complex and will require more time and effort, thus, the amount of assets involved, like the amount in controversy, should have a role in the determination of guardianship fees. The amount of work involved and required for each guardianship is another natural factor that should definitely be included. The nature and length of the relationship with the client may be relevant to the extent of the quality of care provided by the guardian in relation to the client and whether they are satisfied with the guardian's work can be very telling of their deservedness of guardianship fees. The experience of the guardian is also an important factor since more experienced guardians, like attorneys, should be entitled to higher compensation than those with less experience because they have built up wisdom through their years of practice. Finally, the type of fee arrangement (fixed, hourly, or contingent) is not as applicable in the guardianship context as it is for the typical practicing attorney.

D. National Guardianship Association (NGA) Standards

One consideration in determining reasonable fees could be compliance with guidelines and ethics. If a court is partaking in a reasonable compensation analysis, maybe it would be worthwhile to evaluate the guardian's actions not only for the quality of their work, but also their adherence to proper guardianship standards.¹⁴⁰ The National Guardianship Association Standards of Practice suggest that guardians are entitled to reasonable compensation. Specifically, "[a]ll fees related to the duties of the guardianship must be reviewed and approved by the court. Fees must be reasonable and be related only to guardianship duties."¹⁴¹ Guardians should support their fee request by considering:

- powers and responsibilities under the court appointment;
- necessity and quality of the services;
- the guardian's experience, skills, and licensure;
- the character and difficulty of the work to be done;
- the circumstances under which the work was done, i.e., emergencies;

140. See STANDARDS OF PRACTICE (NAT'L GUARDIANSHIP ASS'N, 5th ed. 2022), <https://www.guardianship.org/wp-content/uploads/NGA-Standards-2022.pdf> [<https://perma.cc/BSX8-KRLX>].

141. *Id.* at Standard No. 22.

- time expended;
- benefits of the services to the individual;
- fees customarily paid for like services; and
- the extent to which the services were consistent with the guardian's plan.¹⁴²

Further, the guardian should disclose a detailed explanation for the claim for fees, basis for fees, and a projection of annual fees within 90 days of appointment.¹⁴³ The fees or expenses should be documented similar to how a law firm bills its time—date and time spent on task, duty performed, expenses incurred, and who performed the duty.¹⁴⁴ Most importantly, in terms of avoiding the Debra Woods issue, the NGA guidelines instruct guardians to limit their caseload to a manageable amount that allows the guardian to adequately and accurately support the individual by at least one visit per month and regular contact with service providers.¹⁴⁵ The size of one's caseload must be analyzed based on an objective evaluation of the time required in each case, activities expected, and ancillary support available to the guardian.¹⁴⁶ These considerations determine the appropriate volume of cases for any one guardian or guardianship organization. The guidelines also instruct that a guardian shall actively pursue and facilitate periodic independent review of their services.¹⁴⁷ Including this factor as part of the law would increase oversight in addition to a court's review of services rendered for the purposes of guardianship fees.

The NGA standards are not binding on state or federal courts.¹⁴⁸ Additionally, no national bill of rights exists to protect the rights of those under guardianship.¹⁴⁹ Without any binding standards to hold guardians to, courts may rely on fees and review of services rendered by guardians as an appropriate oversight mechanism. This judicial oversight will act as an incentive to guardians to perform adequate services for their clients. Otherwise, as a means of keeping costs down, the legislature could simply fix the allowable guardianship fee set-aside at a higher amount. This would have the benefit of not wasting quite as many judicial resources but still encourage better work and more attention per client, keeping in mind the Debra Woods case study. Further,

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.* at Standard No. 23.

146. *Id.*

147. *Id.* at Standard No. 24.

148. Hamre & Nord, *supra* note 4 at 1; Michael A. Kirtland, *Rights of Persons Under Guardianship*, ABA (Aug. 26, 2020), https://www.americanbar.org/groups/senior_lawyers/resources/voice-of-experience/2010-2022/rights-persons-under-guardianship/ (on file with author).

149. Though, there is a resident bill of rights for those in nursing homes. *See Your Rights and Protections as a Nursing Home Resident*, CTRS. FOR MEDICARE & MEDICAID, https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf [<https://perma.cc/Y529-DXEJ>] (last visited Jan. 31, 2025); Hamre & Nord, *supra* note 4.

it would avoid taking other oversight measures to prevent fraud and abuse through guardianships. Some states have taken to requiring the appointment of an independent counsel to oversee the work of court-appointed guardians. In some cases, the independent legal counsel provides legal services to one under guardianship without any costs to the incapacitated individual.¹⁵⁰ Other states require that a guardian ad litem be appointed to represent the respondent (potential protected person) in the guardianship hearing as a representative of the court and to report their findings on the best interests of the respondent to the court.¹⁵¹ These are helpful measures to protect the guardian, but they may only be available to a small number of county court systems within the State and the greater issue at hand is reducing caseload to improve outcomes for protected persons under guardianship while adequately funding an area of increased importance. Stated differently, there are adequate ethical safeguards in place for bad actors, the issue is providing sufficient funding for enough personnel to address the burgeoning guardianship problem.

IV. CONCLUSION

It is difficult to demonstrate the enormous social benefits that guardianship organizations, specifically VASIA programs provide. This is because their benefit cannot always be quantified and there is very little data currently available measuring the amount of money paid by Medicaid for the care of individuals under adult guardianship. The only somewhat quantifiable measure of the impact of increasing guardianship fees is a rudimentary assessment conducted in the Indiana General Assembly's Ways and Means Committee that struck Senate Bill 396 down. That bill would have increased the allowable guardianship fee to \$175 per person per month. Instead, the fiscal impact statement dissuaded the committee's adoption of SB 396. Yes, the increase in guardianship fees would be substantial, but that should not be the end of the assessment, and a different approach could be taken that would have more success in the General Assembly. A middle ground limit of \$100 per month per protected person based on reasonable compensation could work. At the very least, data demonstrating the current fiscal impact based on the number of adults under guardianship or an attempt to show the benefits of VASIA programs or

150. Bloomberg Law had a series of articles detailing the issues dealt with in the guardianship system, with several focusing on issues of fraud and abuse. One article in the series addresses solutions to potential fraud and abuses by guardians. Nevada has taken the approach of instituting legal reform that eliminates unnecessary guardianships and aims to eliminate the fraud and abuses in the Bloomberg series. "Nevada in 2017 began requiring independent lawyers be assigned to represent adults whenever a petition for guardianship is filed. This legal help comes at no cost, much like in criminal cases where indigent defendants are guaranteed free counsel." Ronnie Greene, *Guardians' Abuses Persist as One State's Easy Fix Goes Unmatched*, BL (Mar. 10, 2023), <https://news.bloomberglaw.com/us-law-week/guardians-abuses-persist-as-one-states-easy-fix-goes-unmatched> [<https://perma.cc/2ZGL-9WFZ>].

151. FROLIK & BARNES, *supra* note 1, at 360.

relieving the burdens of government would be extremely helpful.

Until such data is available, logic and anecdotal evidence will have to suffice. Stories of fraud and mishandled guardianships suggest that the system in place is encouraging bad actors and poor work. This leads to resources being taken away from the State when not actually used to carry out guardianship services, but also worse health outcomes due to inattention to the needs of protected persons under guardianship. With such a low fixed amount allocated towards reimbursing guardians for their care of protected persons without the means to pay, guardians are incentivized to take on too many clients. The number of incapacitated people with a court-appointed guardian who can pay the guardianship fees is relatively small.

Consequently, court-appointed guardians logically have to take on several clients in order to make anything close to reasonable revenue, even if they do receive a grant from the State. With the growing population of older individuals and those with a serious mental illness, the need for guardianship services is inevitably going to be in high demand. In order to address this impending issue, Indiana should consider the approaches outlined above. These include: increasing the fixed rate to a number between \$35 and \$175, making the fees subject to “reasonable compensation” like for those who have the ability to pay guardianship fees, adopting the NGA standards, and limitation of a higher guardianship fee to certified VASIA programs. State budgets may be strained, but the capacity of guardianship organizations is significantly strained as well. The grants made by the State to guardianship organizations are remarkably beneficial and recognize the need for this kind of work. However, the grants will not likely be able to keep up with the proportion of demand in certain counties and there will not be enough to go around.

Of course, the fiscal impact should be a large consideration, but it should be balanced with the quality of work and health outcomes. With the growing prevalence of societal issues that necessitate guardianship, the State would greatly benefit from more coordinated and experienced management of vulnerable individuals’ assets and medical care. What politicians care about is the perception of a crisis among their population, like homelessness, people being unable to receive medical care, or mental health issues. That storm is going to hit hard in the coming years, and it is only going to become more noticeable, especially in the age of technology, where incapacitated individuals are increasingly falling prey to online scams.¹⁵² More importantly, these demographics have been neglected, ignored, and not taken seriously in terms of their care.

Improving access to guardianships will have related improvements in health outcomes by ensuring protected persons are getting proper treatment and experience greater overall stability and happiness, thereby improving their quality of life. Additionally, improved access to guardianships will help

152. See e.g., *Leitner v. Leitner (In re Leitner)*, No. A-11-191, 2012 Neb. App. LEXIS 29 (Neb. Ct. App. Feb. 14, 2012); FROLIK & BARNES, *supra* note 1, at 377–80.

protected persons manage their assets more effectively, which would likely protect creditors and family members by reducing waste and ensuring that obligations are honored. The State of Indiana should reward and encourage the public good that guardianship organizations provide in addressing societal problems, take a proactive approach to dealing with a growing issue, and improve the health (physical, mental, and financial) of its citizens. If there is no money in this work, recruitment of personnel will be difficult, and may even force good guardians to leave the profession. While guardianship is meant to be a benevolent act as opposed to a business,¹⁵³ there still has to be some money supporting this public good. The State has the responsibility of taking care of protected persons through the philosophy of *parens patriae*. To properly carry out this duty, guardianship should be supported with adequate funding.

153. Greene & Barker, *supra* note 106.

REGULATING HEALTHCARE COMPETITION IN INDIANA: THE UNCERTAIN FUTURE OF CERTIFICATE OF PUBLIC ADVANTAGE LAWS

SOPHIA MARIE SISTEVARIS*

I. INTRODUCTION

What happens when state laws shield hospital mergers from federal antitrust enforcement? The rise of Certificate of Public Advantage (“COPA”) laws has sparked debate over whether they protect public interests or merely create monopolistic healthcare systems with less oversight. Indiana’s adoption of a COPA law brings this debate to the forefront, raising critical questions about how state-sanctioned hospital mergers interact with federal preemption and impact healthcare competition.

A. Certificates of Public Advantage and Legislation

The Supremacy Clause of the United States Constitution establishes that federal laws are “the supreme Law of the Land” and preempt state laws.¹

The constitution, therefore, declares, that the constitution itself, and the laws passed in pursuance of its provisions, shall be the supreme law of the land, and shall control all state legislation and state constitutions, which may be incompatible therewith; and it confides to this court the ultimate power of deciding all questions arising under the constitution and laws of the United States.²

In recent years, preemption has been circumvented in certain states which have enacted COPA laws that allow hospitals to merge without the threat of federal antitrust scrutiny.³

Indiana is one of nineteen states to have enacted a COPA law.⁴ These states are Florida, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Nebraska, New York, Ohio, Oregon, South Carolina, Tennessee, Texas, Virginia,

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1. U.S. CONST. art. VI, cl. 2.

2. *McCulloch v. Maryland*, 17 U.S. 316, 326–327 (1819).

3. *See Certificates of Public Advantage (COPAs)*, FED. TRADE COMM’N, <https://www.ftc.gov/news-events/features/certificates-public-advantage-copas#:~:> [https://perma.cc/E7HM-64VV] (last visited Jan. 1, 2026).

4. Amy Y. Gu, *States with Certificate of Public Advantage (COPA) Laws*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION (Aug. 10, 2021), <https://sourceonhealthcare.org/updated-states-with-certificate-of-public-advantage-copa-laws/> [https://perma.cc/989T-DJFN].

Washington, West Virginia, Wisconsin, and Wyoming.⁵ Five other states have repealed COPA laws: Minnesota, Montana, North Carolina, North Dakota, and Colorado.⁶ Some states have repealed their COPA law post-merger to remove oversight on the merged hospital; other states have repealed their COPA law to prevent a COPA-related merger altogether.⁷

B. Reasons Hospitals Seek COPA Laws

Hospitals that seek COPA-related mergers urge that there are a variety of reasons to set federal antitrust laws aside and allow the mergers.⁸ Drafters of COPA laws claim that antitrust laws impede the ability of hospitals to provide healthcare in underserved communities more efficiently and economically.⁹ They argue that COPA allows for better healthcare, which otherwise would be denied to patients if hospitals were required to adhere to federal antitrust laws.¹⁰ The Federal Trade Commission (“FTC”) provides a list of arguments that hospitals ostensibly claim to support COPA laws: elimination of wasteful duplication; reduction of healthcare costs and generation of efficiency; rural hospitals would close if not for the merger; quality of patient care would improve; and mergers would enhance access to healthcare facilities and create more jobs.¹¹

The FTC provides counter arguments for all these claims, emphasizing that competition in the healthcare facility market benefits patients, employers, and hospital employees.¹² The agency has consistently advocated for applying federal antitrust laws to protect consumers, employees, and employers. Competition is not wasteful or unnecessary; it actually incentivizes hospitals to invest in improvements.¹³

Further, the FTC posits that many hospital mergers do not achieve the savings and efficiencies that proponents of COPA claim, but rather any cost

5. *COPA-Approved Hospital Transaction Exempted from Federal Antitrust Laws*, DUANE MORRIS LLP (Oct. 4, 2023), [https://www.duanemorris.com/alerts/copa_approved_hospital_transaction_exempted_federal_antitrust_laws_1023.html#:~: \[https://perma.cc/XPZ8-5R26\]](https://www.duanemorris.com/alerts/copa_approved_hospital_transaction_exempted_federal_antitrust_laws_1023.html#:~: [https://perma.cc/XPZ8-5R26]).

6. Jeffrey J. Amato, Conor Reidy, & Dana Cook-Milligan, *The FTC Picks a Fight Against the COPA Hospital Merger System*, WINSTON & STRAWN LLP (Sept. 2022), [https://www.winston.com/en/blogs-and-podcasts/competition-corner/the-ftc-picks-a-fight-against-the-copa-hospital-merger-system#:~: \[https://perma.cc/TLU7-TQHL\]](https://www.winston.com/en/blogs-and-podcasts/competition-corner/the-ftc-picks-a-fight-against-the-copa-hospital-merger-system#:~: [https://perma.cc/TLU7-TQHL]).

7. Fred Ashton, *FTC Warns That Monopoly Hospitals Use State COPA Laws to Evade Antitrust Enforcement*, AMERICAN ACTION FORUM, (Sept. 27, 2022), [https://www.americanactionforum.org/insight/ftc-warns-that-monopoly-hospitals-use-state-copa-laws-to-evade-antitrust-enforcement/ \[https://perma.cc/3X9V-HA5L\]](https://www.americanactionforum.org/insight/ftc-warns-that-monopoly-hospitals-use-state-copa-laws-to-evade-antitrust-enforcement/ [https://perma.cc/3X9V-HA5L]).

8. *Key COPA Facts*, FED. TRADE COMM’N 2, [https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf \[https://perma.cc/2SQE-8LS4\]](https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf [https://perma.cc/2SQE-8LS4]) (last visited Jan. 1, 2026).

9. *Id.* at 2.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

savings are a direct result of the elimination of services and job reductions.¹⁴ This raises broader concerns about whether laws, such as COPAs, truly serve the public interest or merely provide regulatory carveouts and an unfair advantage for specific entities.

C. Special Legislation

Special legislation is “[any] law that ‘pertains to and affects a particular case, person, place, or thing, as opposed to the general public.’”¹⁵ Indiana’s Constitution largely prohibits special legislation stating that “in all ... cases where a general law can be made applicable, all laws shall be general, and of uniform operation throughout the State.”¹⁶ Given these constitutional constraints, Indiana’s COPA law warrants closer examination. Indiana’s COPA law, discussed below, has the hallmarks of special legislation, as the only subject of this particular law is a single merger of hospitals in the single county qualifying under the statute.¹⁷ In his article, “*State Constitutional Prohibitions on Special Laws*,” Justin Long explains the motivation behind the prohibition of special legislation enshrined in many state constitutions:

Since the nineteenth century, most states have had constitutional clauses prohibiting “special laws.” These clauses were ratified to protect the people of each state from domination by narrow economic elites, who would use their economic power to win grants of privilege from the state legislatures. To fight the corrupt favors garnered by private interests in this way, state constitutional drafters wrote clauses requiring their legislatures to pass only “general laws” that would apply equally to all members of the regulated class. For a brief period, these clauses were enforced in the courts—but more to protect economic elites than the democratic prerogatives of common people.¹⁸

Indiana’s COPA law raises similar concerns, as it appears to grant a unique regulatory privilege to a specific hospital merger rather than to establish a broadly applicable framework. This favoritism not only conflicts with the constitutional mandate for general laws but also underscores the risk of legislative capture, where private interests shape laws to their advantage rather than serving the public good. Given these factors, a closer examination of Indiana’s COPA law in light of special legislation prohibitions is both necessary and timely.

14. *Id.*

15. *City of Hammond v. Herman & Kittle Properties, Inc.*, 119 N.E.3d 70, 78 (Ind. 2019).

16. IND. CONST. art. IV, § 23.

17. *Certificate of Public Advantage*, IND. DEP’T OF HEALTH, <https://www.in.gov/health/cshcr/certificate-of-public-advantage/> [<https://perma.cc/78G2-EDL2>] (last visited Jan. 1, 2026).

18. Justin R. Long, *State Constitutional Prohibitions on Special Laws*, 60 CLEV. ST. L. REV. 719 (2012).

D. Thesis

This note argues that the impending merger between two Indiana hospitals in Vigo County is not in the public's best interest as it is unlikely to provide the efficiencies and lower costs it purports to achieve. Instead, as the FTC argues, Vigo County residents will likely see increased healthcare costs and potentially longer wait times to be seen by a healthcare provider. Furthermore, Indiana's COPA law that permits these hospitals to apply to merge is contrary to Indiana's constitution by creating special legislation that pertains to and affects a particular entity rather than the general public. Finally, the merger contravenes federal antitrust laws by fostering a potential monopoly in the Vigo County healthcare market, undermining competition and harming Indiana consumers.

All COPA laws inherently conflict with federal antitrust principles and should not be exempt from appropriate scrutiny. Healthcare is a sector where quality of care should take precedence over motives for profit. Nonetheless, hospitals around the country are seeking COPA laws to secure the business advantages of monopolistic practices, almost exclusively at the expense of the consumers – patients who depend on affordable and accessible care.

First, this note provides background information detailing Indiana's COPA law, the state constitution's provisions on special legislation, relevant federal antitrust statutes, the FTC's stance on COPA laws, and a brief timeline of events relevant to this note. Second, this note analyzes many critical aspects of this debate: the language of Indiana's COPA statute, the hospitals' initial application, the Indiana Department of Health's requests for additional information, the FTC's and Indiana Attorney General's responses to the application, local reactions and comments at a town hall meeting regarding the proposed merger, the hospitals' decision to withdraw their initial application, a proposed bill repealing the COPA law, the hospitals' second application, the merger's implications for federal preemption, the application of Indiana's leading case on special legislation, the Indiana Department of Health's determination approving the merger, and the critical importance of maintaining affordable healthcare in Vigo County. Finally, this note concludes with discussing solutions to keep healthcare in Vigo County affordable and accessible.

