

Indiana Health Law Review

Volume XXIII

2026

Number 2

ARTICLES

INNOVATION TO INTEGRATION: LEGAL PATHWAYS FOR SUSTAINABLE HEALTH CARE COVERAGE

JULIA LYNCH, J.D.,* ERIKA HANSON, J.D.,**
CARMEL SHACHAR, J.D., M.P.H.***

ABSTRACT

Over the last several decades, the U.S. health care system has seen a substantial shift towards value-based care, creating an environment increasingly capable of supporting innovative, yet non-traditional, health care interventions. Despite strong evidence of improved outcomes and reduced costs, many of these innovative services, such as doula, community health worker, and nutrition services, have struggled to transition from community-based programs into sustainable, reimbursable benefits integrated within traditional health insurance systems. Absent integration, these services risk remaining trapped in short-term funding limbo, limiting their impact and long-term sustainability.

This Article examines why many promising, innovative services fail to achieve lasting coverage and argues that successful integration depends on alignment with the legal frameworks that govern health care coverage. Focusing on Medicaid, Medicare, and the Affordable Care Act, we argue that alignment is possible given the flexibility embedded into each program. To bridge the gap between health care innovation and governing legal infrastructures, we identify three recurring legal and structural barriers that inhibit integration: benefit design, provider credentialing, and billing and reimbursement. Through examples, we trace how and why these challenges arise, how each issue is governed under insurance program legal structures, and how some innovative programs and services have successfully navigated these barriers. In doing so, the Article reframes legal compatibility not as an insurmountable obstacle or late-stage hurdle, but as a critical design component at every stage of

* Harvard Law School. The author would like to thank Alexandra Colby for her thoughtful comments and suggestions on an earlier draft of this article.

** Clinical Instructor, Health Law and Policy Clinic, Center for Health Law and Policy Innovation at Harvard Law School and Lecturer on Law, Harvard Law School.

*** Assistant Clinical Professor of Law, Harvard Law School and Faculty Director, Health Law and Policy Clinic, Center for Health Law and Policy Innovation at Harvard Law School.

development. When stakeholders understand and proactively align service models with statutory and regulatory requirements, long-term integration is both achievable and consistent with the core attributes that drive innovative success.

TABLE OF CONTENTS

I. Introduction	
II. The Road to Coverage: The Life Cycle of Innovative Services	
<i>A. Phase One: Grant-funded Community-based Provision</i>	
<i>B. Phase Two: Piloting and Experimentation</i>	
<i>C. Phase Three: Full Integration as a Covered Benefit</i>	
III. Understanding the Structural Gap: Examining Service Models and Legal Frameworks to Address Barriers to Health Care Integration	
<i>A. Differences Between Traditional and Innovative Service Provision and Coverage</i>	
<i>B. Barriers to Sustainable Integration into Health Care Coverage</i>	
1. <i>Benefit Design</i>	
<i>a. Medicaid benefit design rules</i>	
<i>b. Medicare benefit design rules</i>	
<i>c. Affordable Care Act benefit design rules</i>	
<i>d. Challenges and lessons learned in innovative service benefit design</i>	
2. <i>Licensing and Credentialing Providers</i>	
<i>a. Licensing and credentialing across coverage frameworks</i>	
<i>b. Structuring credentialing pathways to support non-traditional providers</i>	
3. <i>Billing and Reimbursement</i>	
<i>a. Medicaid rate setting and reimbursement structure</i>	
<i>b. Medicare rate setting and reimbursement structure</i>	
<i>c. Affordable Care Act rate setting and reimbursement structure</i>	
<i>d. Challenges arising from billing and reimbursement</i>	
<i>e. Alternative payment models present new opportunities</i>	
IV. Conclusion	

I. INTRODUCTION

Of all the high-income nations, the United States experiences the worst health outcomes.¹ This is both despite spending the most on health care, \$4.9 trillion or \$14,570 per person in 2023, and having record health insurance enrollment—92.5% in 2023.² Many commentators believe that these are the consequences of our “sick care” system of health care that primarily focuses on treating illness and disease after they occur, rather than proactively promoting health and preventing disease.³ The consequences of this system are not distributed evenly. Health outcome disparities exist and continue to persist along race, ethnicity, gender, geography, socioeconomic status, and more.⁴

However, over the past several decades, the United States health care system has slowly shifted toward value-based models that prioritize quality and patient-centered delivery.⁵ This shift has ushered in new approaches to care that move beyond mere disease treatment to confront the root causes of chronic diseases, promote whole-person care, and address the social determinants of

1. David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System*, THE COMMONWEALTH FUND (Sep. 19, 2024), <https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024> [<https://perma.cc/KP8C-X8VN>].