II. BACKGROUND INFORMATION

A. Indiana's COPA Law

Indiana's COPA law was enacted and added to the Indiana Code to take effect on July 1, 2021.¹⁹ Indiana Code § 16-21-15-.05(a) provides the purpose and goals of the COPA law.²⁰ Subsection (a)(1) states that “[a] hospital merger

19. IND. CODE § 16-21-15-1 (2025).

20. IND. CODE § 16-21-15-.05(a) (2025).

may benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services offered to the public.”²¹ Subsection (a)(2) provides further that “[b]enefits resulting from a hospital merger may outweigh any anticompetitive effects of joining together competitors, including addressing unique challenges in providing health care services in rural areas.”²²

The statute sets forth criteria for counties in which hospitals would be eligible to apply for a COPA merger.²³ The county must (1) have a population less than 140,000 and not contiguous to a county with a population of more than 250,000, (2) have only two hospitals that are both in the statewide trauma care system and one of the hospitals must be a teaching hospital with a medical residency program, and (3) be a predominantly rural county.²⁴

Eligible hospitals seeking a COPA must submit an application to the Indiana Department of Health (“IDOH”) to govern any merger agreement and must have done so before May 13, 2025 (formerly).²⁵ The application must include a copy of the merger agreement and a description of the nature and scope of the merger.²⁶

The IDOH website lists Vigo County as the only county eligible under the law.²⁷ Two hospitals in Vigo County submitted their first COPA application to merge on September 14, 2023.²⁸ The period for comment for the Vigo County merger closed, and the review period was set to close on December 4, 2024.²⁹ However, before the IDOH could release a decision on approval, the hospitals withdrew the application on November 25, 2024,³⁰ and submitted a second application on February 5, 2025.³¹

On January 8, 2025, Indiana Senators Ed Charbonneau and Tyler Johnson introduced Senate Bill 119 to repeal the state’s existing COPA law.³² Prior to Senate Bill 119, the hospitals had until July 1, 2026 to submit any other new applications under the COPA law.³³ However, Senate Bill 119 ultimately

21. IND. CODE § 16-21-15-.05(a)(1) (2025).

22. IND. CODE § 16-21-15-.05(a)(2) (2025).

23. IND. CODE § 16-21-15-1 (2025).

24. *Id.*

25. S.B. 119, 124th Gen. Assemb., Reg. Sess. (Ind. 2025).

26. IND. CODE § 16-21-15-3(b) (2025).

27. *See* IND. DEP’T OF HEALTH, *supra* note 17.

28. *See Application for Certificate of Public Advantage*, UNION HOSP., INC. & TERRE HAUTE REG’L HOSP., L.P. (Sept. 14, 2023), <https://www.in.gov/health/cshcr/files/Redacted-COPA-Application-with-Attachments.pdf> [<https://perma.cc/7MR9-Y4Y2>] [hereinafter *September 2023 Application*].

29. *See* IND. DEP’T OF HEALTH, *supra* note 17.

30. Samantha Liss, *Indiana hospitals pull merger application after pushback over monopoly concerns*, WFYI (Nov. 28, 2024), <https://www.wfyi.org/news/articles/indiana-hospitals-pull-merger-application-after-pushback-over-monopoly-concerns> [<https://perma.cc/3TLP-8DYV>].

31. *See* Union Hosp., Inc. & Terre Haute Reg’l Hosp., L.P., *2025 Application for Certificate of Public Advantage*, IN.GOV (Feb. 5, 2025), <https://www.in.gov/health/cshcr/files/COPA-2025-Application-Reduced.pdf> [<https://perma.cc/Y3AA-Q5V9>] [hereinafter *February 2025 Application*].

32. S.B. 119, 124th Gen. Assemb., Reg. Sess. (Ind. 2025).

33. IND. DEP’T OF HEALTH, *supra* note 17; *see* IND. CODE § 16-21-15 (2025).

amended the COPA law, rather than repealed it, and shortened that window; it required the hospitals to submit their final application by May 13, 2025, and directed the IDOH to approve or deny the application by November 9, 2025.³⁴ This narrowed the timeframe for Union Health and Terre Haute Regional to obtain approval by more than a year. While the latest application, dated February 5, 2025, includes additions intended to strengthen its chances of approval by the IDOH, the initial application remains worth analyzing, as the hospitals' arguments did not significantly change between the two applications. This is likely due to the time constraint the hospitals faced in light of Senate Bill 119.

Under Indiana Code § 16-21-15-5, the hospitals must be monitored for at least five years after merging and then may elect to opt out of COPA.³⁵ Monitoring mergers is a concession merging hospitals make in order to justify antitrust exclusion. However, the five-year monitoring requirement provided in the statute, and the opt-out provision are now effectively moot. Notably, Indiana Code § 16-21-15-6, which covers the state department's annual review of approved certificates of public advantage, expires July 1, 2026, making the originally stipulated five years of review impossible for the proposed merger.³⁶ A successful merger under this language of Indiana's COPA statute would be monitored only for only a few months, after approval, with no opt-out notice required.

B. Special Legislation in Indiana

Indiana's COPA statute is specifically tailored for Union Health Hospital, Inc. ("Union Health") and Terre Haute Regional Hospital ("Terre Haute Regional") in Vigo County. This is made clear by the fact that it is listed as the only eligible county on the IDOH COPA page.³⁷

The Indiana Supreme Court recently addressed the constitutionality of special legislation in *Holcomb v. City of Bloomington*.³⁸ In *Holcomb*, the Indiana Supreme Court held that a state statute violated the Indiana Constitution prohibiting special legislation.³⁹ The legislature enacted a law that targeted only the city of Bloomington when it could have enacted a law that applied generally throughout Indiana.⁴⁰

The Court in *Holcomb* provided a two-pronged inquiry when dealing with special legislation: (1) assess whether the law is special or general and (2) if the law is special, assess whether it is permissible under the Indiana constitution.⁴¹

34. S.B. 119, 124th Gen. Assemb., Reg. Sess. (Ind. 2025).

35. IND. CODE § 16-21-15-5 (2025).

36. See IND. CODE § 16-21-15-6 (2025).

37. See IND. DEP'T OF HEALTH, *supra* note 17.

38. See *Holcomb v. City of Bloomington*, 158 N.E.3d 1250 (Ind. 2020).

39. *Id.* at 1255.

40. *Id.* at 1253.

41. *Id.* at 1264.

“[T]he constitutionality of special legislation hinges on the uniqueness of the identified class and the relationship between that uniqueness and the law.” A special law is permissible “when an affected class’s unique characteristics justify the differential treatment the law provides to that class.” But a special law is not permissible “when there are no unique circumstances of an affected class that warrant the special treatment—meaning that a general law could be made applicable.”⁴²

C. Relevant Federal Antitrust Statutes

The issue of whether the federal antitrust laws should preempt Indiana’s COPA law is significant. There are three primary federal antitrust laws: The Sherman Act, The Clayton Act, and The Federal Trade Commission Act. These laws aim to protect consumers by preventing corporations from minimizing competition through monopolistic practices.

The Sherman Act makes it illegal for companies to “monopolize, conspire to monopolize, or attempt to monopolize a market for products or services.”⁴³ A firm has unlawfully monopolized if it has obtained or maintained market power by suppressing competition and engaging in anticompetitive conduct, rather than through competition.⁴⁴

The Clayton Act prohibits certain actions that might restrict competition.⁴⁵ Examples of this are tying agreements, predatory pricing, and mergers that could lessen competition. The Department of Justice (“DOJ”) explains that:

[a]n illegal merger occurs when two companies join together in a way that may substantially lessen competition or tend to create a monopoly in a relevant market. This reduction in competition can harm consumers by potentially leading to higher prices or fewer choices for products or services. It can also harm workers by potentially leading to lower wages or fewer choices for employment.⁴⁶

Finally, the Federal Trade Commission Act empowers the FTC to, among other things, prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁴⁷

The FTC has provided “*Statements of Antitrust Enforcement Policy in Health Care*” to provide guidance on how the FTC and DOJ believe antitrust

42. *Id.* at 1253 (quoting *Herman & Kittle Props., Inc.*, 119 N.E.3d 70, 84 (Ind. 2019)).

43. 15 U.S.C. § 2; see *The Antitrust Laws*, U.S. DEP’T OF JUST., <https://www.justice.gov/atr/antitrust-laws-and-you#:~:> [<https://perma.cc/E4B2-HNWH>] (last updated Dec. 20, 2023).

44. *Id.*

45. 15 U.S.C. § 12; see U.S. DEP’T OF JUST., *supra* note 43.

46. *Id.*

47. 15 U.S.C. §§ 41–58; see *Federal Trade Commission Act*, FED. TRADE COMM’N, <https://www.ftc.gov/legal-library/browse/statutes/federal-trade-commission-act> [<https://perma.cc/QXV9-2NAZ>] (last visited Jan. 1, 2026).

statutes should be enforced in the healthcare industry.⁴⁸ In the Statements, the agencies lay out an antitrust safety zone where they “will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years, absent extraordinary circumstances.”⁴⁹

D. The Federal Trade Commission’s View on COPAs

The FTC strongly disfavors COPA-related mergers. In a detailed report, the FTC extensively covers what COPA-related mergers look like and their effects.⁵⁰ The report analyzes the effects of COPA-related mergers in each state that has passed a COPA law. Five helpful examples are COPA-related mergers that occurred in North Carolina, Montana, Tennessee and Virginia, South Carolina, and Maine. When a state’s COPA law expires or state legislatures repeal the statute, oversight over the merged hospitals ceases.

In North Carolina, 20 years after the Merger of two Asheville hospitals, the state’s COPA law was repealed, and no competitive or regulatory constraints were imposed on the merged hospital.⁵¹ The merged hospital increased prices by at least 20% more than “peer hospitals” during the COPA period, and by another 38% after the COPA law was repealed.⁵²

In Montana, when the only two general hospitals in Great Falls merged, the merged hospital increased its prices by 20% when the State COPA law was repealed.⁵³

Two healthcare entities merged in Portland, Maine under the state’s COPA: Southern Maine Medical Center and Maine Medical Center.⁵⁴ Southern Maine Medical Center increased its prices by about 8% to 13% during the COPA period, and by almost 50% after the COPA expired.⁵⁵ Maine Medical Center’s prices increased its prices by 38% during the COPA period and by 62% after the COPA expired.⁵⁶

A 2018 COPA-related merger resulted in “Ballad Health,” a twenty-hospital

48. See generally *Statements of Antitrust Enforcement Policy in Health Care*, U.S. DEP’T OF JUST. & FED. TRADE COMM’N (Aug. 1996), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf [https://perma.cc/8XWC-5XNL].

49. *Id.* at 8–9.

50. See *FTC Policy Perspectives on Certificates of Public Advantage*, FED. TRADE COMM’N (Aug. 15, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf [https://perma.cc/NS29-K55R].

51. *Id.* at 8.

52. *Id.*

53. *Id.*

54. *Id.* at 12.

55. *Id.* at 10.

56. *Id.*

chain in Tennessee, Virginia, North Carolina, and Kentucky.⁵⁷ Ballard Health is “the only option for hospital care for most of the approximately 1.1 million people in a 29-county swath of Appalachia.”⁵⁸ Initially, the hospitals held by Ballard Health were permitted to continue operations if, after an annual review, both states affirmed that Ballard Health’s control provided a public benefit.⁵⁹ Recently, Tennessee lawmakers lowered the standard applied to Ballard Health: “the minimum score Ballard needs to meet to show a ‘clear and convincing’ public benefit has been lowered from 85 out of 100 to 70 out of 100.”⁶⁰ Lowering this standard significantly undermines the function of oversight because reducing the bar for the hospital’s public benefit is essentially the same as having no oversight at all.

In contrast, a merged hospital in Columbia, South Carolina was subject to rate and revenue controls under its COPA law.⁶¹ Research on the price effects showed that prices remained consistent with surrounding competition; the FTC submits that this is because there was still surrounding competition, and the merger did not result in a monopoly.⁶² Oversight on merged hospitals is continuous and non-expiring under South Carolina’s COPA statute.⁶³ The examples above illustrate that regulatory oversight in COPA-related mergers is more effective at controlling costs for patients than the absence of oversight.

Zack Cooper, an Associate Professor of Public Health and Associate Professor of Economics at Yale University, provided an estimate of the increase in costs in an official comment to the proposed merger in Terre Haute.⁶⁴ Cooper estimated that the Union Health and Terre Haute Regional merger “would raise commercial prices by between 10% and 30%, raise local insurance premiums by 3% to 10%, lower nurses’ wages by approximately 5%, and cause approximately 500 job losses outside the health sector.”⁶⁵ Cooper also noted that this significant level of job loss could result in “one to two excess deaths in the community from suicide or overdose.”⁶⁶ These projections highlight that the merger’s impact extends far beyond hospital finances, threatening broader community well-being and public health.

57. About Us, BALLAD HEALTH, <https://www.balladhealth.org/about-us>. [https://perma.cc/YZQ2-NLUN] (last visited Feb. 26, 2026).

58. Brett Kelman, *Ballad Health’s Hospital Monopoly Underperformed. Then Tennessee Lowered the Bar*, KFF HEALTH NEWS (Jun. 3, 2025), <https://kffhealthnews.org/news/article/ballad-health-copa-hospital-monopoly-underperformed-tennessee-lowered-standards-public-health-benefit-appalachia/> [https://perma.cc/X4DW-T3C5].

59. *Id.*

60. *Id.*

61. FED. TRADE COMM’N, *supra* note 50, at 9.

62. *Id.*

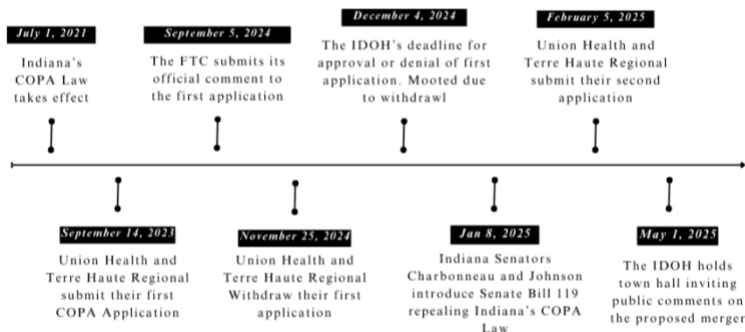
63. S.C. Code Ann. § 44-7-570 (2024).

64. See Zack Cooper, *Public Comment to the Indiana Department of Health Regarding the Certificate of Public Advantage Application of Union Health and Terre Haute Regional Hospital*, YALE TOBIN CTR. OF ECON. POL’Y (Mar. 21, 2025), https://tobin.yale.edu/sites/default/files/2025-03/20250321_public_comment.pdf [https://perma.cc/Y9D9-DKSN].

65. *Id.* at 1.

66. *Id.* at 2.

E. Timeline of Key Events



Although IDOH was to approve or deny the application by June 21, 2025, that deadline was extended to November 9, 2025, on which date the IDOH ultimately approved the merger.⁶⁷

III. ANALYSIS

Indiana healthcare costs are currently the eighth highest in the United States.⁶⁸ As highlighted above, COPA law mergers often lead to higher healthcare costs for patients, especially when not under state oversight and when competition becomes extremely scarce to nonexistent. This analysis will cover the language of Indiana's COPA statute, the hospitals' initial application and their communications with the IDOH, the FTC's and local responses to the proposed merger, the withdrawal of the initial application and Senate Bill 119, the effect of state law in light of federal preemption, the potential for a circuit split and possible outcomes in higher courts, application of the *Holcomb* framework, and, finally, why it is crucial for healthcare to remain affordable in Vigo County.

A. The Language of Indiana's COPA Statute

If the IDOH approves the hospitals' final application and the hospitals merge close to the sunset provision date of July 1, 2026, they may never be

67. *The decision On Merger Between Union & Regional Delayed*, WVIG THE LEGEND, (Jun. 20, 2025), <https://www.wvigthelegend.com/2025/06/20/the-decision-on-merger-between-union-regional-delayed/> [<https://perma.cc/A8Q5-R5WC>]; Casey Smith, *Indiana approves Terre Haute hospital merger despite competition concerns*, IND. CAP. CHRON. (Nov. 11, 2025 7:00 AM), <https://indianacapitalchronicle.com/2025/11/11/indiana-approves-terre-haute-hospital-merger-despite-competition-concerns/> [<https://perma.cc/WW9H-SGY9>].

68. Whitney Downard, *Indiana hospital prices 8th-highest in nation, study finds, but hospitals dismiss analysis*, IND. CAP. CHRON. (May 14, 2024 7:00 AM), <https://indianacapitalchronicle.com/2024/05/14/indiana-hospital-prices-8th-highest-in-nation-study-finds-but-hospitals-dismiss-analysis/> [<https://perma.cc/6XSC-YAA2>].

subject to oversight. This defeats the original purpose of the statute and any protections the statute lays out for consumers are made a nullity. Regardless of the narrowing window of time, strict county qualifications preclude any other facilities from qualifying under COPA. The statute expires after five years, and regulatory oversight expires shortly before the statute expires entirely. The statute contains tightly controlled provisions that pave the road to merging in a single county with a single merger target and with very little oversight and regulation set to expire soon.

B. Union Health and Terre Haute Regional's Initial Application

Union Health and Terre Haute Regional submitted their first application under the COPA law on September 14, 2023.⁶⁹ While this application was withdrawn and a new application was submitted, this initial application remains worth analyzing, as some of the statements between the two applications vary.

In the initial application, the hospitals address the anticipated staff reduction and couch the reduction in terms of employees “wish[ing] to seek other employment opportunities.”⁷⁰ The hospitals appear cognizant of the fact that it is very likely that employees will need to seek employment elsewhere. They provide examples such as competing healthcare facilities, critical access hospitals in other counties, home healthcare and hospice agencies, and private practices.⁷¹ If employees wish to remain employed in Vigo County, they can also seek employment at a new battery component manufacturer as well as a casino resort which will be hiring residents of Vigo County.⁷²

As to how the workplace may change for employees, the hospitals include a table of employee initiatives in the application.⁷³ The table lists items such as employee wellness screenings, health advocate coaches, and a weight loss clinic.⁷⁴ However, neither the table, nor the application as a whole, provides how the merger will affect employee salaries. This is a crucial part of employee retention.

The application seems to downplay the inevitable profitability that the proposed merger would bring. It states that “substantially reducing operating costs is not a primary goal of the Merger;” however, because costs to the hospitals will certainly be reduced, this “should not be interpreted as disregard for the health care costs paid by the residents of Vigo County.”⁷⁵ The hospitals also claim that the “Post-Merger Initiatives implemented by [Union Health] will reduce health care costs, will improve the quality of care provided by the

69. See *September 2023 Application*, *supra* note 28.

70. *Id.* at 8.

71. See *id.* at 9.

72. *Id.*

73. *Id.* at 469 (citing page 1 of appended document “Enhanced Population Health Services-Initiatives”).

74. *Id.*

75. *Id.* at 19.

Combined Clinical Platform, and will significantly improve the health status of the residents of Vigo County . . .”⁷⁶

Economist Milton Friedman famously said that the primary responsibility of a business is to maximize profits for shareholders, and that businesses should not engage in socially responsible activities unless they directly benefit the company’s profits, as doing so would essentially be spending other people’s money without their consent.⁷⁷ Friedman has been criticized for this position. Many companies attempt to distance themselves from Friedman and follow the concept of corporate social responsibility (“CSR”).⁷⁸ This trend is driven in part by consumer awareness influencing purchasing decisions.⁷⁹

It is important to question the true nature of the motivation for this merger. By downplaying the topic of profits as much as the application does (there is no forecast of future profits in the publicly available documents), one can wonder if that is not the true driver of seeking the merger. While Friedman’s view is unpopular and even immoral to some economists, it is still worth considering the true motives of the only two hospitals in one county seeking to merge. The hospitals can argue that it is socially responsible to merge in order to provide better healthcare to the citizens of Vigo County; however, given the historic trend in other states where COPA-related mergers occurred under similar conditions as Vigo County’s, costs to patients will likely rise, profits will substantially increase, and competition will be eliminated. Especially because Indiana’s COPA law limits oversight. Avoiding antitrust should carry a heavy burden, particularly for COPA laws which historically harm the consumer and employees.

In its official comment to the proposed merger, the FTC notes that both hospitals are financially stable.⁸⁰ Terre Haute Regional is part of the HCA Healthcare network of hospitals, which is the largest and most profitable of all health systems in the United States, with net patient revenues nationally of over \$51 billion in the most recent twelve months tracked by Definitive Healthcare,

76. *Id.*

77. Milton Friedman, *A Friedman doctrine-- The Social Responsibility of Business Is to Increase Its Profits*, N.Y. TIMES (Sept. 13, 1970), <https://www.nytimes.com/1970/09/13/archives/a-friedman-doctrine-the-social-responsibility-of-business-is-to.html> [https://perma.cc/LA2J-NJ9Q]; see also Brian P. Schaefer, *Shareholders and Social Responsibility*, 81 J. OF BUS. ETHICS 297, 297 (2008) (on file with author).

78. Hildegunn Mellesmo Aslaksen, Clare Hildebrandt & Hans Chr. Garmann Johnsen, *The long-term transformation of the concept of CSR: towards a more comprehensive emphasis on sustainability*, 6 INT’L J. CORP. SOC. RESP. 1, 3 (2021).

79. Jennifer Dublino, *Can You Make a Profit and Be Socially Responsible?*, BUSINESS.COM, (Jul. 3, 2023), <https://www.business.com/articles/can-you-make-a-profit-and-be-socially-responsible/> [https://perma.cc/7CZX-JTCC].

80. *Staff Submission to Indiana Health Department Regarding the COPA Application of Union Health and Terre Haute Regional Hospital*, FED. TRADE COMM’N, at 10, <https://www.ftc.gov/legal-library/browse/advocacy-filings/staff-submission-indiana-health-department-regarding-copa-application-union-health-terre-haute> [https://perma.cc/H3NR-PLJL] [hereinafter *Staff Submission*].

a data analytics company.⁸¹ Terre Haute Regional very likely has the wherewithal to fill alleged gaps in healthcare services without skirting antitrust laws and quashing its only competition.

C. Responses to the Indiana Department of Health's Request for Interrogatories

The IDOH submitted requests for interrogatories (“FR12”) from the hospitals.⁸² In RFI2, the IDOH requested input on the consequences of granting the COPA and denying the COPA.⁸³ The hospitals exhibit, “Attachment O,” states that granting the COPA provides benefits in “Access, Quality and Safety, Patient Experience and Service Continuity, Pricing, and Efficiency.”⁸⁴ “Attachment P,” which states the effects of denying the COPA, is not available publicly in either PDF file of requests and responses.

D. The Federal Trade Commission's Response to the First COPA Application

The FTC responded to the Union Health and Terre Haute Regional's COPA application through an official comment on September 5, 2024.⁸⁵ As stated above, it is in the FTC's power to prevent methods of unfair competition under the Federal Trade Commission Act.⁸⁶ Its response highlights concerns about the effect the COPA would have on consumers, especially concerning healthcare costs, quality of care, innovation reduction, reduced access to care, and lower wages for hospital employees.⁸⁷

Moreover, the FTC's comment emphasizes the importance of competition in any market, as well as the dangers of a possible monopoly and how monopolies harm consumers, stating that “mergers resulting in a combined share of 30% or more are presumptively unlawful under the antitrust laws.”⁸⁸

81. *Top IDNs by net patient revenue*, DEFINITIVE HEALTHCARE (Jul. 18, 2025), <https://www.definitivehc.com/resources/healthcare-insights/top-idns-by-net-patient-revenue#:~:text=The%20top%20IDN%20in%20the,the%20number%20of%20staffed%20beds> [https://perma.cc/G9Q3-CNNM].

82. *Applicants' Responses to the Second Request for Information*, IN.GOV 1, <https://www.in.gov/health/cshcr/files/RFI-2-Initial-Response.pdf> [https://perma.cc/M7W6-UJ5P] (last visited Jan. 5, 2026).

83. *Union Hospital Inc.'s Subsequent Submission for the Department of Health's Second Request for Information*, IN.GOV 68, <https://secure.in.gov/health/cshcr/files/RFI-2-Subsequent-Submission-.pdf> [https://perma.cc/2GM8-JFNW] (last visited Jan. 5, 2026).

84. *Union Hospital Inc.'s Subsequent Submission for the Department of Health's Second Request for Information* 68, IN.GOV, <https://www.in.gov/health/cshcr/certificate-of-public-advantage/pendingapproved-copas/> [https://perma.cc/2GM8-JFNW].

85. *See Staff Submission*, *supra* note 80, at 1.

86. 15 U.S.C. §§ 41–58.

87. *See Staff Submission*, *supra* note 80, at 1.

88. *Id.* at 3; *see also Competition And Monopoly: Single-Firm Conduct Under Section 2 Of The Sherman Act: Chapter 2*, U.S. DEPT. OF JUSTICE, <https://www.justice.gov/archives/atr/>

The merger between Union Health and Terre Haute Regional would result in a combined share of nearly 74% of commercially insured inpatient hospital services.⁸⁹ This should sound alarms. Some Vigo County residents may have to travel or incur significant medical death if their health insurance does not cover care at the merged hospital.

The comment also points out that both hospitals are financially stable enough to continue operation without the proposed merger.⁹⁰ The hospitals can frame this to bolster their argument that they are financially stable enough to be both pro-patient and pro-employee; however, there are many ways that patients and employees will actually be worse off now that the IDOH has approved the application for merger. The merger will “eliminate competition between the two parties to hire employees.”⁹¹ Additionally, “the proposed merger [may] give the combined hospital system increased bargaining leverage with insurers to negotiate significantly higher reimbursement rates, because insurers would no longer be able to credibly threaten (either implicitly or explicitly) to temporarily terminate one competitor from in-network status during negotiations.”⁹² This is why the sunset provision in the statute is important: while the hospitals’ application states they intend to avoid increased healthcare costs for patients, and is silent on whether employee wages will be lowered, this oversight has an expiration date after which they can engage in practices, including monopolistic ones, which are most profitable for the hospital, even if that means higher costs to patients, lower wages for employees, and, in turn, compromised quality of care for patients.

The sunset provision is also crucial when taking into account price increases from hospital mergers that were COPA-related in other states. Every example provided by the FTC illustrates that merged hospitals drastically increased prices once the COPA in the state expired.⁹³ The notable exception to this is South Carolina, whose oversight never expired. The COPA in Indiana, including oversight, will expire shortly after the merger.

Terre Haute Regional paid just over \$500,000 in county taxes for 2023.⁹⁴ “This revenue could be lost if [Terre Haute Regional] is acquired by Union Health, a non-profit hospital that is exempt from paying taxes.”⁹⁵ While taxes are not a traditional antitrust concern, the economic impact of losing one of the county’s major tax-paying businesses could be detrimental. It is worth

competition-and-monopoly-single-firm-conduct-under-section-2-sherman-act-chapter-2#:~:text=Monopoly%20power%20entails%20both%20greater,the%20existence%20of%20monopoly%20power. [https://perma.cc/G57F-383V]. There is no hardline rule for the threshold of what percentage of the market share indicates a monopoly. Some courts say at or above 50% is a violation. Either way, 74% would be an absolute violation in the Federal Court system.

89. See *Staff Submission*, *supra* note 80, at 3.

90. *Id.* at 10.

91. *Id.* at 54.

92. *Id.* at 34.

93. See FED. TRADE COMM’N, *supra* note 50, at 7–9; see *supra* Part II.

94. *Id.* at 65.

95. *Id.* at 65.

considering this amount of loss in taxpayer dollars, especially coupled with the possible effects of the merger to patients and employees in a small community like Vigo County. When Vigo County loses this tax revenue, its citizens could experience an increase in taxes and health care costs, and a decrease in wages.

This merger is also not in the antitrust safety zone laid out by the FTC and DOJ Enforcement Policy.⁹⁶ The two hospitals have neither an average of fewer than 100 licensed beds over the three most recent years, nor an average daily inpatient census of fewer than forty patients over the three most recent years that the FTC and DOJ zone of safety lays out.⁹⁷ Union Health is licensed for 341 beds⁹⁸ and Terre Haute Regional is licensed for 278 beds,⁹⁹ and neither hospital has an inpatient census of fewer than forty patients.¹⁰⁰

E. Local Responses to the Proposed Merger

While the FTC remains avidly against COPA-related mergers, local responses to the COPA are mixed. Some community members express concern over the impact the merger would have on healthcare access and costs, while others view it as a necessary measure for hospital sustainability.

IndyStar article authors Gloria Sachdev and Zack Cooper point out that hospital monopolies result in higher prices.¹⁰¹ They predict that residents of Vigo County would see a 10% or more increase in the cost of healthcare, a 7% cut in nurses' pay, and about 500 jobs lost as a result of the merger.¹⁰² "Not all hospital mergers are bad; however, when close competitors merge, a large body of research shows that prices increase."¹⁰³

Conversely, local proponents of the Vigo County COPA merger insist that the existing competition between the two hospitals is not benefiting the community, and that the merger would overcome persistent health disparities.¹⁰⁴ Proponents also claim the merger will result in economies of scale that will create access to new, more affordable expertise and resources that enhance the quality of care.¹⁰⁵

While the local proponents raise a fair point, their argument is unpersuasive.

96. See U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 48, at 8.

97. *Id.* at 8–9.

98. See FED. TRADE COMM'N, *supra* note 50, at 5.

99. *Id.* at 6.

100. *Id.* at 15.

101. Gloria Sachdev & Zack Cooper, *Opinion: Terre Haute hospital merger would raise health care costs in Vigo County*, INDYSTAR, <https://www.indystar.com/story/opinion/2024/10/22/union-health-terre-haute-regional-merger-raise-prices/75775348007/> [<https://perma.cc/7J4A-ALXW>] (last updated Oct. 24, 2024).

102. *Id.*

103. *Id.*

104. Steve Holman, *Terre Haute hospital merger would improve Wabash Valley health care*, INDYSTAR, <https://www.indystar.com/story/opinion/readers/2024/09/09/union-health-terre-haute-regional-hospital-merger-health-care/75105398007/> [<https://perma.cc/SJ69-8MZW>] (last updated Mar. 2, 2025).

105. *Id.*

Historical evidence from COPA mergers in other states strongly contradicts the expectation of cost efficiency; once state oversight lapses, anticipated cost savings often fail to materialize. Instead, healthcare costs often significantly increase due to diminished competition and inefficiencies that arise from market consolidation. These examples underscore that relying solely on the assumption of cost efficiency, without robust and ongoing regulatory mechanisms, is both speculative and unsupported by real-world outcomes.

The IDOH held a town hall regarding the merger on May 1, 2025. The Mayor of Terre Haute, Brandon Sakbun, initially opposed the proposed merger in its early stages, but now supports it.¹⁰⁶ Mayor Sakbun stated that “based off of *that* data, based off of *those* numbers, and based off of the unfortunate reality that my options are to support a decision to keep jobs here or to not support and have a chance of jobs leaving.”¹⁰⁷ It is unclear what data and numbers he was referring to. The mayor’s allegations would directly conflict with Professor Cooper’s conflation regarding job loss.

Union Health and Terre Haute Regional employees spoke out at the town hall as well.¹⁰⁸ The employees were either actively against the merger, or indifferent.¹⁰⁹ Employees that were against the merger expressed fear for the state of their employment at their respective hospitals.¹¹⁰ Although there were signs of indifference from some of the speakers, none of the employees that spoke at the town hall expressed support for the merger.¹¹¹

F. Withdrawal, FTC Response, and the Future of Indiana’s COPA Law

On November 25, 2024, Union Health and Terre Haute Regional withdrew their September 2024 application.¹¹² Union Health’s statement regarding the withdrawal states that the hospitals wanted to “continue to work with IDOH, to ensure the benefits, including improved access, quality, prevention and early intervention, are outlined in the new application.”¹¹³ The withdrawal suggests the hospitals’ had serious concerns that they faced denial.

In its statement about the withdrawal, the director of the FTC’s Office of Policy Planning is quoted saying the withdrawal is “good news for patients and

106. Cole Nobbe, *Local residents voice opinion on hospital merger*, MYWABASHVALLEY (May 1, 2025), <https://www.mywabashvalley.com/news/local-news/local-residents-voice-opinion-on-hospital-merger/> [<https://perma.cc/MJJ8-P5C2>].

107. *Id.* (emphasis added)

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. Liss, *supra* note 30.

113. *Union Health COPA Application Update*, UNION HEALTH (Nov. 25, 2024), <https://www.union.health/news/unionhealthcopaapplicationupdate> [<https://perma.cc/G8WH-T4LX>] (referring to archived information accessed via permalink).

healthcare workers in Indiana's Wabash Valley region.”¹¹⁴ The statement implies that the IDOH is taking the application seriously and is carefully considering the application, the FTC's official comment, and the 360 other unique comments that the IDOH received.¹¹⁵ The FTC maintains its strong opposition to anticompetitive hospital mergers, including those involving COPA agreements.¹¹⁶

On January 8, 2025, Indiana Senators Ed Charbonneau and Tyler Johnson introduced Senate Bill 119 to repeal, and which ultimately amended, the state's COPA law.¹¹⁷ Senator Charbonneau, who chairs the Senate health committee, helped create the COPA law in 2021.¹¹⁸ Senator Charbonneau admitted that he “didn't think [he] was doing 100% the right thing last time,” but now believes repealing the COPA law is the right decision.¹¹⁹

The withdrawal and proposed amendment to the COPA law was not the death knell for the Vigo County hospitals' merger attempt, but rather a strategic pivot to meet a rapidly shifting legislative deadline. Originally, hospitals had until July 1, 2026, to secure COPA approval. Senate Bill 119 amended that timeline twice: first moving the deadline to July 1, 2025, and then extending it slightly to November 9, 2025. As a result, Union Health and Terre Haute Regional faced a significantly shortened window to obtain approval. The compressed timeline created a race against time; any delay would have left the hospitals without the regulatory shield that COPA status provides. Given the FTC's strong stance against COPA-related mergers and those resulting in a market share exceeding 30%, the accelerated deadlines could have jeopardized the partnership before it begun.¹²⁰ However, because the hospitals submitted a new application before the deadline, the amendment did not prevent them from continuing their efforts to merge.

G. Union Health and Terre Haute Regional's Second Application

The two hospitals submitted a second application on February 5, 2025.¹²¹ The timing of the withdrawal of the first application November 24, 2024, and the filing of the second on February 5, 2025, were mere days after the November

114. *Statement Regarding Union Health's COPA Application Withdrawal*, FED. TRADE COMM'N (Nov. 26, 2024), <https://www.ftc.gov/news-events/news/press-releases/2024/11/statement-regarding-union-healths-copa-application-withdrawal> [<https://perma.cc/A2VT-AGDP>].

115. *Id.*

116. *Id.*

117. S.B. 119, 124th Gen. Assemb., Reg. Sess. (Ind. 2025).

118. Samantha Liss, *Indiana State Senator Moves To Scrap Hospital Monopoly Law He Helped Create*, KFF HEALTH NEWS (Jan. 8, 2025), <https://kffhealthnews.org/news/article/indiana-copa-state-senate-legislation-repeal-hospital-merger-monopoly/> [<https://perma.cc/D43T-AQYW>].

119. *Id.*

120. See U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 48.

121. *February 2025 Application*, *supra* note 31.

5, 2024 Presidential election, and likely a result of an impending change in FTC leadership.

The FTC's submission to the first application is dated September 5, 2024. The position of the FTC was to vigorously oppose the proposed merger. The hospitals may have decided that with a change of guard at FTC, they would be in a better position to reboot the whole process.

On January 20, 2025, Andrew N. Ferguson, a former FTC Commissioner, was sworn in as the new FTC Chairman.¹²² Sixteen days later, on February 5, 2025, the hospitals submitted the second application.

According to the NY Times Deal Book Newsletter, the appointment of Ferguson "validates the view of corporate deal makers that a second Trump administration would be good for [mergers and acquisitions], after [former FTC Chair Lina] Khan challenged big takeovers to help shift antitrust case law."¹²³

The second application, as expected, reiterates many of the same points as the first application. The second application, however, adds an attempt to convince the IDOH that the merger would enhance competition "at the State and regional level by facilitating the entrance of a new, lower-cost regional provider to the Indiana hospital market."¹²⁴ The relevant points from the new application to this note are how the hospitals plan to address employee retention and healthcare costs to patients. The second application also seeks to bolster the argument by citing recent case law relating to an abandoned hospital merger in North Carolina.¹²⁵

When it comes to employment, the second application provides an "Analysis of the effects (both positive and negative) of the proposed merger agreement on: Employment, the healthcare workforce, recruiting and retention."¹²⁶ The analysis immediately states that the hospitals "do not anticipate any negative impacts on employment or the healthcare workforce as a result of the Merger."¹²⁷ Their second application backpedals on their position in the first application about post-merger opportunities of current employees. The section relating to employment in the second application makes the following "commitments" to current and potential employees:

1. Union Hospital or an Affiliate will offer employment to all employees who are employed by Regional Hospital and Regional Healthcare Partners at the time of the Merger.¹²⁸

122. Press Release, Fed. Trade Comm'n, *Andrew N. Ferguson Takes Over as FTC Chairman*, (Jan. 22, 2025), <https://www.ftc.gov/news-events/news/press-releases/2025/01/andrew-n-ferguson-takes-over-ftc-chairman> [<https://perma.cc/P2B6-VK9A>].

123. Andrew Ross Sorkin, et al., *The F.T.C.'s Next, More Deal-Friendly Leader*, N.Y. TIMES (Dec. 11, 2024), <https://www.nytimes.com/2024/12/11/business/dealbook/ftc-trump-ferguson-khan.html> [<https://perma.cc/5US7-UFSR>] (on file with author).

124. *February 2025 Application*, *supra* note 31, at 14.

125. *Id.* at 51.

126. *Id.* at 91.

127. *Id.*

128. *Id.* at 92.

2. Union Hospital or an Affiliate will offer employment to Regional Hospital and Regional Healthcare Partners employees at salary and hourly wage levels that are the same as, or better than, Regional Hospital and Regional Healthcare Partners levels.¹²⁹
3. Union Hospital or an Affiliate will honor full credit for paid time off balances of Regional Hospital and Regional Healthcare Partners employees who transition to employment by Union Hospital or an Affiliate.¹³⁰
4. Union Hospital will conduct annual employee and physician satisfaction surveys to help reduce turnover and improve retention of employees of the Combined Enterprise, and will report the results in each Annual Report.¹³¹
5. Union Hospital will invest at least \$6,900,000 in Graduate Medical Education each year during the first five years of the Merger.¹³²

These commitments are vastly different from the first application's suggestion that affected employees seek employment at a new battery component manufacturer or a casino resort hiring residents of Vigo County.¹³³

Each commitment is supplemented with an “accountability mechanism” intended to assure that the hospitals will fulfill their promises. While these commitments may provide reassurance to current employees and potentially influence the IDOH's decision on the application, their true impact is questionable given that oversight expires shortly after the proposed merger is implemented. The so-called accountability mechanisms merely require that commitments be mentioned in an annual report, but, without oversight, who will verify their inclusion? More importantly, who will enforce compliance if the promises are not upheld?

The second application further asserts that healthcare service prices will not be negatively impacted by the merger.¹³⁴ However, the post-merger impact on costs to patients is inconsistent throughout the application. First, it states that reducing operation costs—and, by extension, patient costs—is “not a primary goal of the merger.”¹³⁵ Yet, it later promises that, while not a primary goal, “the Post-Merger Initiatives implemented by Union Hospital will reduce health care costs, will improve the quality of care provided by the Combined Clinical Platform, and will significantly improve the health status of the residents of Vigo County and the other counties of the Service Area.”¹³⁶ Although this may be what the IDOH needs to hear, the FTC's historical analysis on COPA laws

129. *Id.* at 93.

130. *Id.*

131. *Id.*

132. *Id.* at 94.

133. *September 2023 Application*, *supra* note 28, at 9.

134. *February 2025 Application*, *supra* note 31, at 14.

135. *Id.* at 36.

136. *Id.*

predicts a very different outcome.

It is difficult to reconcile an outlay of \$34.5 million over five years for medical education and retainment of employees, while at the same time lowering costs to patients after the merger. From a financial standpoint, retaining all employees after a merger ignores the economies of scale inherent to a merger, and offers little credibility to an argument that there are economic savings to be passed on to the patients.