2. Anne B. Martin et al., *National Health Expenditures in 2023: Faster Growth as Insurance Coverage and Utilization Increased*, 44 HEALTH AFFS. 12, 12 (2024).

3. See Farshad Fani Marvasti & Randall S. Stafford, *From “Sick Care” to Health Care: Reengineering Prevention into the U.S. System*, 367 NEW ENG. J. MED. 889, 889–890 (2012) (advocating for reorientation of medical education and health care delivery toward homeostasis and prevention rather than disease treatment and diagnosis).

4. Nat’l Acads. of Scis., Eng’g & Med., *Communities in Action: Pathways to Health Equity* 2 (Alina Baciú et al. eds., Nat’l Acads. Press 2017), <https://www.nationalacademies.org/projects/IOM-BPH-15-15/publication/24624> [<https://perma.cc/SRM8-EQLM>].

5. See Michael E. Porter, *Value-Based Health Care Delivery*, 248 ANNALS OF SURGERY 503 (2008), https://journals.lww.com/annalsofsurgery/citation/2008/10000/value_based_health_care_delivery.1.aspx [<https://perma.cc/E34B-7H5F>]; *Value-Based Care*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/key-concepts/value-based-care> [<https://perma.cc/K5HP-4M5G>] (last updated Feb. 27, 2025) (“In value-based care, doctors and other health care providers work together to manage a person’s overall health, while considering an individual’s personal health goals . . . This approach to care also can help people avoid the emergency department and keep them out of the hospital.”); Hannah L. Crook et al., *A Decade of Value-Based Payment: Lessons Learned and Implications for the Center for Medicare and Medicaid Innovation, Part 1*, HEALTH AFFAIRS (June 9, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210607.656313/> [<https://perma.cc/MH3S-9ND2>]; see also Zahy Abou-Atme et al., *Investing in the New Era of Value-Based Care*, MCKINSEY & CO. (Dec. 16, 2022), <https://www.mckinsey.com/industries/healthcare/our-insights/investing-in-the-new-era-of-value-based-care> [<https://perma.cc/U7QQ-59FD>] (describing investment in value-based care (VBC) over the past 10 years and forecasted growth potentials); WENDY GERHARDT ET AL., DELOITTE CTR. FOR HEALTH SOLUTIONS, ROAD TO VALUE-BASED CARE (2015) (detailing the shift from fee-for-service to VBC in 2015, including that “some health care organizations are actively preparing for the transition to VBC while others are hesitating.”); Vaibhav Awasthi, *What is the History of Value-Based Care?*, INNOVACCER (Aug. 23, 2023), <https://innovaccer.com/resources/blogs/what-is-the-history-of-value-based-care> [<https://perma.cc/LAE4-AKXV>] (explaining broader trend towards VBC, including the coining of the term “Value-based Care” in 2006).

health.⁶ Parallel to this system transformation, numerous “innovative interventions”⁷—from doula services to nutrition and housing support services—have demonstrated their ability to improve outcomes, creatively address disparities, and lower costs by preventing the “compounding complexity and disease progression that drive the need for more care.”⁸ Some scholars, however, caution that the benefits of these interventions may be overstated.⁹