Ensuring that the hospitals uphold these promises requires ongoing oversight. Unfortunately, that oversight is set to expire quickly under Indiana's COPA law. Ultimately, while the hospitals pledge to lower costs through specific initiatives, there will be no method of enforcement once the merger is complete.

Finally, the hospitals bring up recent case law about a non-COPA proposed merger in North Carolina. The application states:

In *FTC v. Novant Health, Inc.*, the district court denied the FTC's request for a preliminary injunction to prevent Novant's acquisition of two competitor hospitals from CHS under similar circumstances. In that case, one of the target hospitals was at risk of imminent closure and the other had already discontinued key services. Although one target hospital was profitable "for now," the court held that because at most it could only hope to maintain its already limited competitive position for a short time, "the proposed merger carries at least as much likelihood of competitive benefits as it does competitive harm and the FTC is unlikely to ultimately be successful in proving that the transaction may 'substantially lessen competition.'"

Although the transaction was ultimately abandoned after the Fourth Circuit granted the FTC an emergency injunction pending its appeal of the district court's decision, the district court's competitive analysis still resonates. There are many close parallels between the challenges the seller (CHS) faced in that case and Regional Hospital's present situation. The court reasoned that the target hospital's competitive problems were "real" because they related broadly to the seller's belief that the hospital lacked a sufficient physician practice network and other access points of care to justify investments. And like Regional Hospital, these problems predated the decision to sell the hospital. The court found that under these circumstances the public interest favored allowing the merger to proceed rather than risk the loss of services from the community. The same is true in *Terre Haute*.¹³⁷

The competitive analysis in *Novant* is case-specific and lacks broader

137. *Id.* at 55 (citing *Fed. Trade Comm'n v. Cmty. Health Sys., Inc.*, 736 F. Supp. 3d 335 (W.D.N.C. 2024), *opinion vacated, appeal dismissed sub nom.*, *Fed. Trade Comm'n v. Novant Health, Inc.*, 2024 WL 3561941 (4th Cir. July 24, 2024)).

applicability. It pertains to Novant Health, Inc.’s proposed acquisition of two hospitals from Community Health System, a distinct transaction with its own market dynamics. Moreover, the analysis holds no precedential value in this context. The case was litigated in federal court, appealed to the Fourth Circuit, and voluntarily dismissed, whereas Indiana falls within the jurisdiction of the Seventh Circuit. As a result, any legal or economic analyses drawn from that case are not binding and have little applicability to the present merger.¹³⁸

Shortly after Union Health submitted the second application and opponents displayed pushback, HCA Healthcare, which owns Terre Haute Regional, stated that if the IDOH denied the application, “market conditions are such that HCA [would] need to seriously consider ending services or closing the hospital.”¹³⁹ This is a precarious argument. As previously noted, HCA is the largest and most profitable health system in the United States. Issuing such a statement and threatening closure if the application were denied appears to be a calculated tactic to pressure the IDOH into approving the application, disregarding the concerns of current patients, potential patients, and employees.

H. The Indiana Attorney General’s Opposition

On April 17, 2025, Indiana’s Attorney General, Todd Rokita, provided his opinion and recommendation on the merger in an official statement.¹⁴⁰ The Attorney General stated that “consolidation at the expense of free-market competition is not the way to address...” challenges that hospitals often face.¹⁴¹ Rokita ultimately recommended that the IDOH deny the COPA re-application.¹⁴²

Attorney General Rokita also expressed that approval of the COPA merger would “lead to the monopolization of Terre Haute hospital systems that (would) be unchecked in raising healthcare costs, stifling innovation, suppressing wages, and reducing access to care for the citizens of Terre Haute and the surrounding community.”¹⁴³

The letter from Attorney General Rokita continues by pointing out the importance of competition that “fosters efficiency, ingenuity, and technological

138. *See* U.S. v. Articles of Drug Consisting of 203 Paper Bags, 818 F.2d 569, 572 (7th Cir. 1987) (stating that “[a] single district court decision...has little precedential effect. It is not binding on the circuit, or even on other district judges in the same district.”).

139. Ron Southwick, *As proposed Indiana hospital merger faces opposition, a warning of a closure without a deal*, CHIEF HEALTHCARE EXEC. (May 23, 2025), <https://www.chiefhealthcareexecutive.com/view/as-proposed-indiana-hospital-merger-faces-opposition-a-warning-of-a-closure-without-a-deal> [https://perma.cc/S5T9-2MCC].

140. Letter from Attorney General Todd Rokita to the Indiana Department of Health 1 (Apr. 17, 2025), <https://image.subscription.in.gov/lib/fe2e11747364047b721071/m/1/19d30b17-7feb-46ca-838d-b6dbbea7afe6.pdf> [https://perma.cc/6WUN-GGKS].

141. *Id.*

142. *Id.*

143. *Id.*

advancement.”¹⁴⁴ Rokita cautioned that removing competitive pressure would erode these benefits, ultimately harming both the quality of care and the long-term sustainability of healthcare services in the region.¹⁴⁵

I. Effect of Ignoring Federal Preemption

COPA laws, like Indiana’s, by their nature are set up to avoid the scrutiny of federal antitrust laws. Adhering to federal antitrust laws must be weighed against the healthcare opportunities and overall benefits to the consumer that come from these COPA laws. Richard Squire states in his article that:

[I]n cases of conflict between state economic regulation and the Sherman Antitrust Act . . . the Court applies its doctrine of ‘state-action immunity,’ under which a state regulation is unenforceable only if it arises from or causes a ‘violation’ of the same federal antitrust rules that restrict the market conduct of private firms.¹⁴⁶

Indiana’s case is not merely about a company becoming a monopoly, it is about a company seemingly attempting to become a monopoly with the help of the State’s law, which circumvents existing federal laws enacted to prevent monopolies. The federal antitrust laws were put in place for the specific purpose of protecting consumers and employees. States have gotten around the doctrine of federal preemption with the ruling in the 1943 decision *Parker v. Brown*.¹⁴⁷ In *Parker*, the Supreme Court stated that “[t]he Sherman Act makes no mention of the state as such, and gives no hint that it was intended to restrain state action or official action directed by a state.”¹⁴⁸

The 74% market share resulting from the merger of Union Health and Terre Haute Regional would certainly violate the Sherman Act, as it exceeds the 30% threshold that the FTC provides for presumption of an unlawful merger. If not for Indiana’s COPA law backed by the *Parker* case, these hospitals would never be permitted to merge. When companies need to lobby the state legislature to allow a merger that otherwise would be federally illegal, good policy guidelines should require them to present strong support for a social benefit that outweighs the waiver. The paucity of regulation in this case argues against merger.

J. Existing Case Law, Potential for a Circuit Split, and Supreme Court Involvement

The FTC has litigated COPA laws in other states. In *Louisiana Children’s Med. Ctr. v. Att’y Gen. of United States*, the District Court held that Louisiana’s

144. *Id.* at 2.

145. *Id.* at 4.

146. Richard Squire, *Antitrust and the Supremacy Clause*, 59 STAN. L. REV. 77, 78 (2006).

147. *Parker v. Brown*, 317 U.S. 341 (1943).

148. *Id.* at 351.

COPA law is valid and “that the Hospitals’ transaction [was] exempt from the federal antitrust laws and need not comply with Section 7A [of the Clayton Act]’s requirements.”¹⁴⁹ The Court found that under the State Action Doctrine, “Congress does ‘not intend to compromise the States’ ability to regulate their domestic commerce’ absent a clear statement to the contrary.”¹⁵⁰ The Court further quotes the Supreme Court in *Parker* which states that “the Sherman Act by its terms applied to ‘[e]very person,’ ... the State of California did not qualify as a ‘person’ absent a clear statement of Congress’s intent to reach states”¹⁵¹

If COPA laws are challenged by the FTC, any appeal to the United States Supreme Court could be detrimental to consumers across the United States. It is well known that the current Supreme Court leans toward curtailing administrative power.¹⁵² Depending on the outcome of such a decision, more states could easily enact COPA laws with similar sunset provisions and healthcare costs could increase severely across the country. This could also create opportunities for states to pass laws that circumvent federal antitrust scrutiny in other markets, potentially leading to higher prices for essential goods and services.

K. Applying the Framework from Holcomb

Even if Indiana’s COPA law is not preempted by the federal antitrust laws because of *Parker*, or the State Action Doctrine, Indiana’s COPA statute may violate Indiana’s State Constitution prohibiting special legislation. The framework from *Holcomb* should be applied to this case.

Like the controversial statute in *Holcomb*, which targeted only the city of Bloomington, Indiana’s COPA law is clearly a special law because it targets only Vigo County, and only the proposed merger in question.

The next step in the *Holcomb* framework is assessing whether the special law is permissible: a strong argument against permissibility is that there are no unique characteristics or circumstances about the affected class, which includes residents of Vigo County or the two hospitals, that warrant special treatment for these parties.

As Long states in his article, special legislation is prohibited in many states to prevent exactly what Indiana’s COPA law empowers: “domination by narrow economic elites.”¹⁵³ The merger between the Vigo County hospitals is not a lawful opportunity, but rather the product of exploiting a narrowly tailored statute that violates Indiana’s Constitution. If state departments, such as the

149. *Louisiana Children’s Med. Ctr. v. Att’y Gen. of United States*, No. CV 23-1305, 2023 WL 6293887 at 12 (E.D. La. Sept. 27, 2023).

150. *Id.* at 5 (quoting *S. Motor Carriers Rate Conf., Inc. v. United States*, 471 U.S. 48, 56 (1985)).

151. *Louisiana Children’s Med. Ctr.*, 2023 WL 6293887, at 5.

152. *See Loper Bright Enterprises v. Raimondo*, 603 US __ (2024) which removed the Chevron Deference Doctrine for which courts were required to defer to an agency’s reasonable interpretation of an ambiguous statute that the agency administered.

153. Long, *supra* note 18.

IDOH, or the judiciary overlook unconstitutional statutes, the legislature may push the boundaries further, resulting in the enactment of laws that are unconstitutional in even more respects. The *Holcomb* framework applies to the case in Vigo County and is likely a violation of Indiana's Constitution.

L. The IDOH's Determination and Its Implications

The IDOH approved the merger on November 9, 2025.¹⁵⁴ In its decision, the department admitted that the merger would be anticompetitive and “result in a monopoly for inpatient acute care services in Vigo County.”¹⁵⁵ The department provided conditions in an attempt to ensure that the public benefits and harm from reduced competition is avoided.¹⁵⁶ The hospital must follow commitments to maintain or improve quality, keep average pricing below 265% of Medicare rates, get permission before raising hospital-based service charges, ensure that care remains accessible to Vigo County residents, and protect employment of staff.¹⁵⁷ However, the major concerns surrounding violations of federal antitrust law, violations of Indiana Constitutional law, and lack of oversight remain.

The IDOH's determination itself acknowledges that the merger is anticompetitive and would result in a monopoly. By approving the merger under these conditions, the Department appears to have accepted conduct that would otherwise violate federal antitrust laws, relying instead on the COPA framework to justify it. Although one of the original concerns surrounding Indiana's COPA statute was that active supervision might rarely occur in practice, the Department's approval permits the hospital to terminate oversight after only five years. Given the long lifespan of a hospital, a five-year term is brief, and the underlying competitive and consumer protection concerns will persist long after oversight expires.

M. Healthcare Must Remain Affordable in Vigo County

Vigo County is a vulnerable community where maintaining affordable healthcare is essential. In 2022, the county faced significant challenges: the poverty rate was 20%, only 48,800 residents out of the total population of 106,355 were employed, and the median household income was just under \$53,000,¹⁵⁸ which is substantially lower than the United States median

154. *Determination: Application for Certificate of Public Advantage, Union Hospital, Inc. and Terre Haute Regional Hospital, L.P.*, IND. DEPT. OF HEALTH (Nov. 9, 2025), <https://www.in.gov/health/cshcr/files/COPA.Determination.2025.pdf> [<https://perma.cc/P2JA-AVDU>] (last visited Jan. 5, 2026).

155. *Id.* at 2.

156. *Id.* at 3.

157. *Id.* at 5–13.

158. *Vigo County, IN*, DATA USA, <https://datausa.io/profile/geo/vigo-county-in?redirect=true#:~:text=In%202022%2C%20the%20median%20household,previous%20year's%20value%20of%20%2448%2C552> [<https://perma.cc/RV92-UJ4J>] (last visited Dec. 18, 2025).

household income of \$77,540 in the same year.¹⁵⁹

Vigo County residents will strongly feel the financial effects of increased healthcare prices, and a greater tax burden to make up for any shortfall resulting from the merger. Union Health and Terre Haute Regional are two of the county's largest employers, providing jobs for a combined 2,779 Terre Haute residents.¹⁶⁰ Where the COPA application provides alternative places of work, which some are completely unrelated to healthcare, it is likely suggesting that this merger will cost many of these employees their jobs.

Ultimately, the merger poses a triple threat to Vigo County: increased healthcare costs for a financially vulnerable population, potential job losses that could further strain the local economy, and reduced tax revenue from the non-profit status of merged hospitals. These concerns underscore the importance of carefully scrutinizing the long-term economic and social impact of proposed consolidations.

IV. CONCLUSION

To best protect patients, the merger should be blocked through the courts under the Sherman Act, the Clayton Act, the Federal Trade Commission Act, Article 4 of Indiana's Constitution, and the *Holcomb* case, or the agreed COPA terms should be amended to eliminate the sunset provision and guarantee ongoing oversight. As seen in the FTC's list of states that had COPA-related mergers occur, the only hospital that merged and *did not* drastically increase prices was one hospital in South Carolina, where the COPA never expired and legislative oversight on the hospital remained.

The only other hospital on the FTC's list, which had prices consistent with competitors, was the merger in Maine. This was due to remaining competition in the area; Vigo County does not have such competition because the hospitals involved in the merger are the only two hospitals in the county. It is true that some of the hospitals' initiatives will be successful; however, based on the effects consumers have faced in other states that have approved COPA mergers, Vigo County residents will likely be adversely affected financially and will be left with limited options for affordable healthcare.

The creators and proponents of Indiana's COPA law constructed a Trojan Horse to breach the walls of antitrust protections. With the application now approved, the FTC stands precariously close to taking on the role of Cassandra, warning fruitlessly of impending harm, which may or may not materialize.

159. *Median Household Income in the United States from 1967 to 2024*, STATISTA, <https://www.statista.com/statistics/200838/median-household-income-in-the-united-states/> [https://perma.cc/PGE9-BZYD] (last visited Feb. 26, 2026).

160. *Major Employers - by Number of Employees*, TERRE HAUTE ECON. DEV. CORP., <https://terrehauteedc.com/top-employers-terre-haute-vigo-county-indiana> [https://perma.cc/8YCG-Y526] (last visited Dec. 18, 2025) (referring to archived information accessed via permalink).

PRACTICING MEDICINE THROUGH PAPERWORK AND ALGORITHMS: HOW HEALTH INSURERS PROMOTE PATIENT HARM AND WHAT CONGRESS SHOULD DO ABOUT IT

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I. INTRODUCTION

For every American, except the wealthy, what care a health plan *will pay* for determines what care the patient *will receive*.¹ Care is not determined by the patient and her doctor, or by what is the most effective evidence-based intervention at that time. It is not even determined by what a *minimally competent* physician would do to avoid malpractice—the “generally accepted standard of care” (GASC)² developed by practicing clinicians and their non-profit medical and clinical societies.³

A health plan approves or denies care based on its own medical review standards or on standards purchased from another company; in many cases, that company is either a subsidiary of the plan or a for-profit, proprietary clinical-guideline developer.⁴ The committees that develop these proprietary guidelines may not include clinicians in active practice or in the specialty area of concern, and often, information about these committees and their process is not readily

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1. See Shameek Rakshit et al., *How Does Cost Affect Access to Healthcare?*, KFF HEALTH SYS. TRACKER (Jan. 12, 2024), <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/> [https://perma.cc/AHH7-GLCY] (According to the 2022 KFF National Health Interview Survey, 43% of adults reported they or a family member in their household postponed needed health care due to cost from being uninsured or underinsured).

2. Peter Moffett, M.D. & Gregory Moore, M.D., J.D., *The Standard of Care: Legal History and Definitions: the Bad and Good News*, 12 WEST J. EMERG. MED. 109, 111 (2011) (discussing The Modern Definition of Standard of Care: “That which a *minimally competent* physician would do under similar circumstances.” (emphasis added)).

3. Wit v. United Behav. Health, No. 14-CV-02346-JCS, 2019 WL 1033730, at *14–15 (N.D. Cal. Mar. 5, 2019) (defining generally accepted standards of care with references to several non-profit medical and clinical societies) (*aff’d* in part, *rev’d* in part, and *remanded*, 79 F.4th 1068, 1089-90 (9th Cir. 2023)).

4. *Id.* at *10; see *Clinical Guidelines*, UNITED HEALTHCARE, <https://www.uhcprovider.com/en/policies-protocols/clinical-guidelines.html#:~:text=UnitedHealthcare%20uses%20evidence%2Dbased%20clinical,not%20a%20guarantee%20of%20coverage> [https://perma.cc/BW67-5JW9] (last visited Oct. 21, 2025); see also *Clinical Editors*, MCG, <https://www.mcg.com/about/clinical-editors/> [https://perma.cc/H3TJ-FDZC] (last visited Oct. 21, 2025) (describing the role of MCG’s clinical editors in overseeing MCG’s care guidelines).

available to providers and patients alike.⁵ Further, unlike individual clinicians, no one involved in the design, implementation, or application of these care-determining guidelines has accountability or legal liability for wrongfully denying care and any damage it may cause to the patient. For most Americans, *coverage denied is likely care denied*.⁶

Since coverage largely determines access, why do health plans not use the available treatment standards from non-profit medical and clinical societies whose members are *practicing* clinicians, such as the American Academy of Pediatrics, the American Psychiatric Association, the American College of Emergency Physicians or the American College of Obstetrician-Gynecologists? Why reinvent the wheel? The short answer appears to be profit.⁷ The more detailed story involves the ways our insurer-focused health care industry rewards middlemen, consultants, and bloated corporate bureaucracies that have not added value, but cost an enormous amount.⁸ Since health insurers widely incorporated managed care procedures—such as prior authorization, medical necessity review, proprietary medical guidelines, utilization management systems, and pharmacy benefit managers—into their offerings to health plans of all funding types, health care costs have steadily increased while our population health has decreased, with many already disadvantaged communities feeling disproportionate effects.⁹

Why are health insurance companies and third-party administrators (TPAs) not held accountable for the real health and economic damages patients suffer when care is unjustifiably denied? When insurer clinical guidelines or coverage decisions fall below GASC, these denials cause a host of problems for patients and clinicians involving significant, sometimes irreparable, economic, physical

5. *Id.*; see also INST. OF MED., CLINICAL PRACTICE GUIDELINES WE CAN TRUST (Robin Graham et al. eds., The Nat'l Acad. Press, 2011). <https://www.nam.edu/cpgstandards> [<https://perma.cc/3H9H-YWUB>] (discusses issues with lack of transparency and conflicts of interest in the current system of clinical guideline development and recommends standards by which trustworthy guidelines should be developed and assessed).

6. Rakshit et al., *supra* note 1.

7. See Press Release, Letitia James, Attorney General, State of New York, Attorney General James Provides \$13.6 Million to Consumers Who Were Denied Mental Health Care Coverage (May 20, 2022), <https://ag.ny.gov/press-release/2022/attorney-general-james-provides-136-million-consumers-who-were-denied-mental> [<https://perma.cc/PA8J-A6ZE>]; see also T. Christian Miller et al., “Not Medically Necessary”: Inside the Company Helping America’s Biggest Health Insurers Deny Coverage for Care, PROPUBLICA (Oct. 23, 2024), <https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations> [<https://perma.cc/RQG5-LKKN>].

8. See William H. Shrank et al., *Waste in the US Health Care System: Estimated Costs and Potential Savings*, 332 JAMA 15, 1501–09 (Oct. 15, 2019) (discusses estimated cost of administrative complexity of \$265.6 billion compared to cost of “overtreatment” \$75.7 billion to \$101.2 billion.)