6. See, e.g., Exec. Order No. 14212, 90 Fed. Reg. 9833, 9833–36 (Feb. 19, 2025) (setting United States policy towards aggressively combatting chronic diseases by, *inter alia*, prioritizing research on root causes); *Strategic Direction*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/about/strategic-direction> [https://perma.cc/BC8P-85E2] (last updated Mar. 16, 2026, 7:11 PM) (outlining Innovation Center’s 2025 strategy of incentivizing preventive care to help people avoid illness and optimally manage chronic disease); Press Release, U.S. Dep’t. of Health & Hum. Servs., HHS Announces Transformation to Make America Healthy Again (Mar. 27, 2025), <https://www.hhs.gov/press-room/hhs-restructuring-doge.html> [https://perma.cc/8FR6-UBXL]. Chronic conditions impose substantial burdens on health outcomes and health care costs. These conditions, such as diabetes, heart disease, and cancer, are among the leading causes of death and disability in the United States. They are also the leading drivers of the nation’s annual \$4.9 trillion in health care spending. See generally *About Chronic Diseases*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 4, 2025) https://www.cdc.gov/chronic-disease/about/?CDC_AAref_Val=https://www.cdc.gov/chronic-disease/about/index.htm. [https://perma.cc/TD5J-LNVX]; see generally *Whole Person Health: What It Is and Why It’s Important*, NAT’L CTR. FOR COMPLEMENTARY & INTEGRATIVE HEALTH, <https://www.nccih.nih.gov/health/whole-person-health-what-it-is-and-why-its-important> [https://perma.cc/TM2B-FCN9] (last updated May 2021) (“Whole person health involves looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease.”); OFF. OF THE ASSISTANT SEC’Y FOR PLAN. & EVALUATION, U.S. DEP’T OF HEALTH & HUM. SERVS., BUILDING THE EVIDENCE BASE FOR SOCIAL DETERMINANTS OF HEALTH INTERVENTIONS (2021) (evaluating “the existing evidence for effective interventions to address social determinants of health (SDOH) and social needs and identify potential next steps for further developing the evidence base for effective interventions.”).

7. This paper uses terms such as “innovative interventions,” “innovative services,” and “non-traditional” care and services interchangeably.

8. See Elizabeth Teisberg, Scott Wallace & Sarah O’Hara, *Defining and Implementing Value-Based Health Care: A Strategic Framework*, 95 ACAD. MED. 682 (2019) (“A patient whose diabetes does not progress to kidney failure, blindness, and neuropathy is, over time, dramatically less expensive to care for than a patient whose condition continually worsens.”); see generally Allison Orris, Anna Bailey & Jennifer Sullivan, *States Can Use Medicaid to Help Address Health-Related Social Needs*, CTR. ON BUDGET AND POL’Y PRIORITIES (Feb. 27, 2024), <https://www.cbpp.org/research/health/states-can-use-medicaid-to-help-address-health-related-social-needs> [https://perma.cc/9X4S-CQT4]. For instance, reimbursement for nutrition support or housing assistance has improved health outcomes and lowered costs by addressing the underlying drivers of illness rather than merely treating the symptoms. See Alexandra Bryan et al., *Addressing Malnutrition Through Advances in Value-Based Care*, HEALTH AFFS. (Apr. 2, 2025), <https://www.healthaffairs.org/content/forefront/addressing-malnutrition-through-advances-value-based-care> [https://perma.cc/2VWD-H5N9].

9. See, e.g., Katherine Baicker & Amitabh Chandra, *Can Prevention Save Money?*, 6 JAMA HEALTH FORUM 1, 2 (2025) (“[P]resently, there is little evidence for lifestyle and behavioral health promotion programs that reduce future health care costs by enough for a large enough share of participants to save money overall—and many may not even improve health outcomes.”). Baicker and Chandra argue, thus, that innovations should be evaluated not based on whether they “save money” but “whether they improve health sufficiently based on their cost.” *Id.*

The rise of value-based payment models, expanded public and private funding for the piloting and development of non-traditional interventions,¹⁰ and bipartisan momentum for whole-person care¹¹ are converging to create an environment conducive to supporting the scaling of services that address the U.S. health care system's most pressing needs. Still, all these developments present a legal and administrative challenge: can innovative approaches, which often leverage non-medical professionals and deliver services beyond traditional clinical settings, be integrated into existing legal frameworks and coverage and reimbursement systems without sacrificing the very attributes that have made them successful?

Legal scholars have examined the statutory and administrative constraints on health care innovation, often focusing on the “purposes” of the U.S. health insurance systems, particularly in Medicaid. Many scholars have addressed how the statutory language and surrounding case law interpreting the Social Security Act do or do not allow for or constrain innovation, such as coverage of nutrition and housing supports or imposition of work requirements via Medicaid Section

10. Federal programs, states, and private insurers have formalized and expanded reimbursement pathways for several innovative services and payment models. See Sahil Sandhu et al., *Integrated Health and Social Care in the United States: A Decade of Policy Progress*, 21(4) INT'L J. OF INTEGRATED CARE 1, 2 (2021), <https://pmc.ncbi.nlm.nih.gov/articles/PMC8570194/pdf/ijic-21-4-5687.pdf> [<https://perma.cc/GTF3-4MF3>] (“Innovative approaches to integrate health and social services expanded rapidly with the shift towards value-based payment models and the growing evidence that adverse social determinants of health (SDOH) are major drivers of poor health.”); see Alice T. Chen et al., *The Community as a Full Partner: A New Model for Public Health*, 43 HEALTH AFFAIRS 805 (2024), <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2024.00033> [<https://perma.cc/K7PR-HY25>] (advocating for continued support for community-based partnerships post-pandemic); see, e.g., Amy Chen, *State of the States (November 2024): Efforts to Expand Access to Doula Care in Medicaid and Private Insurance*, NAT'L HEALTH L. PROGRAM (Dec. 6, 2024), <https://healthlaw.org/resource/state-of-the-states-november-2024-efforts-to-expand-access-to-doula-care-in-medicaid-and-private-insurance/> [<https://perma.cc/6H2L-XUU6>] (collecting data on eighteen states that have implemented Medicaid doula coverage and eight states which require private health plans to cover doula care); U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., SHO# 21-001 RE: OPPORTUNITIES IN MEDICAID AND CHIP TO ADDRESS SOCIAL DETERMINANTS OF HEALTH (SDOH) (2021) (identifying key federal authorities that can be used to support innovative strategies to improve care and reduce costs, in the context of addressing Social Determinants of Health); Exec. Order No. 14212, 90 Fed. Reg. 9833, 9833–36 (Feb. 19, 2025) (directing agencies to “ensure the availability of expanded treatment options and the flexibility for health insurance coverage”); *Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. 1 (2023), <https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf> [<https://perma.cc/FSE6-ELYG>] (identifying opportunities for states to address health-related social needs through Medicaid authorities); but see U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., RESCISSION OF GUIDANCE ON HEALTH-RELATED SOCIAL NEEDS (2025) (rescinding November 2023 guidance but restating commitment “to working with states to help identify strategies to support innovation and improvement in Medicaid and CHIP.”).

11. See Exec. Order No. 14,212, 90 Fed. Reg. 9833–36 (Feb. 19, 2025); U.S. Dep't of Health & Hum. Servs., *supra* note 6.

1115 demonstration waivers.¹² Others have focused on structural barriers to the development of responsive services within our health care systems. These commentators have highlighted how front-end inhibitors, such as weak market incentives and insufficient evaluative mechanisms, direct innovation away from “socially valuable” services.¹³

Today, the innovation landscape has evolved. Many programs have overcome early-stage barriers, leveraging grant funding and community-based efforts to fill gaps left by traditional health care delivery and develop effective service models.¹⁴ However, this bottom-up approach to service innovation and development presents new challenges of navigating health care integration at scale. As these initiatives seek to pursue health care reimbursement, the tension between innovative, value-based care models and health insurance statutory frameworks has become more salient. Many of these innovative services are currently functioning as pilots—e.g., via Medicaid Section 1115 demonstration authority—and struggle to transition to fully covered benefits, a critical legal distinction that implicates long-term sustainability.¹⁵ The consequences of this struggle for integration are particularly acute for patients. When services are not covered by health insurance, patients—especially those in need of care the

12. See, e.g., Laura S. Richman & Barak D. Richman, *The Objectives of Medicaid: The Legal Definition Behind America's Most Important Health Program*, GW L. FAC. PUBL'NS (2024), <https://dx.doi.org/10.2139/ssrn.5067576> [<https://perma.cc/L9EB-96T2>]; Kristen Underhill, *Purchasing Health? The Promise and Limits of Public Health Insurance*, 119 COLUM. L. REV. F. 302 (2019); Nicole Huberfeld, *Medicaid Waivers, Administrative Authority, and the Shadow of Malingering*, 49 J. L., MED. & ETHICS 394 (2021).