9. CHRISTI A. GRIMM, DEP’T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., OEI-09-19-00350, HIGH RATES OF PRIOR AUTHORIZATION DENIALS BY SOME PLANS AND LIMITED STATE OVERSIGHT RAISE CONCERNS ABOUT ACCESS TO CARE IN MEDICAID MANAGED CARE 2, 22 (July 2023), <https://oig.hhs.gov/oei/reports/OEI-09-19-00350.asp> [<https://perma.cc/78SE-EZYK>]

and mental harm.¹⁰

A. Thesis Statement

This Note argues Congress must act to pass federal legislation, modeled in part on the Jim Ramstad Model Legislation for States but expanded to include all health care funding sources.¹¹ This proposed legislation will ensure health plans of all types are rid of “discretionary clauses” so they are accountable and liable for medical review criteria and coverage decisions that fall below the GASC, just as practicing clinicians may be liable for *malpractice* if their treatment falls below the GASC. Further, health insurers need to have the same level of liability for bad faith as other types of insurers.¹² When health insurers and TPAs act in bad faith, the consequences can be irreparable, even deadly. Current regulatory actions and available remedies are a small price for insurers to pay for the profit gained from denying medically necessary GASC. Scores of patients are harmed every day with little recourse.¹³ This must change, and Congress must change it.

B. The Jim Ramstad Model Legislation for States

The Jim Ramstad Model Legislation for States¹⁴ was inspired by the

10. *Id.* at 22; see generally Anna Jo Bodurtha Smith et al., *Insurance-Mediated Disparities in Gynecologic Oncology Care*, 139 OBSTET. GYNECOL. 305, 305–12 (Feb. 2022).

11. See generally *New Guide Helps Consumers Fight Coverage Denials of Mental Health & Addiction Care*, KENNEDY FORUM (Apr. 22, 2021), <https://www.thekennedyforum.org/press-releases/new-guide-helps-consumers-fight-coverage-denials-of-mental-health-addiction-care/> [<https://perma.cc/L32K-3WBY>] (the “Proposed Ramstad for All Care Act” is the author’s proposed modification of the Jim Ramstad Model Legislation for States. The state parity model legislation is aimed at increasing mental health parity law protections at the state level. The author’s Proposed Ramstad for All Care Act is proposed *federal* legislation that would apply to all health care conditions and all types of health plans regulated in whole or in part under federal law).

12. The American health insurance system is a complicated patchwork of publicly and privately funded health plans with a complicated regulatory system beyond the scope of this Note. For the purposes of this Note, the term “health insurers” refers to the corporate entities who provide managed care and TPA services to both public and privately funded health plans. The term “health plan” is used to describe health insurance coverage generically. Managed Care Organization (MCO) refers to the health insurer corporate entities and subsidiaries that contract with health plans to provide utilization management and medical review.

13. See Francis Beifuss, *Illusory Remedies: Why Lacking Oversight and Penalties Leave Half of the Country With Only a Shadow of Healthcare*, 62 UNIV. LOUISVILLE L. REV. 761, 761. (2024); see also Grimm, *supra* note 9 (raising concerns that some Medicaid recipients under managed care organizations may not receive medically necessary services that should be covered because of a lack of state oversight and access to external medical reviews).

14. David Lloyd, *Jim Ramstad Model State Legislation to Advance Mental Health and Addition Equity By Requiring Compliance with Generally Accepted Standards of Care*, Kennedy Forum, <https://www.thekennedyforum.org/app/uploads/2021/05/Ramstad-Model-Legislation-May-2021.pdf> [<https://perma.cc/L32K-3WBY>] (last visited Oct. 31, 2025) (See Appendix A for relevant Ramstad Act language).

California Mental Health Parity Act Update, also known as SB 855, passed in response to the 9th Circuit's class action decision in *Wit v. United Behavioral Health (UBH)*.¹⁵ Governor Gavin Newsom signed S.B. 855 into law on September 25, 2020 with the goal of improving California's state enforcement of mental health parity protections. The new law applies to all California health plans and disability insurance policies issued, amended, or renewed on or after January 1, 2021. S.B. 855's relevant language states:

In March 2019, the United States District Court of the Northern District of California ruled in *Wit v. United Behavioral Health*, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019), that United Behavioral Health created flawed level of care placement criteria that were inconsistent with generally accepted standards of mental health and substance use disorder care in order to 'mitigate' the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.¹⁶

As *Wit v. UBH* demonstrates, despite having over fifteen years to comply, some insurers and TPAs maintain persistent resistance to, and in some cases, ongoing defiance of mental health parity law, especially as it applies to medical review policies and criteria.¹⁷ *Wit* also represents a larger concern with managed care organization (MCO) medical review criteria in general – the use of proprietary clinical guidelines that may not comport with evidenced-based GASC and which appear to focus on cost control over quality of care.¹⁸ The Ramstad Model Act for states seeks to improve mental health parity law compliance by requiring state-regulated health plans to use mental health (MH) and substance use disorder (SUD) review guidelines that comport with GASC, rid health plan contracts of discretionary clauses, and prohibit denial of services “primarily for the economic benefit of the insurer [or] purchaser.”¹⁹ The proposed Ramstad for All Care Act expands upon these requirements by requiring all medical review criteria used in any health plan, for any condition, to comply with GASC. As discussed below, this reform is necessary to protect

15. *Cal. Health & Safety Code* §§ 1367.045, 1374.721, 1374.72 (West 2021); *Cal. Ins. Code* §§ 10144.52, 10144.5 (West 2021); S.B. 855, The California Mental Health Parity Act Update, https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855 [<https://perma.cc/5XNS-U4K8>] (modified several sections of California code to require insurance carriers doing business in California to incorporate GASC into their medical necessity review processes for mental health and substance use disorder treatment, among other provisions).

16. S.B. 855, Sec. 1(k), (Cal. 2020), https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855 [<https://perma.cc/5XNS-U4K8>].

17. *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, 2019 WL 1033730, at *22 (N.D. Cal. Mar. 5, 2019).

18. *Id.* at *47–48; see INST. OF MED., *supra* note 5, at 7; see also Moffett & Moore, *supra* note 2, at 111; see generally Annie Waldman, *How UnitedHealth's Playbook for Limiting Mental Health Coverage Puts Countless Americans' Treatment at Risk*, PROPUBLICA (Nov. 19, 2024), <https://www.propublica.org/article/unitedhealth-mental-health-care-denied-illegal-algorithm>, [<https://perma.cc/M9K4-6Y7Z>].

19. Lloyd, *supra* note 14.

patients, employers, and taxpayers from sub-par outcomes and diminishing returns for money spent on health care.

II. BACKGROUND ON THE ISSUE – THE COMPARATIVE COST OF AMERICAN HEALTH CARE AND THE ROLE OF MANAGED CARE ORGANIZATIONS

According to the Organization for Economic Co-operation and Development (OECD), the United States spent an estimated \$12,742 per person on health care in 2022, the highest among similar nations. The second-highest spending nation was Switzerland, which spent \$9,044 per capita. Average spending among the OECD nations, excluding the United States, was \$6,850 per capita.²⁰ Far and away, the U.S. is an outlier in administrative expenditures, spending \$1,001 per capita compared to the second highest, Switzerland, at \$392 per capita. OECD nations spend an average of \$213 per capita, and the lowest spending nation, Japan, spends \$74 per capita.²¹

Does this higher spending translate into better patient experiences and better health outcomes, providing more value for our health care dollar? It appears the answer is no. The U.S. does not outperform its lower spending counterparts in most health categories, and in several common categories, such as diabetes management, childbirth safety, infant mortality and life expectancy, the U.S. performs worse.²² The high administrative costs American employers and taxpayers fund are attributed predominately to insurance company profits and provider overhead dedicated to billing and record keeping for claims submissions.²³ In a national survey of insured adults, most rated their health plan favorably; however, most also reported having difficulties with denied claims, prior authorization problems, and network provider access problems.²⁴ Of those who experienced difficulties with insurance coverage, nearly half were unable to resolve the issue.²⁵ As a result of their insurance issue, 17% of survey respondents could not access needed physical care, 43% could not access needed mental health care, and 15% reported a decline in health status due to the coverage problems.²⁶ The data indicates that our expensive MCO-driven system creates complicated processes for patients and providers that does not translate into improved access, quality of care, or health outcomes.

20. *How Does the U.S. Healthcare System Compare to Other Countries?*, PETER G. PETERSON FOUND., <https://www.pgpf.org/article/how-does-the-us-healthcare-system-compare-to-other-countries/> (last updated Aug. 16, 2024) [<https://perma.cc/2ADX-NKS5>].

21. *Id.*

22. *Id.*

23. Emily Gee & Topher Spiro, *Excess Administrative Costs Burden the U.S. Health Care System*, CTR. FOR AM. PROGRAM (Apr. 8, 2019), <https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/> [<https://perma.cc/3LCR-ANF5>].

24. Karen Pollitz et al., *Survey of Consumer Experiences with Health Insurance*, KFF (June 15, 2023), <https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/> [<https://perma.cc/YP39-VUNT>].

25. *Id.*

26. *Id.*

Despite these results, a small number of MCO parent companies are increasingly in control of our health system. Consolidations among health insurers over the last several years has led to the same limited number of MCOs controlling what medical care Americans can access – all without accountability or liability for physical harm, mental anguish, or pain and suffering when medically necessary care is delayed or denied.²⁷ According to a recent Health and Human Services report, in July 2020, approximately 72% of Medicaid enrollees received their coverage through MCOs and more than half of Medicaid spending in fiscal year 2021 was paid to MCOs.²⁸ Medicaid-managed care programs are increasingly responsible for enrollees in long-term care and supports services—nursing home patients, medically fragile children, and people with physical, intellectual and developmental disabilities—who are ill-positioned to navigate the labyrinth of information, rules and requirements of managed Medicaid.²⁹ Like Medicaid, Medicare is increasingly managed by MCOs. In 2024, 32.8 million people, or 54% of the eligible Medicare population, were enrolled in a Medicare Advantage plan, and the Medicare Advantage MCOs received \$462 billion, or 54%, of total federal Medicare spending. Medicare Advantage enrolls a disproportionate share of people of color in Medicare as well as an increasing number of dual eligible beneficiaries, or people who are eligible for both Medicaid and Medicare.³⁰ The vast majority of self-insured employer plans use MCOs as TPAs.³¹ State regulated employer-sponsored plans and Affordable Care Act Marketplace health plans rely heavily on large national MCOs.³² Health insurance premium costs for employers increased by 27% from 2018 to 2023, with employee contributions increasing by 19%.³³ Health care spending accounted for over 17% of the Gross Domestic Product in 2022, at \$13,493 per person.³⁴ Consequently, as taxpayers and insured persons, Americans have significant interest in MCOs' ability to determine what medical care patients receive and the conditions under which

27. Leemore S. Dafny, *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience*, 33 COMMONWEALTH FUND ISSUE BRIEF 1, 1–2 (Nov. 20, 2015), <https://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-impact-health-insurance-industry-consolidation> [https://perma.cc/D8JF-7DXG].

28. Grimm, *supra* note 9, at 2.

29. *Id.* at 2–4.

30. Meredith Freed et al., *Medicare Advantage in 2024: Enrollment Update and Key Trends*, KFF (Aug. 8, 2024), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/> [https://perma.cc/LZW5-PUYP].

31. Fred Hunt, *Everything You Wanted to Know About TPAs But Were Afraid to Ask*, SOC'Y OF PRO. BENEFITS ADMIN., <https://spbatpa.org/article/everything-you-wanted-know-about-tpas-were-afraid-ask> [https://perma.cc/WB2Z-6Y8Y] (last visited Nov. 20, 2024).

32. Dafny, *supra* note 27.

33. *2023 Employer Health Benefits Survey*, KFF (Oct. 18, 2023), <https://www.kff.org/report-section/ehbs-2023-summary-of-findings/> [https://perma.cc/FM6F-M8XB].

34. *National Health Expenditure Accounts Data*, CMS, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical#:~:text=U.S.%20health%20care%20spending%20grew,see%20the%20downloadable%20files%20below> [https://perma.cc/DPU8-SNYY] (last visited Oct. 31, 2025).

the decisions are made. Americans should expect our representatives in Congress to act when MCO medical review decision-making deficiencies lead to significant harm to patients and an increase in costs that impact American families and employers.³⁵

*A. Examples of Harm Caused by Typical Managed Care:
Organization Medical Reviews*

Typical managed care review processes have long disadvantaged patients, especially the most vulnerable. For example, applied behavior analysis therapy (ABA) has been considered GASC for autism spectrum disorder (ASD) for over twenty-five years.³⁶ ASD is a complex, lifelong developmental condition that typically appears during early childhood and can impact a person's social skills, communication, relationships, and self-regulation. ASD manifests differently in each person. It is defined by a certain set of behaviors that affect language, social skills and executive functioning.³⁷ ASD is often referred to as a "spectrum condition" because it affects people differently and to varying degrees.³⁸ ABA is an intensive outpatient treatment that improves the disabling features of autism, such as deficits in language/communication, cognitive functioning, executive functioning, understanding social cues, and regulating repetitive, compulsive, injurious, or aggressive behaviors that interfere with daily living and learning. Conservative estimates indicate the lifetime costs for supporting a person with autism, outside of medical care, is \$2 to 3 million³⁹ ABA therapy can save \$1.6 million per person through reduced need for special education and other taxpayer-funded support services costs outside of medical care.⁴⁰ Because it is intensive and provided in one-to-one or small group sessions for up to 40 hours per week, ABA is too expensive for most families to afford without insurance coverage. Despite all available evidence, and the endorsements by

35. See PETER G. PETERSON FOUND., *supra*, note 20.

36. *Scientific, Professional and Government Organizations' Position on the ABA from the Neurobehavioral Unit (NBU)*, KENNEDY KRIEGER, <https://www.kennedykrieger.org/patient-care/centers-and-programs/neurobehavioral-unit-nbu/applied-behavior-analysis/scientific-professional-and-government-organizations-position-on-the-aba-from-the-neurobehavioral-unit-nbu> [https://perma.cc/47MB-4U22] (last visited Oct. 31, 2025).

37. *The Autism Experience: Understanding Autism*, AUTISM SOC'Y OF AM., <https://autism.society.org/the-autism-experience/> [https://perma.cc/U5KS-3RJK] (last visited Oct. 31, 2025).

38. *Id.*

39. *Autism Costs Estimated to Be \$500 Billion, Potentially \$1 Trillion, by 2025*, U.C. DAVIS (July 28, 2015), <https://www.universityofcalifornia.edu/news/autisms-costs-estimated-be-500-billion-potentially-1-trillion-2025> [https://perma.cc/U26M-DLTF]; Penn Today, *Lifetime Costs for Autism Spectrum Disorder May Reach \$2.4 Million Per Patient, Penn Study Finds*, UNIV. OF PA. (June 9, 2014), <https://penntoday.upenn.edu/news/lifetime-costs-autism-spectrum-disorder-may-reach-24-million-patient-penn-study-finds#:~:text=In%20a%20study%20published%20online,to%20cost%20%241.4%20million%20in> [https://perma.cc/LH4J-B6ME].

40. Eric Larsson, *Is Applied Behavior Analysis and Early Intensive Behavioral Intervention an Effective Treatment for Autism? A Cumulative History of Impartial Independent Reviews*, LOVAAS INSTIT. (2013), <https://www.behavior.org/resources/649.pdf> [https://perma.cc/2AS7-6Z7H].

major medical societies, health insurers generally refused to cover ABA until parents advocated for state laws or mandates.⁴¹ It took parent advocates over twenty years to get coverage in all fifty states through a combination of legislation, executive action, and mental health parity enforcement action.⁴² During that time, thousands of people with autism who could not access prescribed ABA therapy suffered irreparable harm from the lost opportunity for treatment. This is especially true for people from middle class or lower socioeconomic backgrounds and already disadvantaged communities who continue to access clinical autism treatment at much lower levels.⁴³ Consequently, families and taxpayers will incur significantly greater costs of care for this generation deprived of the opportunity to access GASC treatment.

Many insurers and TPAs refuse to approve ABA therapy at the number of hours that are GASC level; they simply deem the hours to not be medically necessary, often without a more detailed explanation.⁴⁴ Further, some TPAs advise self-insured employers against offering any ABA coverage despite GASC, federal mental health parity requirements, and the fact that state autism mandate laws demonstrate ABA is a GASC treatment for ASD.⁴⁵ Historically, TRICARE, a health program for military families, has provided even more limited access to autism treatment than private insurance because it ignores GASC and health insurance industry standards in favor of its own opaque standards, research, and determinations about what treatments are effective.⁴⁶ The TRICARE ABA “pilot program” effectively prohibits delivery of ABA

41. See *History of Autism Mandate Laws*, Arc of Ind. (2022), <https://cdn.arcind.org/wp-content/uploads/2022/05/Historyof-Autism-Mandate-Laws-1.pdf> [https://perma.cc/3FM4-NXYE].

42. *Id.*

43. Jessica E. Rast et al., *Hospital Inpatient Stays for Autistic Youth and Youth With Other Disabilities*, 149 PEDIATRICS S1 (2022), <https://publications.aap.org/pediatrics/article/149/Supplement%204/e2020049437R/185642/Hospital-Inpatient-Stays-for-Autistic-Youth-and?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000> [https://perma.cc/MCV6-BQRN].

44. Telephone Interview with Karen Fessel, Executive Director, Mental Health and Autism Insurance Project (Mar. 27, 2024).

45. U.S. DEP’T OF LAB., 2022 MHPAEA REPORT TO CONGRESS at 52, 23, 44, <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022.pdf> [https://perma.cc/V74Q-MUKW].

46. See generally *How TRICARE’s Autism Care Demonstration Differs*, NCAAS (June 21, 2023), <https://www.nationalautismcoalition.org/news/2023/6/21/how-tricares-autism-care-demonstration-differs> [https://perma.cc/Q9ZM-NYKE]; *Independent Analysis of Department of Defense’s Comprehensive Autism Care Demonstration Program*, NAT’L ACADEMIES, <https://www.nationalacademies.org/our-work/independent-analysis-of-department-of-defenses-comprehensive-autism-care-demonstration-program> [https://perma.cc/QA7L-2B87] (last visited Oct. 31, 2025); Nat’l Acad. of Sci., Eng’g, and Med., *The Comprehensive Autism Care Demonstration: Solutions for Military Families*, NAT’L ACAD PRESS, <https://www.nationalacademies.org/read/29139/chapter/7#130> [https://perma.cc/7AXA-65FJ] (last visited on Feb. 3, 2026).

according to relevant GASC.⁴⁷ If TRICARE is permitted to ignore GASC in common conditions like autism, our military readiness could be affected negatively by causing families to leave military service to access minimally competent care for their loved ones.⁴⁸

Women are also greatly affected by substandard care that results from gynecologic oncology prior authorization-related treatment delays and insurer clinical guidelines that do not comport with GASC. Prior authorization is associated with an over two-week delay in gynecological cancer treatment, which impacts survival, and disproportionately affects women in already marginalized communities.⁴⁹ Medical review guidelines and network policies that ignore GASC significantly impact the quality-of-care women receive, as outlined in the *Insurance-Mediated Disparities in Gynecologic Oncology Care* study quoted below:

One third of women with a gynecologic cancer never see a gynecologic oncologist. Up to 40% of Medicare Advantage plans lack an in-network gynecologic oncologist, and 33% of private insurance plans do not include an in-network National Cancer Institute-accredited cancer center, limiting access to surgical advances and clinical trials. Women with Medicaid insurance and gynecologic cancer are *25% less likely to receive guideline-concordant care*. Among insured women, 50% experience financial [hardship] during gynecologic cancer treatment, and costs may be even higher for certain Medicare enrollees.⁵⁰

Further, Medicare–Medicaid coverage is associated with less guideline-concordant care with 44% of dually eligible beneficiaries receiving chemotherapy compared with 60% of exclusively Medicare-covered or privately insured individuals. In ovarian cancer, having private insurance was associated with a 6-month longer survival compared with having public insurance after controlling for sociodemographic, cancer, and treatment factors, a survival gain similar to those seen in recent chemotherapy advances.⁵¹

Issues in work-up are known contributors to racial disparities with

47. Anne Marshall-Chalmers, *Troops Weigh Leaving Service Over Lack of Care for Kids With Autism Under Tricare*, WAR HORSE (Oct. 19, 2023), <https://thewarhorse.org/us-military-kids-with-autism-lack-treatment-under-tricare/> [https://perma.cc/2H87-URK2].

48. *Id.*, see also Karen Ruedisueli, *Independent Review Will Examine TRICARE's Autism Coverage*, MOAA (Nov. 7, 2023), <https://www.moaa.org/content/publications-and-media/news-articles/2023-news-articles/advocacy/independent-review-will-examine-tricares-autism-coverage/> [https://perma.cc/P63P-3KMQ].

49. Anna Jo Bodurtha Smith et al., *Insurance and Racial Disparities in Prior Authorization in Gynecologic Oncology*, 46 GYNECOLOGIC ONCOLOGY REP. 1, 1–3 (Mar. 11, 2023).

50. Anna Jo Bodurtha Smith et al., *Insurance-Mediated Disparities in Gynecologic Oncology Care*, 139(2) OBSTET. GYNECOL. 305, 305–12 (Jan. 5, 2022).

51. *Id.* at 308.

Black women more likely to face diagnostic delays—and twice as likely to die of endometrial cancer.⁵²

Although 90% of gynecologic cancer prior authorizations appealed are ultimately approved by insurers, 80% of patients and clinicians never try to appeal insurer denials because of time and limited staff resources.⁵³ Prior authorization has been associated with two-week or greater delays in treatment initiation and significant patient stress.⁵⁴ When a patient needs insurance coverage for lifesaving GASC treatment, inappropriate delays and denials unnecessarily add to the costs and the physical and emotional toll.

The staff members that medical practices must designate to handle prior authorizations, appeals, and peer review calls that involve below GASC insurer guidelines could be better utilized to provide value-added patient education, care coordination, and patient follow-up calls.⁵⁵ This would allow physicians to spend more time with patients and allow staff more time to assist with value-added, patient-focused activities that increase quality of care and patient, staff, and physician satisfaction.⁵⁶

Vulnerable seniors, many of whom are disabled or have chronic conditions, are at similar risk of harm from substandard care resulting from inappropriate denials from Medicare Advantage MCOs. According to a report from KFF, a non-profit, non-partisan health care policy organization, in 2021, over 80% of Medicare Advantage appeals for denied care were decided in favor of the patient, but only 11% of denials were appealed. One MCO, Centene, overturned 94% of its denials upon appeal. Therefore, a significant number of Medicare Advantage beneficiaries go without needed care, are denied unjustifiably, and suffer from undue treatment delays or forgone treatment.⁵⁷

After allegations that some MCOs were inappropriately delaying or denying medically necessary care for Medicaid beneficiaries, Congress requested the Health and Human Services Office of Inspector General (HHS-OIG) to study managed Medicaid denials.⁵⁸ These delays and denials are especially troubling for the vulnerable and disadvantaged groups covered by Medicaid, which includes people who are poor, pregnant women, babies, children and adults with

52. *Id.* at 307.

53. *Id.*

54. *Id.* at 308.

55. Vinayak Madhusoodanan et al., *Is Time Spent on Prior Authorization Associated with Approval?* 19(2) J. NURSING PRAC. 1, 1–5 (Feb. 2023); see Ani Turner et al., *Impacts of Prior Authorization on Health Care Costs and Quality*, NAT'L INST. FOR HEALTH CARE REFORM (Nov. 2019), <https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf> [<https://perma.cc/Q3YG-S873>].

56. Joan Stephenson, *U.S. Surgeon General Sounds the Alarm on Health Worker Burnout*, 3(6) JAMA 1, 1–2 (June 7, 2022).

57. Jeannie Fugelsten Biniek et al., *Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023*, KFF (Jan 28, 2025), <https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/> [<https://perma.cc/WM3S-MC9S>].

58. Grimm, *supra* note 9, at 1.

disabilities, foster children, and elderly nursing home patients. Medicaid is a federal and state-funded program administered by the states.⁵⁹ Federal Medicaid regulations require states to monitor MCOs' appeals and utilization management processes,⁶⁰ yet the HHS-OIG report concluded most states do not routinely review MCO denials for appropriateness.⁶¹ Further, many states do not have a mechanism for patients and providers to submit a prior authorization (PA) denial to an independent medical reviewer; that is, the same MCO reviews its own denials.⁶² For Medicaid enrollees who do have access to external review, 46.3% of MCO denials were reversed in whole or in part.⁶³ For many Medicaid enrollees, the state administrative fair hearing process is intimidating, cumbersome, and difficult to navigate.⁶⁴ First, the HHS-OIG report found several MCOs that did not notify Medicaid beneficiaries about fair hearing availability and processes in a timely and understandable fashion as required by federal regulation, and they often missed required timeframes for PA decisions.⁶⁵ Medicaid enrollees only appealed 11.2% of MCO PA denials, and a bare 2.1% of Medicaid enrollees requested a fair hearing, though the study found 38.3% of appealed denials were overturned.⁶⁶

Overall, Medicaid denial rates were over double the denial rates seen in Medicare Advantage managed care plans.⁶⁷ One MCO, Molina, had a PA denial rate of over 40%.⁶⁸ The HHS-OIG report raises significant concerns about health equity and quality of care for vulnerable groups who are significantly impacted by care delays and disruptions.⁶⁹ OIG expressed concern that while federal regulations require that MCOs may not arbitrarily deny or reduce a required service because of a patient's diagnosis, type of illness, or condition, risk-based payment systems such as capitation, coupled with the profit motive may incentivize MCOs to deny access to covered services.⁷⁰ Further, Medicaid enrollees have low incomes and approximately 50% of enrollees are people of color.⁷¹ These individuals are already at a higher risk of experiencing barriers to access quality health care, have increased poor outcomes, and are more likely to forgo burdensome appeals and administrative fair hearing processes.⁷² These administrative burdens, coupled with low reimbursement, may cause providers to refuse to contract with Medicaid or to limit the number of Medicaid patients

59. KFF *Medicaid 101* (October 8, 2025), <https://www.kff.org/medicaid/health-policy-101-medicaid/?entry=table-of-contents-introduction> [<https://perma.cc/2VFX-HRQ4>].

60. 42 C.F.R. § 438.66.

61. Grimm, *supra* note 9, at 9.

62. *Id.* at 12–14.

63. *Id.* at 35.

64. Grimm, *supra* note 9, at 7.

65. *Id.* at 15–16.

66. *Id.* at 34–36.

67. *Id.* at 7.

68. *Id.* at 32.

69. *Id.* at 17.

70. *Id.* at 1.

71. *Id.*

72. *Id.*

they will see, further exacerbating health inequities experienced by Medicaid enrollees. Disadvantaged populations are more likely to experience treatment abandonment due to administrative burdens of medical review, leading to further health inequities.⁷³

While certain to elicit pushback from the powerful insurance lobby,⁷⁴ these proposed reforms are reasonable and necessary to fulfill long standing promises from Congress to address consumer concerns with the rising costs and diminishing returns for money spent on health care. Requiring all plans to follow GASC will serve to better meet the reasonable expectations of the insured. According to a 2023 American Hospital Association press release, a recent survey found 83% of patients want their medical providers to determine what care they receive – not their insurance company.⁷⁵ GASC represents a basic level of care patients should expect in terms of clinical competence;⁷⁶ it follows that this basic level of care is expected to be covered. Surely, employers, the government and taxpayers expect the minimum level of competent care to be purchased for our health care dollars. Patients expect coverage for chronic conditions, not simply acute, urgent, or emergency care. Patients expect reasonable parameters for chronic condition management and on-going care. Patients, clinical providers, and employers expect value, transparency and reasonably accurate information from insurers.⁷⁷ Patients with chronic conditions should not expect to have to fight the same fight over and over with their insurer every authorization period or fight the same fight each and every time they are required to switch insurers by their employer. Patients should not discover years later that a denied mental health treatment was required to be covered under federal mental health parity law. After the death of a family member from cancer, loved ones should not suffer from knowing the deceased may have survived if the insurer had approved the GASC diagnostic test or chemotherapy agent prescribed. Congress and insurers must recognize access to basic health care is increasingly seen as a human right and required component to liberty.⁷⁸ A recent survey shows an overwhelming majority of Generation Z believes health care is a human right, including 87% of respondents overall and

73. Turner, *supra* note 55.

74. Joseph Choi & Karl Evers-Hillstrom, *How a lobbying blitz led to weaker Medicare Advantage reforms*, THE HILL (Apr. 7, 2023), <https://thehill.com/policy/healthcare/3938311-how-a-lobbying-blitz-led-to-weaker-medicare-advantage-reforms/> [https://perma.cc/JG3S-XJES].

75. Press Release, American Hospital Association, *New Surveys Find Majority of Patients, Doctors & Nurses Say Health Insurer Policies Reduce Access to Care* (July 11, 2023), <https://www.aha.org/press-releases/2023-07-11-new-surveys-find-majority-patients-doctors-nurses-say-health-insurer-policies-reduce-access-care> [https://perma.cc/5CDT-4Z7Z].

76. Moffett & Moore, *supra* note 2, at 111.

77. Am. Hosp. Ass'n, *supra* note 75; Pollitz et al., *supra* note 24.

78. Mary Gerisch, *Health Care As a Human Right*, AM. BAR ASS'N (Nov. 19, 2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/health-care-as-a-human-right/ [https://perma.cc/NFB4-D4MC].

77% of Generation Z conservatives.⁷⁹ Consistently, most Americans, including a majority of conservatives, believe government has a role in ensuring access to health care.⁸⁰

American health insurance pricing is highest in the world,⁸¹ yet it is not guaranteed to cover the GASC, the minimally competent physician standard.⁸² How is this acceptable to taxpayers and the Congress that represents them, or to employers that fund Employee Retirement Income Security Act (ERISA) plans and rely on TPAs? The price paid does not match expectations. Requiring all health plans to cover GASC should also help increase health equity by better protecting Medicaid and Medicare beneficiaries. GASC mandated coverage would promote recognition that it is artificial to separate physical and mental health. This artificial mental health/physical health distinction leads to stigma, inequities, suboptimal care, poor care coordination, poor outcomes and therefore higher costs.⁸³

B. Background and Gaps in the Law – Wit v. UBH, MHPAEA, and ERISA

Wit v. United Behavioral Health (UBH) demonstrates gaps in the law that promote outcome inequity, substandard care and higher costs. Approximately 50,000 beneficiaries of as many as 3,000 ERISA-governed and state-governed health benefit plans formed three putative classes to take action against the claims administrator, UBH, for breach of fiduciary duty and improper denial of benefits for residential and other mental health/substance use disorder (MH/SUD) treatments.⁸⁴ The plaintiffs claimed the TPA improperly developed and relied on internal guidelines that were inconsistent with plan terms, state-mandated criteria (for state regulated plans) and GASC, despite the fact the plans required a treatment be GASC as a pre-condition for coverage. The plaintiffs alleged UBH breached its fiduciary duties to act solely in the interests of the participants and beneficiaries by developing and implementing coverage criteria inconsistent with GASC.⁸⁵

79. Ebonie Megibow et al., *Generation Z Takes the Reins*, AAMC (May 1, 2023), <https://www.aamchealthjustice.org/news/polling/generation-z-takes-reins> [https://perma.cc/8D5E-5B87].

80. Jocelyn Kiley, *Most continue to say ensuring health care coverage is government's responsibility*, PEW RESEARCH CTR. (Oct. 3, 2018), <https://www.pewresearch.org/short-reads/2018/10/03/most-continue-to-say-ensuring-health-care-coverage-is-governments-responsibility/> [https://perma.cc/KQP4-FD3C].

81. PETER G. PETERSON FOUND., supra note 20.

82. Employee Benefits Security Administration, *Compliance Assistance Guide: Health Benefits Coverage Under Federal Law*, Dep't of Lab., <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf> [https://perma.cc/V4E8-WLMQ] (last visited Aug. 29, 2025).

83. David Osborn, *The poor physical health of people with mental illness*, 175 W. J. MED. 329, 332 (Nov. 2001).

84. *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, 2019 WL 1033730, at *4 (N.D. Cal. Mar. 5, 2019).

85. *Id.*

The District Court held UBH's internal medical review guidelines were deficient in eight categories compared to GASC guidelines.⁸⁶ "In the context of this case, generally accepted standards of care are the standards that have achieved widespread acceptance among behavioral health professionals. There is no single source of generally accepted standards of care. Rather, they can be gleaned from multiple sources, including peer-reviewed studies in academic journals, consensus guidelines from professional organizations, and guidelines and materials distributed by government agencies."⁸⁷ The court found, because of financial incentives to keep benefit expense down, UBH regularly reviewed detailed financial forecasts that included projections of expected benefit expense and benefit expense targets it wanted to achieve. It tracked performance monthly, taking action to address benefit expenses that exceed its projections. The court determined the internal clinical guidelines were "infected" with financial considerations.⁸⁸ UBH placed representatives of its Finance and Affordability Departments in key roles in the clinical guideline development process throughout the class period, including membership on the committee that would ultimately approve or veto guidelines.⁸⁹ The court noted, "[p]erhaps the most telling example of the emphasis UBH placed on financial considerations in its decision making with respect to the Guidelines relates to UBH's decision *not* to adopt the American Society of Addiction Medicine (ASAM) Criteria for making substance use disorder coverage determinations Despite the clear consensus among UBH addiction specialists that the ASAM Criteria were preferable to UBH's own Guidelines from a clinical standpoint, UBH consistently refused to replace its own Guidelines with ASAM Criteria without first obtaining approval from the Finance Department."⁹⁰ Consequently, the court held UBH's interpretation of the ERISA plan requirements was unreasonable and an abuse of discretion due to structural and financial conflicts of interest.⁹¹ For the ERISA plans, the court determined UBH breached its fiduciary duties of loyalty and care by adopting more restrictive coverage guidelines than the GASC.⁹² For the state regulated plans, the court held UBH violated mandated level-of-care requirements in four states.⁹³ The court ordered UBH to reprocess the claims according to GASC, and appointed a special master to oversee compliance for 10 years.⁹⁴ UBH did not appeal the district court's ruling that its guidelines violated the state law mandated criteria; however, it did appeal the ERISA-based claims to the 9th Circuit.⁹⁵

UBH was granted a 9th Circuit panel review, which reversed the district

86. *Id.* at *14 and *22.

87. *Id.* at *14.

88. *Id.* at *47.

89. *Id.*

90. *Id.* at *49.

91. *Id.* at *52–53.

92. *Wit v. United Behav. Health*, 79 F.4th 1068, 1080 (9th Cir. 2023).

93. *Id.* at 1079.

94. *Id.* at 1081.

95. *Id.* at 1068.

court judgement that UBH wrongfully denied benefits to ERISA beneficiaries.⁹⁶ The panel concluded that UBH was not required to provide coverage according to GASC, as the plan's discretionary clause grants UBH authority to interpret plan terms.⁹⁷ The 9th Circuit panel held the district court abused its discretion by ordering claims reprocessing, citing *Cigna Corp. v. Amara*, stating “[p]laintiffs and the district court did not explain or refer to precedent showing how reprocessing constitutes relief that was typically available in equity for infirm Guidelines unrelated to Plaintiffs’ claim for benefits.”⁹⁸

The *Wit* case is on-going. The 9th Circuit panel vacated its January 2023 ruling, potentially opening the door for some plaintiffs’ claims to be reprocessed, and 15 states, the District of Columbia, the Department of Labor, the Kennedy Forum and other advocates filed amici briefs to support the plaintiffs’ petition for rehearing en banc by the 9th Circuit Court of Appeals.⁹⁹

State regulators continue to attempt to bring United Healthcare, the nation’s largest health insurer and UBH parent company, and its subsidiaries into compliance with state and federal mental health parity law via enforcement action. For example, in 2022, the New York Attorney General announced the completion of \$13.6 million in payments to consumers denied health care coverage under a landmark agreement with United Healthcare.¹⁰⁰ The payments resolved New York’s federal lawsuit against UBH for illegally denying coverage of outpatient psychotherapy for thousands of members.¹⁰¹

In 2021, Illinois passed Public Act 102-0579¹⁰² based upon the Jim Ramstad Model Legislation for States to address insurers’ ongoing efforts to defy compliance with mental health parity law. The Act provides for increased enforcement to benefit consumers, civil monetary penalties, and a “no dumping on public programs” provision to combat the insurance industry’s practice of designing benefit restrictions and plan terms to encourage potential enrollees to seek services from public programs.¹⁰³ The Illinois legislature cited the *Wit* case as the impetus for enacting additional measures. “Despite the strong actions taken by the Illinois General Assembly, the court in *Wit v. United Behavioral*

96. *Id.* at 1088.

97. *Id.*

98. *Wit v. United Behav. Health*, 79 F.4th 1068, 1088 (9th Cir. 2023) (citing *Cigna Corp. v. Amara*, 563 U.S. 421, 439 (2011)).

99. Press Release, The Kennedy Forum, The Kennedy Forum Applauds the Upholding of District Court Findings in *Wit v. United Behavioral Health* by U.S. 9th Circuit Court of Appeals <https://www.thekennedyforum.org/press-releases/the-kennedy-forum-applauds-the-upholding-of-district-court-findings-in-wit-v-united-behavioral-health-by-us-9th-circuit-court-of-appeals/> [<https://perma.cc/HN6V-NSBZ>].

100. *Attorney General James Provides \$13.6 Million to Consumers Who Were Denied Mental Health Care Coverage*, OFF. OF THE N.Y. STATE ATT’Y GEN. (May 20, 2022), <https://ag.ny.gov/press-release/2022/attorney-general-james-provides-136-million-consumers-who-were-denied-mental> [<https://perma.cc/8B2E-R9VH>].

101. *Id.*

102. Generally Accepted Standards of Behavioral Health Care Act of 2021, Pub. Act No. 102-0579, 2021 Ill. Laws 10633.

103. *Id.*

Health demonstrated how insurers can mitigate compliance with parity laws by denying medically necessary mental health and treatment by using flawed medical necessity criteria.”¹⁰⁴

ProPublica, an independent, nonprofit newsroom that produces investigative journalism, scrutinized United Healthcare’s mental health review practices in jurisdictions that had not yet engaged in enforcement action.¹⁰⁵ Despite being declared illegal in four states, United simply rebranded one of its mental health review algorithms and continues to use it throughout its other markets.¹⁰⁶ The above-described state actions and the results of the ProPublica investigation demonstrate that even though multiple states are scrutinizing the insurer for violating *the same federal law*, United persists in its unlawful behavior in the rest of its market areas.¹⁰⁷ “For United’s practices to be curbed, mental health advocates told ProPublica, every single jurisdiction in which it operates would have to successfully bring a case against it.”¹⁰⁸ Consequently, insurers have little incentive to follow the law due to the complexity of enforcement and the lack of true, make-whole remedies available to consumers in certain health plans, especially Medicaid and ERISA plans.

C. HHS Final Mental Health Parity Rule - Relevant Provisions That Reveal General Gaps in Enforcement

In September 2024, the U.S. Departments of Health and Human Services (HHS), Labor (DOL), and the Treasury issued final rules for implementing federal mental health parity law.¹⁰⁹ The final rules acknowledge, in the over fifteen years since federal mental health parity law was passed, the disparities in coverage for MH/SUD treatment have persisted and grown with “marginalized communities disproportionately impacted.”¹¹⁰ The Departments noted, to promote compliance, they have provided extensive guidance and assistance materials, but disparities continue, especially in terms of nonquantitative treatment limitations (NQTLs).¹¹¹ NQTLs are treatment limitations that are not quantifiable in nature, such as medical review criteria, prior-authorization review processes and procedures, treatment level of care determinations, network requirements and

104. *Id.* at § 2(c)(3).

105. Waldman, *supra* note 18.

106. *Id.*

107. *Id.*

108. *Id.*

109. *See* Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 Fed. Reg. 77586 (Sept. 23, 2024) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–147).