13. See, e.g., Daniel J. Hemel & Lisa Larrimore Ouellette, *Valuing Medical Innovation*, 75 STAN. L. REV. 517, 520–21 (2023) (“the system fails to provide adequate incentives . . . to invest in the medical innovations that would do the most to improve health”); Rachel E. Sachs, *Integrating Health Innovation Policy*, 34 HARV. J.L. & TECH. 58, 61 (2020) (“private market signals may distort innovative activity away from a class of therapies that would be highly socially valuable”); Amy Kapczynski & Talha Syed, *The Continuum of Excludability and the Limits of Patents*, 122 YALE L.J. 1900, 1956 (2013) (raising concerns that the complexity and costs of evaluating the success of non-medical interventions “may ultimately prove insurmountably high” because of confounding variables and nonquantifiable outcome measures).

14. Rachael Zimlich, *Community-Based Care Programs Fill Gaps in Traditional Health Services*, MANAGED HEALTHCARE EXEC. (Jan. 3, 2019), <https://www.managedhealthcareexecutive.com/view/community-based-care-programs-fill-gaps-traditional-health-services> [<https://perma.cc/Z27G-6D8C>] (referencing Carrie E. Fry et al., *Evaluating Community-Based Health Improvement Programs*, 37 HEALTH AFF. 22 (2018)); see also Amelia Whitman et al., *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts* 13, OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION (Apr. 1, 2022), <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf> [<https://perma.cc/CMG8-LD9Y>] (identifying CDC's “REACH” grants, pilot projects, and other investments into community-based services); see also Katie Garfield, Julia Koprak & John Haughton, *Addressing Nutrition and Food Access in Medicaid*, THE FOOD TR., https://thefoodtrust.org/wp-content/uploads/2022/07/report_addressing-nutrition-and-food-access-in-medicaid_2021.original.pdf [<https://perma.cc/E34J-V5MW>] (last visited Apr. 5, 2026) (detailing food and nutrition interventions, grant funders such as HHS, USDA, states, and health care entities).

15. See, e.g., 42 U.S.C. § 1315(f)(6).

most—may be unable to pay for the services out-of-pocket and therefore may not be able to access them.¹⁶

This Article argues that, despite seeming facial incompatibility, the U.S. coverage systems—structured under Medicare, Medicaid, and the Affordable Care Act (ACA)—are flexible enough to support the sustainable inclusion of innovative services. But successful integration requires proactive alignment with the legal frameworks that govern these systems.¹⁷ By clarifying the statutory and regulatory contours of the three major U.S. coverage pathways, this Article seeks to bridge the gap between health care innovation and the legal infrastructure that governs it.

Armed with the knowledge of how their interventions may be evaluated, measured, and reimbursed by insurers, drivers of innovation can proactively structure their services to maximize scalability and future coverage opportunities. Full integration of these community-based services into traditional coverage frameworks not only enhances access and financial sustainability but also amplifies the core goals of value-based care: improved health outcomes, cost reductions, and greater satisfaction among patients and providers.¹⁸ Even if not every innovator, service provider, or stakeholder seeks to secure long-term health care funding, structuring programs in alignment with existing legal standards will promote stability and consistency across programs while keeping long-term coverage opportunities on the table.

This Article proceeds in three parts. Part II outlines the innovative service “life cycle” from community-based program to sustained health care reimbursement. Part III draws distinctions between traditional and innovative service models and identifies the structural and legal misalignments that often inhibit long-term health care integration and coverage. The section then examines three recurring barriers to integration that arise from this misalignment: benefit design, provider credentialing, and billing and reimbursement. By drawing on examples, it analyzes how these barriers emerge

16. Grace Sparks et al., *Americans’ Challenges with Health Care Costs*, KFF (Jan. 29, 2026), <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs> [https://perma.cc/6U4J-K4M3] (“[36% of] adults say that in the past 12 months they have skipped or postponed getting health care they needed because of the cost . . . [75% of uninsured adults under 65] say they went without needed care because of the cost.”); see, e.g., Rory Peters & Alexis Robles-Fradet, *2024 Update: Medicaid Coverage for Doula Care Requires Sustainable and Equitable Reimbursement to be Successful*, NAT’L HEALTH L. PROGRAM (Jan. 23, 2025), <https://healthlaw.org/2024-update-medicaid-coverage-for-doula-care-requires-sustainable-and-equitable-reimbursement-to-be-successful/> [https://perma.cc/WRG5-84SW] (explaining how out-of-pocket costs for Doula care can be unaffordable for low-income families).