110. *Id.* at 77586.

111. CTR. FOR MEDICARE & MEDICAID SERV. WARNING SIGNS-PLAN OR POLICY NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLs) THAT REQUIRE ADDITIONAL ANALYSIS TO DETERMINE MENTAL HEALTH PARITY COMPLIANCE, <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/mhpeacechecklistwarningsigns.pdf> [<https://perma.cc/9E34-QNHR>](last visited Jan. 31, 2026).

methodologies to determine out of network reimbursement levels.¹¹² The final rule sought to clarify requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA) and the amendments under the Consolidated Appropriations Act of 2021 (CAA).¹¹³ The CAA sets content and timeline requirements for health plans to provide a comparative analysis of the impact any NQTLs have on mental health or substance use disorder (MH/SUD) treatment versus medical/surgical treatments.¹¹⁴

Also, significant to this Note Thesis, the final rule established requirements for health plans to act on disparities found in these analyses, and it prohibits health plans from “using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTLs.”¹¹⁵ The rule provides that health plans must define MH/SUD conditions according to “generally recognized independent standards of current medical practice.”¹¹⁶ This combats the insurance carrier practice of defining a condition in a manner that is most restrictive for coverage to limit access and reduce costs. Further, the final rule winds down the “opt out period” during which self-funded and non-federal governmental plans could choose to forgo compliance with MHPAEA, increasing access to protections for many local government workers and their families.¹¹⁷ Significantly, the rule states, if a health plan provides MH/SUD benefits, they must be “meaningful” when compared to medical/surgical benefits in the same benefits classification, including inpatient and outpatient care, in-network and out-of-network services, emergency care, and prescription drug coverage.¹¹⁸

While the final rule could improve implementation for mental health parity in the covered health plans, patients and clinical providers continue to struggle with health plan policies and procedures that make access to medically necessary GASC difficult. Further, the ERISA Industry Committee challenged the final rule in litigation filed on January 17, 2025, against the “tri-agencies”—Health and Human Services, the Department of Labor and the Internal Revenue Service—arguing the agencies exceeded their authority by fundamentally

112. Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 Fed. Reg. 77586, 77597 (Sept. 23, 2024) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–147); *see also Fact Sheet: Final Rules under the Mental Health Parity and Addiction Equity Act (MHPAEA)*, DEP’T OF LAB., <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea> [https://perma.cc/VD5U-KQEJ] (last visited Oct. 20, 2025).

113. *Id.*

114. *Id.*

115. DEP’T OF LAB., *supra* note 112.

116. *Id.*

117. *Id.*

118. *Id.*; *see also Proposed Updates to 2020 MHPAEA Self-Compliance Tool: Request for Comments*, DEP’T OF LAB. 10, https://www.dol.gov/sites/dolgov/files/ebsa/pdf_files/compliance-assistance-guide-appendix-a-mhpaea-proposed-updates.pdf [https://perma.cc/4S7Z-MNXS] (last visited Oct. 20, 2025).

reshaping MHPAEA and its enforcement.¹¹⁹ The federal government responded in March that the administration would reconsider the regulations and requested a stay in the litigation, which was granted.¹²⁰ With the looming cuts in Medicaid and Affordable Care Act Marketplace Plans that will result from the recently passed tax and budget bill, many Americans believe their access to healthcare will become more difficult and more expensive.¹²¹ More can and must be done through statutory improvement in available remedies for patients denied medically necessary, standard of care services. Congress can help level the playing field for patients and clinicians through the reforms in the proposed Ramstad for All Care Act.

III. REMEDIES – AVAILABLE TO SOME, ACCESSIBLE TO FEW

Because of our disjointed health insurance system, just as enforcement varies from state to state and jurisdiction to jurisdiction, remedies available to patients denied care vary by plan, by funder, by state, and by jurisdiction. As a result of this complexity, many patients do not understand their rights or the provisions of their health policy and feel powerless to appeal denials.¹²² Many clinicians do not have the time, resources, or knowledge of the vast and complex system to navigate appeals.¹²³

For example, as more states outsource Medicaid to MCOs, beneficiaries face a complex system of appeals and fair hearing requirements.¹²⁴ If the patient is in a managed Medicaid plan, he must exhaust the plan's appeal process, which requires researching what that is, and sending the appeal to the correct company and address.¹²⁵ If denied by the Medicaid MCO, many states do not allow for an independent review of the MCO decision.¹²⁶ Only 11% of Medicaid enrollees

119. Complaint, *ERISA Indus. Comm. v. U.S. Dep't of Health & Hum. Servs.*, No. 25-CV-136 (D.C.C Jan. 17, 2025).

120. Lauren Clason, *Trump Weighs Axing Mental Health Rule With Lawsuit on Pause*, BLOOMBERG LAW NEWS May 12, 2025, <https://www.bloomberglaw.com/product/blaw/bloomberglawnews/bloomberg-law-news/X3AOLA84000000> [<https://perma.cc/R7A8-PDJ7>].

121. See Noam N. Levey, *Trump Voters Wanted Relief From Medical Bills. For Millions, the Bills Are About To Get Bigger*, KFF HEALTH NEWS (July 25, 2025), <https://kffhealthnews.org/news/article/medical-debt-trump-policies-little-relief/> [<https://perma.cc/2D38-BZ9R>]; Craig Palosky, *Poll: New Tax and Budget Law Remains Largely Unpopular; Nearly Half Say It Will Hurt Their Families, though Republicans and MAGA Supporters Are More Optimistic*, KFF (Jul 24, 2025), <https://www.kff.org/affordable-care-act/press-release/poll-new-tax-and-budget-law-remains-largely-unpopular-nearly-half-say-it-will-hurt-their-families-though-republicans-and-maga-supporters-are-more-optimistic/> [<https://perma.cc/UJU9-YCXH>].

122. Pollitz et al., *supra* note 24; Rebecca Pifer, *Health Insurers Will Step Off the Roller Coaster in 2025*, DEEP DIVE (Jan. 8, 2025), <https://www.healthcaredive.com/news/health-insurer-2025-predictions/735966/> [<https://perma.cc/W3YN-XLTH>] (discussing insurers' need to regain patient trust because their administrative systems are viewed as barriers to care).

123. Turner, *supra* note 55, at 9 (Turner addresses the appeal process being long and complicated specifically); see generally Madhusoodanan et al., *supra* note 55.

124. See Grimm, *supra* note 9, at 11–16.

125. *Id.* at 2–3.

126. *Id.* at 11–12.

appealed an MCO prior authorization, and the MCOs upheld their own decision 64% of the time.¹²⁷ If an independent medical review is not available, the Medicaid enrollee's next step is a fair hearing, which must be requested, unlike additional levels of appeal that are offered automatically in Medicare and many private plans.¹²⁸ A fair hearing is not conducted by medically trained personnel or a practicing clinician who should be familiar with GASC; it is conducted by an administrative law judge who will determine if the plan followed Medicaid policies and procedures.¹²⁹ A Medicaid patient must wait up to ninety days from the date of request for the fair hearing decision.¹³⁰ Therefore, our most disadvantaged neighbors—the aged, disabled and the poor—have health inequities exacerbated by a complex system to navigate in order to access care in addition to social determinants of health challenges they already face.¹³¹ It is unreasonable that Medicaid enrollees cannot count on being able to access GASC. GASC is not the “best care money can buy” or cutting-edge; it is a *floor* below which a clinical practitioner may be committing *malpractice*.¹³²

For very different reasons, employer plans, especially under ERISA, lack reasonable remedies for patients denied care through medical review processes that do not reflect the GASC.¹³³ For fully-insured, state regulated employer plans, after researching their options on difficult to navigate insurer websites, enrollees must exhaust the health plan's appeal process or actively request an independent medical review.¹³⁴ If their state's insurance regulator is consumer-friendly, and adequately funded, they may be able to obtain assistance from the regulator to address the issue. Some regulators will not address medical review issues due to the clinical nature, or they only will review if the MCO followed the required process, not assess the quality of the review.¹³⁵ While most MCOs have timelines for medical review in their policies that appear to be timely, in reality, fighting an insurance denial may take several weeks or months.¹³⁶ If a state allows for bad faith claims against a health insurer, and the patient's plan

127. *Id.*

128. *Id.* at 12–13.

129. *Id.* at 11–16.

130. *Id.* at 15.

131. Khushbu Chelak & Swarupa Chakole, *The Role of Social Determinants of Health in Promoting Health Equality: A Narrative Review*, CUREUS 4–6 (Jan. 5, 2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9899154/pdf/cureus-0015-00000033425.pdf> [<https://perma.cc/2BPB-TK95>].

132. Moffett & Moore, *supra* note 2, at 111.

133. Francis Beifuss, *Illusory Remedies: Why Lacking Oversight and Penalties Leave Half of the Country With Only a Shadow of Healthcare*, 62 UNIV. LOUISVILLE L. REV. 761, 779–83 (2024).

134. *Why Health Insurance Websites Challenge Patients Seeking Care*, REPUTATION, <https://reputation.com/resources/articles/why-health-insurance-websites-challenge-patients-seeking-care/> [<https://perma.cc/5627-3R66>] (last visited Mar. 7, 2025).

135. See Aaron Swartz et al., *Coverage Denials: Government and Private Insurer Policies for Medical Necessity in Medicare*, HEALTH AFF. 2 (Jan. 2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9465897> [<https://perma.cc/HX27-26ZB>] (discussing the challenges of opacity in the medical necessity reviews for patients, clinicians, regulators, and policy makers).

136. Grimm, *supra* note 9, at 15–16.

is state regulated, he may have options to sue for damages beyond the cost of the care that was denied. If the state does not allow for bad faith claims, or the patient's health plan is federally regulated under ERISA, the patient is limited to suing for reimbursement for care that *should* have been covered, but only if the patient is able to pay out of pocket, get their care and sue later.¹³⁷ Clearly, the vast majority of patients cannot afford to private pay for care and then hire an attorney to seek reimbursement or seek reimbursement from the insurance company on their own.

Nationally, about 136 million people are covered by an ERISA-regulated health plan, making ERISA health insurance the largest segment of the U.S. health insurance market.¹³⁸ Limited options for enrollees in ERISA self-insured employer plans and states where bad faith claims are disallowed result from complex legal realities that must be addressed by Congress.

The confounding lack of remedy is due to a three-part wall. Each layer interlocks, reinforcing the others: (1) damages immunities – insurers of employer-sponsored plans are generally only subject to equitable remedies and are not exposed to consequential or punitive damages; (2) consulting physician malpractice immunity – the doctors that insurers hire to determine if a claim is medically necessary are treated solely as fiduciaries to the plan, avoiding any meaningful duty of care as a medical doctor to the patient/claimant; (3) and, finally a complex system of express, reverse, and implied preemption, where states are charged with creating insurance regulations and monitoring mechanisms but have no enforcement powers – resulting in an bizarre, rigid regulatory terrain.¹³⁹

ERISA health plans are immune from consequential and punitive damages for negligence and most state contract and tort laws are superseded by ERISA, leaving remedies most meaningful for physical, mental and economic harm unavailable.¹⁴⁰ Some state laws that regulate insurance, as opposed to insurance companies, may still apply to ERISA plans, such as the Ramstad Act for All Care ban on discretionary clauses.¹⁴¹ There was very little direction from

137. *A State-by-State Guide for Causes of Action for Bad Faith Claims*, CHARTWELL LAW, <https://www.chartwelllaw.com/bad-faith-claims-map> [<https://perma.cc/AK9V-8BHE>] (last visited Oct. 29, 2025); Peter K. Stris, *ERISA Remedies, Welfare Benefits, and Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA LAB. & EMPL. L. J. 387, 394–395 (2009).

138. Bruce Telkamp, *What is ERISA Health Insurance?*, ASS'N HEALTH PLANS (June 30, 2020), <https://www.associationhealthplans.com/group-health/what-is-erisa-health-insurance/> [<https://perma.cc/FFT7-PNMC>].

139. Beifuss, *supra* note 133, at 784.

140. Lee Black, *ERISA: A Close Look at Misguided Legislation*, 10 J. OF ETHICS AMA, 307, 308–09 (2008) (on file with author).

141. John Morrison & Jonathan McDonald, *Exorcising Discretion: The Death of Caprice in ERISA Claims Handling*, 56 S.D. L. REV. 482, 482–83 (2011) (“Challenged by the insurance

Congress about how ERISA was to regulate health plans.¹⁴² As a result, courts have responded with dramatically different interpretations over the years. The law on MCO liability under ERISA is not settled, but currently substantially favors protecting insurers.¹⁴³ This is contrary to ERISA's primary goal "to protect the interests of *participants and their beneficiaries* in employee benefit plans" (emphasis added).¹⁴⁴

Consulting physicians employed by the MCOs make clinical and diagnostic decisions that determine if a patient will be able to access their prescribed treatment; they can effectively override the patient's treating clinicians without the personal, ethical, or legal accountability of malpractice exposure because they are considered fiduciaries only to the *plan*, not the *plan's beneficiaries*.¹⁴⁵ This defies reality. Patients should be able to expect insurer clinicians to make medical review decisions based upon the patients' long-term health optimization and what a minimally competent clinician would do—that is to follow the GASC. Many subscribers do not have a high level of trust in their health insurance company; one representative survey shows a little more than half of patients expect their health plan to "do the right thing."¹⁴⁶ But, subscribers, patients and funders, whether employers or the taxpayers, *should* expect that their health plan holds some responsibility for the medical reviewer's decisions and behavior. After all, the health plan sets the terms of coverage and the guidelines under which the medical reviewers can approve coverage. Without coverage, patients often postpone or forgo care.

However, in *Pegram v. Herdrich*, the Supreme Court determined that, unless a physician fiduciary to a health plan is also directly treating the *actual* patient (as in a Health Maintenance Organization or HMO), then the physician is not exposed to malpractice, even though the Court recognized "decisions of treatment and eligibility are 'inextricably mixed' de facto medical determinations."¹⁴⁷ Further, as described above, the idea that an insurer is "denying coverage, not denying care" is often a fiction.¹⁴⁸ As discussed, unless a patient is wealthy, he is not going to be able to access medical care that is not going to be covered by insurance without significant financial difficulty, including bankruptcy from medical debt. Additionally, coverage determinations

industry, states have prevailed in two key legal battles. In *Standard Insurance Co. v. Morrison* and *American Council of Life Insurers v. Ross*, the federal courts ruled that ERISA does not preempt the power of state insurance regulators to prohibit discretionary clauses from insured group health and disability insurance policies.").

142. COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE 267 (Mark C. Alexander et al. eds., 6th ed. 2024).

143. Black, *supra* note 140, at 309.

144. *History of EBSA and ERISA*, DEP'T OF LAB., <https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/history-of-ebsa-and-erisa> [<https://perma.cc/R9BG-UY24>] (last visited Jan. 30, 2025).

145. *Pegram v. Herdrich*, 530 U.S. 211, 225–26 (2000).

146. Pifer, *supra* note 122 (discussing that only 56% of patients believe their insurance company will "do the right thing").

147. Beifuss, *supra* note 133, at 783–84.

148. See Appendix A.

are frequently made by individuals acting in administrative or fiduciary capacities rather than as treating clinicians, even though ERISA requires fiduciaries to act solely in the interests of plan beneficiaries when making benefit determinations.¹⁴⁹ However, if a court determines that the *insurer* denies benefits for a particular treatment, claims filed by insureds remain primarily subject to state law.¹⁵⁰ How patients are supposed to understand this distinction and pursue their limited available remedies without the assistance of expensive legal professionals is unclear. This complex system of preemptions and limitations leaves states without enforcement powers to protect consumers, employers or taxpayers from bad actors, even if they repeatedly violate the law or deny medically necessary care.¹⁵¹ The *Wit* litigation and the struggles gynecologic cancer patients face are good examples of the significant challenges any individual patient experiences to secure what is widely recognized as the standard of care treatment if the insurance company resists coverage for whatever reason.¹⁵²

A. Rationale for a Ramstad for All Care Act

General principles of insurance law support this Note thesis. Health insurance contracts are contracts of adhesion, especially for the patient who may be offered only one plan option by their employer. They are also contracts of adhesion for most employers and clinical providers, with only the largest among them having any ability to negotiate in any meaningful way.¹⁵³ There is a power and information asymmetry that is heavily in favor of the insurer or TPA. For patients, it is especially asymmetric, as evidenced by how few patients appeal denied care and how few feel they understand and can navigate their insurance.¹⁵⁴ In other lines of insurance, an insurer is liable if it fails to act in “good faith and fair dealing”—if it unreasonably delays or denies coverage. Other types of insurance carriers are also liable for the physical and mental harm proximately caused by their decisions, or compensatory damages.¹⁵⁵ Exemplary or punitive damages are also available in the event of malice, fraud, or egregious conduct, such as knowingly, repeatedly violating the law.¹⁵⁶ ERISA health plans and the insurance companies and TPAs that managed them are not subject to these damages. The ERISA remedies patients can receive, that would amount to millions of dollars of liability exposure in other cases, are reduced dramatically

149. *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

150. Black, *supra* note 140, at 309.

151. *Id.*

152. *See* Appendix A.

153. *See generally* Chris Stanton, *The Confessions of Insurance Executives*, NEW YORKER, (Mar. 28, 2025), <https://nymag.com/intelligencer/article/insurance-health-care-executives-wendell-potter-whistleblowers.html> [<https://perma.cc/W3P5-XKVZ>].

154. Pollitz et al., *supra* note 24.

155. KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION CASES AND MATERIALS* 85–98 (Saul Levmore et al. eds., 7th ed. 2020).

156. *Id.*

to minimal fines, creating the perverse incentive of making it more profitable to deny care in many instances, especially in the short term for publicly traded, for profit MCOs.¹⁵⁷ Would insurers, like United Healthcare and its subsidiaries, UBH and Optum, continue to use medical review processes deemed illegal in four states across their other markets if viable remedies were available to protect ERISA participants and beneficiaries?¹⁵⁸

Congressional intent when passing ERISA also supports this Note thesis. ERISA's primary goal is "to protect the interests of *participants and their beneficiaries* in employee benefit plans"(emphasis added).¹⁵⁹ Additional goals for ERISA include plan uniformity, participant access to information, and fiduciary trust accountability.¹⁶⁰ If the TPAs and their medical reviewers are not required to protect participants and beneficiaries as fiduciaries, are the employers ultimately responsible for demanding GASC and quality care? A recent survey asked fifty executives from fifty ERISA employers about their decision-making pertaining to health benefits for cancer treatment, where treatment delays and denials can reduce survival.¹⁶¹ The 2022 survey revealed 94% of the survey participants said organizational health care costs were the most influential factor in their health benefit design, and 98% responded that direct cost was the most important information source in their benefits decision-making.¹⁶² This survey suggests employers are not considering the unintended, long-term consequences to health care costs and employee health that may result from MCO cost control measures that delay or deny GASC.¹⁶³ If employer fiduciaries are not protecting participants and beneficiaries' health, Congress must provide the guardrails. "ERISA has the effect of diminishing liability . . . for health plans and, along with it, the responsible decision making that medical malpractice is intended to encourage. . . . [It is] up to Congress to provide more specific guidelines. In an industry as heavily regulated as health care, it takes more than the basic standards provided in ERISA to ensure the safe and effective care of patients."¹⁶⁴ The control health plans exert over determining care is not matched by their level of accountability for poor clinical decision-making.¹⁶⁵ While beyond the scope of this Note, employers must consider whether the health care "cost problem" stems from MCOs' failure to coordinate care,

157. Beifuss, *supra* note 133, at 774.

158. Annie Waldman, *How UnitedHealth's Playbook for Limiting Mental Health Coverage Puts Countless Americans' Treatment at Risk*, PROPUBLICA (Nov. 19, 2024), <https://www.propublica.org/article/unitedhealth-mental-health-care-denied-illegal-algorithm> [<https://perma.cc/58H4-Q4YA>].