17. See, e.g., *Healthy Opportunities for All: A Practitioner’s Recommendations for Success*, REINVESTMENT PARTNERS 14 (Oct. 2022), https://static1.squarespace.com/static/6525b3af3afe0f0c191f9b5f/t/675ab65c0f9ab67d2584138c/1733998173019/Healthy+Opportunities+for+All_1_final.pdf [https://perma.cc/X3D2-22NE] (concluding that—in the context of a state-based pilot which provides food, housing, and transportation assistance to eligible Medicaid beneficiaries—making improvements early in the development of the pilots will increase their likelihood of becoming covered benefits).

18. *Value-Based Care*, *supra* note 5.

and how stakeholders have successfully aligned innovative services with the Medicaid, Medicare, and the Affordable Care Act legal frameworks to promote coverage compatibility. Finally, Part IV offers practical guidance for providers, funders, and policymakers seeking to support the sustainable development and integration of innovative care.

II. THE ROAD TO COVERAGE: THE LIFE CYCLE OF INNOVATIVE SERVICES

Innovators have leveraged a variety of established pathways to secure both short and long-term coverage and reimbursement for services. For example, community health workers (CHWs), frontline public health workers who serve as intermediaries between communities and health and social services, have been funded by Medicaid state plan amendments (SPA), Section 1115 demonstration waivers, managed care organizations (MCOs), and the Medicare Community Health Integration (CHI) program.¹⁹ Food is Medicine (FIM) programs, which provide certain patients with chronic illnesses with nutrition support services such as medically tailored meals, medically tailored groceries, and produce prescriptions, have accessed coverage through several Medicaid authorities, including Section 1915(c) home and community-based services waivers and Section 1115 demonstration waivers.²⁰ And non-emergency medical transportation services (NEMT), which provide Medicaid beneficiaries with transportation to and from medically necessary health care services, have transitioned from a federal “administrative requirement” to a covered Medicaid benefit.²¹

Although services leverage a variety of funding options, many follow a

19. See *Community Health Workers*, AM. PUB. HEALTH ASS’N, <https://www.apha.org/apha-communities/member-sections/community-health-workers> [<https://perma.cc/BB3V-TH26>] (last visited Apr. 5, 2026); see generally *State Community Health Worker Policies*, NAT’L ACAD. FOR STATE HEALTH POL’Y, <https://nashp.org/state-tracker/state-community-health-worker-policies/> [<https://perma.cc/G89Y-JFHW>] (last visited Apr. 5, 2026); Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 78818, 78920–21 (Nov. 16, 2023) (to be codified at 42 C.F.R. pts. 405, 410, 411, 414, 415, 418, 422, 423, 424, 425, 455, 489, 491, 495, 498, & 600).

20. See generally Dariush Mozaffarian et al., “Food Is Medicine” *Strategies for Nutrition Security and Cardiometabolic Health Equity: JACC State-of-the-Art Review*, 83 J. AM. COLL. CARDIOLOGY 843 (2024); FOOD IS MEDICINE: A STATE MEDICAID POLICY TOOLKIT, CTR. FOR HEALTH L. & POL’Y INNOVATION OF HARV. L. SCH. & FOOD IS MED. COAL. 5–22 (July 2024) (detailing four Medicaid/CHIP authorities states can use to pay for and deliver FIM services).

21. *Non-Emergency Medical Transportation*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/medicare/medicaid-coordination/states/non-emergency-medical-transportation> [<https://perma.cc/DV37-ECPJ>] (last visited Apr. 28, 2025); 42 C.F.R. § 431.53 (As an “administrative requirement,” states were required to ensure necessary transportation to and from providers for Medicaid enrollees to receive Medicaid reimbursement); Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, § 209, 134 Stat. 1182, 2988 (2020) (codifying NEMT as a Medicaid Mandatory Benefit); see also MEDICAID & CHIP PAYMENT & ACCESS COMM’N, MANDATED REPORT ON NON-EMERGENCY MEDICAL TRANSPORTATION 154 (2021).

similar trajectory as they transition from community-based interventions to integrated components of health care coverage. This path typically unfolds in three stages: (1) grant-funded community-based provision, (2) piloting and experimentation within formal systems, and (3) full integration as a covered benefit.