159. DEP'T OF LAB., *supra* note 144.

160. *Id.*

161. Matthew Gavidia, *Employer Utilization Management Prioritizes Health Benefit Cost Over Patient Care, Survey Finds*, AM. J. OF MANAGED CARE (Apr. 13, 2022), <https://www.ajmc.com/view/employer-utilization-management-prioritizes-health-benefit-cost-over-patient-care-survey-finds> [<https://perma.cc/DX3L-ZWJW>].

162. *Id.*

163. *Id.*

164. Black, *supra* note 140, at 310.

165. *See supra* Section IV.

conduct value-added activities, and promote long-term health while promoting short-term profit-making activities, their own bloated corporate bureaucracies and related middlemen, such as pharmacy benefit managers.¹⁶⁶

Further MCO and health plan discriminatory practices have led to piecemeal amendments to ERISA and other Congressional acts to protect discrete patient groups—mothers and newborns, women with breast cancer, people with mental health conditions, and people with genetic conditions.¹⁶⁷ Perhaps such piecemeal legislation would not be necessary if all health plans, including ERISA plans, were required to follow GASAC, and were held liable for compensatory and punitive damages when appropriate. To control costs, ERISA plans may rely on exclusions and restrictive coverage decisions that encourage patients to enroll in public health plans and Affordable Care Act state and federally subsidized Marketplace plans. By making their medically necessary treatment inaccessible, these practices perpetuate inequities and discrimination by proxy. State laws like Illinois’s may not be able address this issue in most ERISA plans.¹⁶⁸ Again, Congressional action to improve enforcement and accountability for ERISA plans and their TPAs will go a long way to prevent such costs being transferred to taxpayers.

Congressional action is also needed to clarify ERISA law for the courts, given the conflicting decisions and erosion of intended protections that have resulted.¹⁶⁹ An analysis of ERISA reveals Congress’s purposeful choice to apply existing trust law remedies to ERISA employee pension and welfare plans, including the traditional make-whole principle of trust remedy law.¹⁷⁰ While providing multi-state employers with uniformity, predictability and flexibility in designing and administering their employee benefits plans is an important ERISA goal, the main purpose of ERISA is beneficiary protection from pension default risk and administration risk in both pension and welfare (health, disability, and other benefits) plans.¹⁷¹ Administration risk refers to the danger that plan managers may abuse their authority and discretion when making decisions about investments, plan assets, and *paying claims*.¹⁷² Thus, Congress

166. PETER G. PETERSON FOUND., *supra* note 20; see *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, FED. TRADE COMM’N 1 (July 2024), <https://www.ftc.gov/reports/pharmacy-benefit-managers-report> [<https://perma.cc/7RSV-7SJ2>].

167. SEAN ANDERSON ET AL., *PENSION AND EMPLOYEE BENEFIT STATUTES AND REGULATIONS: SELECTED SECTIONS*, 495–504 (Foundation Press, 2017 ed.); ERISA §§ 701, 702, 711–13 (sections added to ERISA to limit exclusions on preexisting conditions, prohibit discrimination based on health status, limit plans’ ability to request or require genetic testing, require minimum lengths of hospital stays for newborns and mothers, require mental health and substance use disorder parity, and to require coverage for reconstructive surgery after mastectomy for breast cancer).

168. Generally Accepted Standards of Behavioral Health Care Act of 2021, Pub. Act No. 102-0579, 2021 Ill. Laws 10633.

169. John H. Langbein, *What ERISA Means by “Equitable”*: *The Supreme Court’s Trail of Error in Russell, Mertens and Great-West*, 103 COLUM. L. REV. 1317, 1365 (2003).

170. *Id.* at 1317.

171. *Id.* at 1322.

172. *Id.* at 1323.

intended to subject the welfare plans to fiduciary law by bringing them under ERISA, while specifically exempting the welfare plans from other ERISA rules, such as vesting and termination insurance.¹⁷³

The erosion of beneficiary protections began with *Russell* (1985), where Justice Stevens, denied “extracontractual” relief—rather than “consequential damages,”—for a severe delay in paying plan benefits, reasoning that ERISA contained no *express* statutory regulation addressing the “possible consequences of delay . . . in processing of a disputed claim,” even though such a delay would constitute a routine breach of fiduciary practice under trust law.¹⁷⁴ As a result, “[t]he consequence has been that the Court has been treating ordinary applications of traditional fiduciary and remedy law as impermissible extensions of the statute.”¹⁷⁵

The *Russell* decision also influenced the Court in *Mertens*, where Justice Scalia asserted the meaning of the word “equitable” in ERISA § 502(a)(3) precludes monetary damages for consequential injury despite the make-whole principle of trust and equity and the fact that courts routinely award monetary damages when providing equitable relief.¹⁷⁶

By treating relief for consequential injury as an excluded category that Congress must have disapproved by not specifically scheduling it, Justice Scalia closed off the court from the trust law tradition on which ERISA’s drafters relied to give meaning to their grant of “other appropriate equitable relief.” Because both the substantive and the remedial provisions of ERISA arise from trust law, the likely meaning of “appropriate equitable relief” in ERISA is the panoply of remedies, specific and monetary, including make-whole damages for consequential injury, which courts of equity have for centuries applied to correct breaches of trust, and which are “other” than the “benefits due” and injunctive relief that the statute expressly authorizes earlier in section 502(a).¹⁷⁷

As discussed throughout, when patients cannot secure damages beyond the mere cost of their denied medical test or service, they are not made whole when they have suffered real physical, mental, and economic damages from lost function, lost work and out of pocket costs. Congress must correct the Supreme Court error in *Russell* and *Mertens* to re-establish causes of action under ERISA for consequential and punitive damages as are available for other types of insurance. Given the special nature of health insurance—and its fundamental role in survival, liberty, ability to work, and quality of life—physicians who

173. *Id.* at 1323–24.

174. *Id.* at 1328, 1345–47 (employing the term “extracontractual” damages, which predated the decision, to describe relief beyond benefits due under ERISA).

175. *Id.* at 1329.

176. *Id.* at 1336.

177. *Id.* at 1355.

make administrative decisions regarding welfare plan claims payment should be expressly named as fiduciaries. Those fiduciaries must act solely in the interests of plan participants and beneficiaries, consistent with the role of a “disinterested intermediary,”¹⁷⁸ bound by the traditional trust duties of loyalty and prudence.

As the *Wit* case and the ProPublica investigation of United Healthcare clearly document, for-profit MCOs and their medical review processes can be infused with conflicts of interest and perverse incentives to delay or deny care to increase profits and decrease costs without regard to the beneficiaries’ best interests or the long-term health of workers.¹⁷⁹ The HHS-OIG reports on inappropriate denials of medically necessary treatments in Medicaid and Medicare reinforce that deficiencies in MCO medical review processes and clinical guidelines are a system-wide problem.¹⁸⁰ Discretionary clauses allowing the plan’s administrators and fiduciaries discretionary authority to determine benefits and interpret the terms of the plan are key to allowing these conflicts and perverse incentives to flourish. To achieve ERISA’s purpose, Congress must follow the lead of several states and prohibit these clauses to ensure beneficiaries a de novo standard of review in court, should a plan dispute be litigated. Currently, under *Firestone*, the courts will employ a deferential arbitrary and capricious standard of review if the plan language contains a discretionary clause.¹⁸¹ The proposed Ramstad for All Care Act would prohibit such clauses for health and welfare plans.

B. The Proposed Ramstad for All Care Act

With the Jim Ramstad Model Legislation for States, quoted in Appendix A, as a basis, language changes to create a Ramstad for All Care Act (RACA) should include the following provisions:

Section 1 – Statement of Congressional intent and rationale

- a. Over the past 40 years, managed care has moved away from, and eventually abandoned, its roots as clinician-driven entities focused on improving individual patient’s health and thereby reducing costs by optimizing value. As MCOs changed from non-profit to profit driven, they prioritized cost control over quality leading to perverse incentives, bloated bureaucracies engaging in administratively redundant or wasteful processes, and spiraling costs with decreasing population health.
- b. Reform is crucial to maintaining military readiness, worker productivity, the health and welfare of our citizens, and the ability to care for our most vulnerable citizens. Reform must restore managed

178. *Id.* at 1327–28.

179. *See generally* *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).

180. *See generally* Grimm, *supra* note 9.

181. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (discussing conflict of interest and evaluating plan administrator abuse of discretion under ERISA).

care's primary focus—quality care and patient health—by requiring all U.S. health plans to cover GASC or minimally competent care.

- c. Professional clinical societies have been engaged in evidenced-based practice guideline and standard of care study for decades; there is no need for insurance company committees or contractors to duplicate or taint this process with profit motives.¹⁸² Clinical societies are poised to distinguish among GASC (minimally competent care), clinically effective care, and best practice, and to establish guidelines that meet recommended standards of trustworthiness.¹⁸³ Clinical societies consider costs in standard development—in terms of *value* not corporate *profit*.
- d. Congress must reaffirm the primary purpose of ERISA, to protect plan participants and beneficiaries, and amend ERISA to expressly include consequential and punitive damages where appropriate.
- e. To ensure our most vulnerable citizens enjoy similar protection from MCO care delays and denials, automatic independent medical reviews for Medicaid shall be offered as it is for Medicare enrollees.
- f. Medical reviewers shall be fiduciaries, disinterested intermediaries, to all U.S. health plans' *covered lives/beneficiaries*, like trust officers are fiduciaries to the trust beneficiary, not the bank or financial institution.¹⁸⁴
- g. Resources wasted on flawed medical review processes and procedures can be redirected to value-added activities like patient education, care coordination, and patient time with clinical providers.¹⁸⁵
- h. Distinguishing mental health care and physical care is artificial, and results in suboptimal care, increased stigma, and health inequities.¹⁸⁶

Section 2 – Definitions

(a) The following definitions apply for purposes of this Act:

- (1) “Generally accepted standards of care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties for the condition being reviewed. Valid, evidence-based sources reflecting generally accepted standards of care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of

182. *See Wit*, 2019 WL 1033730.

183. INST. OF MED., *supra* note 18, at 5–9.

184. Langbein, *supra* note 169, at 1365 (explaining the importance of trust principles applied to ERISA).

185. Madhusoodanan, *supra* note 55 (finding that prior authorization processes impose substantial administrative and opportunity costs on clinicians without improving approval rates, diverting clinical time from patient care).

186. *See Osborn*, *supra* note 83, at 330 (explaining that separating mental and physical health care obscures their interdependence, contributes to poorer health outcomes, and reinforces stigma against psychiatric patients).

federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) “Medically necessary treatment” means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- (i) In accordance with the generally accepted standards of care.
- (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
- (iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider. . . .

(3) *omitted*

(4) “Utilization review” means either of the following:

- (i) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.
- (ii) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.
- (iii) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

Section 3 – Medical Necessity Determinations Must Follow Generally Accepted Standards

(a) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer’s behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of all covered conditions on current generally accepted standards of care as defined in Section 1 of this Act. All denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of conditions in children, adolescents, and adults, an insurer shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in subdivision (b). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in subdivision (b) to the provider of the service. . . .

(d) To ensure the proper use of the criteria described in subdivision (b), every insurer shall do all of the following:

- (1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.
- (2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.
- (3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.
- (4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.
- (5) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).
- (6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.
- (7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(e) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of conditions covered by an insurance policy, including prescription drugs.

(f) This section applies to an insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(g) If the [state commissioner, EBSA, CMS, other relevant federal regulator] determines that an insurer or third party administrator (TPA) has violated this section, the [regulating entity], after appropriate notice and opportunity for

hearing in accordance with *[relevant section of state and/or federal code]*, by order, assess a civil penalty not to exceed *[five thousand dollars (\$5,000)]* for each violation, or, if a violation was willful, a civil penalty not to exceed *[ten thousand dollars (\$10,000)]* for each violation. The civil penalties available to the [regulator] pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the [regulator] under this code.

(h) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

3. Section 4 – Discretionary Clauses Prohibited

(a) If an insurer contract offered, issued, delivered, amended, or renewed on or after *[effective date]*, contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, the term “discretionary authority” means a contract provision that has the effect of conferring discretion on an insurer or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(c) This section does not prohibit an insurer from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

4. Section 5 – Severability Clause

The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.¹⁸⁷

C. Counter Analysis

Based upon past responses to reform efforts, it is expected insurance companies, and their investors, will resist the proposed Ramstad for All Care Act because they believe these reforms will decrease their profits.¹⁸⁸ However, if the insurer has been acting in good faith and following GASC in its medical review processes, its profits and investor dividends did not depend upon denying

187. Lloyd, *supra* note 14.

188. Choi & Evers-Hillstrom, *supra* note 74.

or delaying medically necessary treatment.¹⁸⁹ The nation must confront the debate about whether basic health care is a right or a commodity and design our health insurance system to support that framework. There is much evidence the health care “market” does not respond to traditional market forces or behave like a regular commodity market.¹⁹⁰ Insurers and politicians have encouraged the concept of “consumer driven care.”¹⁹¹ Given the power and information asymmetry between the patient and insurer, if consumers have little real remedy and cannot be made whole when insurers act in bad faith, consumer driven health care simply is not achievable.

As previously discussed, MCOs have not delivered the lower cost or better outcomes they have promised employers and the government over the past 30 years, and there is no magic wand or incremental tweak of the system that will change this situation. Managed care has increased administrative costs through utilization management and medical review processes that do not deliver value.¹⁹²

Bold reform that re-focuses the system on quality and health outcomes is required. Reform must include insurer accountability, which is sorely lacking under Medicaid and ERISA health plans. Congress must enact legislation to allow for bad faith damages across the board to ensure MCOs comply with existing law and GASC when making coverage decisions.

Some may say this proposed act goes too far. Some employers may balk at the ERISA reforms; however, they are fully in line with Congressional intent, ERISA language, and general principles of insurance and trust law. Further, the reforms benefit employers by delivering better transparency and accountability for one of their major expenses, health insurance costs. Congressional partisanship, inaction, and special interest dominance of the political process will surely provide barriers to enacting reforms. On the other hand, mental

189. Beifuss, *supra* note 133, at 809 (“Although, premiums are determined on the pretext of normal risk, these solutions *will* impact net profits for insurers. Despite the inevitable criticism that these proposed changes will make health insurance less affordable, if the market operated in good faith it should not. Because these changes simply hold welfare benefits insurers accountable for not honoring their obligations, as every other type of insurer already must. For insurers who do not act in bad faith, these changes should have little to no impact on their profitability. In fact, such changes would provide a market advantage for lawful insurers because they could underwrite premiums without the level of consideration for litigation as their dubious competition would have to.”).

190. *Id.* at 775–76.

191. Song G. Yi, *Consumer-Driven Health Care: What Is It, and What Does It Mean for Employees and Employers?*, BUREAU OF LAB. STATS. 4, (Oct. 25, 2010), <https://www.bls.gov/opub/mlr/cwc/consumer-driven-health-care-what-is-it-and-what-does-it-mean-for-employees-and-employers.pdf> [<https://perma.cc/K2G4-NX8E>].

192. PETER G. PETERSON FOUND., *supra* note 20; *see also Connecticut Medicaid Prospers Post Capitated Managed Care*, HEALTH JUST. MONITOR (Mar. 25, 2022), <http://healthjusticemonitor.org/2022/03/25/connecticut-medicaid-prospers-post-capitated-managed-care/> [<https://perma.cc/7RL5-PPYS>].

health parity protections have long enjoyed bi-partisan support.¹⁹³ American families and employers cannot afford to have Congress uphold the status quo in our health insurance system. This proposed legislation leaves the private-public partnership system intact. It continues to provide significant employer control over health insurance options. Congress must acknowledge and address how stigma around mental health, substance use disorder, eating disorders, autism, and developmental and intellectual disabilities result in bias and discrimination in benefit design in all types of health plans. Congress also must acknowledge and address barriers to coverage that notions about “the deserving sick” and “the deserving poor” interject into policymaking. The proposed act is not socialized medicine, a single-payer system or a radical departure from our current structure.

For some, this proposal will not go far enough. Advocates of a single payer system will likely say piecemeal reform does not serve the American public well or move the system closer to treating health care as a human right. Those who believe health insurance companies are profiteering at patients’ expense, damaging our population health and our national economy through ever climbing costs may argue insurers cannot be controlled by reform at all—they will find loopholes to exploit.¹⁹⁴ Some genuinely believe, after experiencing decades of reforms, that only a systems change to universal coverage under a one-payer system will finally address cost and quality issues. Perhaps more robust regulation, ERISA reform through recommitting to trust law remedies, and required reliance on non-profit medical societies to establish the floor of care that must be covered by all health plans will bring us closer to an effective health care system while maintaining the more politically viable public-private health insurance system America has today.

IV. CONCLUSION

Congressional action to better regulate health plan medical review processes is long overdue, especially in ERISA and Medicaid health plans. Such action is paramount in making progress toward consumer driven health care, health equity, and greater patient protection in our disjointed, complex health insurance system. Congress should heed the message from several states and ban discretionary clauses in all types of health plans to level the playing field of remedies for patients harmed by bad actors in the managed care industry. As discussed above, this type of reform should not harm the profitability of insurers acting in good faith. Rather, it would help level the playing field and improve fair competition in the industry. Federal legislation like the proposed Ramstad for All Care Act, with its ban on discretionary clauses and the requirement that all health plans cover GASC as a floor, would go a long way in preventing

193. Sarah Fioroni, *Bipartisan Support for Improving Mental Healthcare Access*, GALLUP (Oct. 24, 2024), <https://news.gallup.com/poll/652079/bipartisan-support-improving-mental-healthcare-access.aspx> [<https://perma.cc/N7T5-MPLU>].

194. *See generally* Stanton, *supra* note 153.

improper care delays and denials. This reform would serve to improve outcomes and reduce costs in the short term by reducing barriers to needed care and reducing the need for insurer and provider staff hours to process and re-process authorizations and appeals. It will serve to improve outcomes and reduce costs in the long run by preventing worsening conditions, treatment interruption and abandonment. Further, by clarifying trust remedies in ERISA and removing immunities for medical reviewers in favor of direct fiduciary responsibility to beneficiaries, patients, employers and taxpayers will be better protected from bad actors and perverse incentives. The high cost of health care in the U.S. does not translate into health care value. In the long run, diminishing administrative burdens and eliminating valueless managed care activities will allow resources to be shifted to value-added activities that do improve individual and population health. Maybe then Americans will start getting real value from their health insurance and experiencing the long-promised lower costs and improved health outcomes.

APPENDIX A: RAMSTAD MODEL ACT RELEVANT LANGUAGE¹⁹⁵

Section 1 – Definitions

(a) The following definitions apply for purposes of this Act:

(1) “Generally accepted standards of mental health and substance use disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) “Medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider. . . .

(3) *omitted*.

(4) “Utilization review” means either of the following:

(i) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(ii) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(iii) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

195. *Jim Ramstad Model Legislation to Advance Mental Health and Addiction Equity By Requiring Compliance with Generally Accepted Standards of Care*, THE KENNEDY FORUM, <https://www.thekennedyforum.org/app/uploads/2021/05/Ramstad-Model-Legislation-May-2021.pdf>, [https://perma.cc/L32K-3WBY] (last visited Feb. 3, 2026).

Section 3 – Medical Necessity Determinations Must Follow Generally Accepted Standards

(a) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care as defined in Section 1 of this Act. All denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, an insurer shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in subdivision (b). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in subdivision (b) to the provider of the service. . . .

(d) To ensure the proper use of the criteria described in subdivision (b), every insurer shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(e) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by an insurance policy, including prescription drugs.

(f) This section applies to an insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(g) If the commissioner determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with *[relevant section of code]*, by order, assess a civil penalty not to exceed *[five thousand dollars (\$5,000)]* for each violation, or, if a violation was willful, a civil penalty not to exceed *[ten thousand dollars (\$10,000)]* for each violation. The civil penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this code.

(h) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

Section 4 – Discretionary Clauses Prohibited

(a) If an insurer contract offered, issued, delivered, amended, or renewed on or after January 1, 2022, contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, the term “discretionary authority” means a contract provision that has the effect of conferring discretion on an insurer or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(c) This section does not prohibit an insurer from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

Section 5 – Severability Clause

The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.