A. Phase One: Grant-funded Community-based Provision

Government and private grants and local funding provide critical resources for seeding, evaluating, and expanding access to interventions.²² For example, Wholesome Wave is a community-based nonprofit that pioneered several innovative interventions to address nutrition insecurity.²³ One such intervention is the produce prescription, which enables medical professionals to provide patients with funds to purchase fruits and vegetables.²⁴ These prescriptions increase access to healthy foods and reduce downstream health care costs associated with diet-related illnesses, particularly chronic diseases.²⁵ Like many other groundbreaking interventions, this program has been supported by grants from the federal government, nonprofit foundations, and local funders and partners.²⁶ Similarly, doula services²⁷ have been sustained and expanded

22. See, e.g., ADVANCING A HEALTHIER WISCONSIN ENDOWMENT, *Community-Led Seed Grants* 3–4 (June 2024) (offering private grants to “support[] community-driven efforts to conduct initial exploration and test innovative ideas to serve as a foundation for future larger, sustainable efforts to improve health.”); *How We Work*, ROBERT WOOD JOHNSON FOUND., <https://www.rwjf.org/en/about-rwjf/how-we-work.html> [<https://perma.cc/LF4T-HVEL>] (last visited Apr. 5, 2026), (supplying private grants for innovative strategies to create lasting change for health equity); Natasha Singer, *Eat an Apple (Doctor’s Orders)*, N.Y. TIMES (Aug. 13, 2010), <https://archive.nytimes.com/www.nytimes.com/2010/08/13/business/13veggies.html> [<https://perma.cc/49CQ-BSYY>]; *Wholesome Wave Awarded USDA Grant*, WHOLESOME WAVE (Dec. 21, 2022), <https://www.wholesomewave.org/news/usda-grant-awarded> [<https://perma.cc/G6PP-BGLT>] (federal government grant awarded for FIM service); see also Food Justice, *2021 Farmers Markets Coupon Program Launched*, CITY OF BOS. (July 2, 2021), <https://web.archive.org/web/20260303172240/https://www.boston.gov/news/2021-farmers-markets-coupon-program-launched> [<https://perma.cc/U4Q3-Y6WJ>] (exemplifying collaboration between nonprofit organizations and state and local governments to develop farmers market nutritional benefits programs).

23. Wholesome Wave, *supra* note 22.

24. See generally *Improving Health by Embedding Produce Prescriptions (PRx) into Healthcare Practice*, NAT’L PRODUCE PRESCRIPTION COLLABORATIVE, <https://nppc.health/> [<https://perma.cc/H6KS-JJHT>] (last visited Apr. 5, 2026).

25. Kurt Hager et al., *Food is Medicine Research Action Plan*, ASPEN INST. 84 (2024), <https://aspenfood.org/wp-content/uploads/2024/04/Food-is-Medicine-Action-Plan-2024-Final.pdf> [<https://perma.cc/9YYS-JTPR>].

26. See *supra* note 22 and accompanying text.

27. Doulas are “non-medical professionals who provide emotional, physical, and informational support and guidance” before, during, and after labor and birth.; *Doula*, CLEV. CLINIC, <https://my.clevelandclinic.org/health/articles/23075-doula> [<https://perma.cc/RT4L-GVD6>] (last updated Jan. 15, 2025); see also *What Is a Doula*, NAT’L HEALTH L. PROGRAM (2020), https://healthlaw.org/wp-content/uploads/2020/04/WhatIsADoula_4.16.2020.pdf [<https://perma.cc/F27B-L7D7>].

through funding from foundations, nonprofit grant makers, departments of public health, and federal grants, which have increased access to culturally competent, supportive care for pregnant individuals.²⁸

Although these early funding streams are instrumental in the initial development of innovative services, they are not long-term or statewide solutions.²⁹ As services develop and demonstrate their capacity to improve health outcomes, reduce costs, and/or address health care disparities, forerunners often seek to expand beyond the community-based model, leading to phase two.

B. Phase Two: Piloting and Experimentation

The second phase involves piloting and experimentation, where innovative services leverage legal flexibilities—such as pilot programs and waivers—offered within traditional health care models.³⁰ These mechanisms permit states and insurers to fund novel, evidence-based interventions and service delivery

28. See, e.g., Press Release, BCBSMA Foundation, BCBSMA Foundation Announces \$360,000 in Grants for Perinatal Health (July 18, 2024), <https://www.bluecrossmafoundation.org/about-us/news-updates/bcbsma-foundation-announces-360000-grants-perinatal-health> [https://perma.cc/6NTH-2494] (providing grant funds for “supporting access to doula care for pregnant people in communities of color”); *Birth Justice Fund*, GROUNDSWELL FUND, <https://groundswellfund.org/funds/birth-justice-fund/> [https://perma.cc/B6UX-5BSQ] (last visited Apr. 5, 2026) (providing nonprofit grants “to make midwifery and doula care and training accessible to women of color, low-income women, and transgender people.”); *Doula Initiative*, COMMONWEALTH OF MASS., <https://www.mass.gov/info-details/doula-initiative> [https://perma.cc/4N4R-NW7Q] (last visited May 11, 2025) (the Massachusetts Department of Health “Doula Training Scholarship provides financial support for individuals pursuing doula training or continuing education”); Healthy Start Supplement: Community-Based Doulas, HEALTH RES. & SERVS. ADMIN., <https://www.hrsa.gov/grants/find-funding/HRSA-22-148> [https://perma.cc/GC3K-6X3L] (last visited May 11, 2025) (providing federal supplemental funding to increase the availability of doulas in “areas most affected by infant and maternal mortality and to increase the number of women with a higher risk of poor birth outcomes receiving doula services.”).

29. See, e.g., Carl Rush, *Sustainable Financing of Community Health Worker Employment*, NAT’L ASS’N OF CMTY. HEALTH WORKERS 1 (2020), <https://nhchw.org/resource/chw-sustainable-financing-2020/> [https://perma.cc/9DDT-Y6Z7]; see also Molly Knowles et al., *Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States*, 44 ANN. REV. PUB. HEALTH 363, 371 (2023) (“Lack of sustainable financing is consistently identified as one of the most significant barriers to CHW expansion and integration with health care.” (internal citation omitted)).

30. See, e.g., Alison Aubrey, *Fresh Food Advocate Links Farmers, Doctors, Low-Income Families*, NPR (Apr. 27, 2012, 11:53 AM), <https://www.npr.org/sections/thesalt/2012/04/26/151473374/fresh-food-advocate-links-farmers-doctors-low-income-families> [https://perma.cc/FU2Y-5SV4] (discussing interest in pilot program for produce prescription program with Wholesome Wave co-founder); Amy Chen, *Best Practices for Medicaid Coverage of Doula Care*, NAT’L HEALTH L. PROGRAM, <https://healthlaw.org/doulamedicaidproject-bestpractices/> [https://perma.cc/Y4EU-EBYV] (last updated Mar. 2026) (discussing pilot programs for doula services which allow “local, regional, and state actors to test out different types of doula projects”); *MTM Program Pilot Act*, FOOD IS MED. COAL., <https://fimcoalition.org/policy/policy-priorities/mtm-pilot-act/> [https://perma.cc/Z6NP-FDEG] (last visited Apr. 5, 2026) (supporting a bill to establish a Medicare pilot program for Medically Tailored Home-Delivered Meals).

approaches, sometimes by waiving certain legal requirements.³¹ For example, the joint federal-state Medicaid program, administered by the Centers for Medicare & Medicaid Services (CMS), is one of the leading drivers of innovation financing in health care.³² Some Medicaid financing options include Section 1115 demonstration waivers³³ and Medicaid Managed Care In-lieu of Services (ILOS).³⁴ With this more formalized support, programs can build the evidence base for broader expansion and integration into standard coverage pathways.

Importantly, while these options enable innovators to test, evaluate, and refine service delivery models, they are not meant to provide long-term coverage.³⁵ Medicaid Section 1115 demonstration waivers, for example, are typically approved for an initial five-year period.³⁶ Although there is no cap on the number of times a demonstration waiver can be renewed or extended, there is also no guarantee of reauthorization.³⁷ Moreover, eligibility for pilot programs or waivers does not ensure compatibility with the heavily regulated health care

31. *See, e.g.*, 42 U.S.C. § 1315(a)(1) (permitting HHS Secretary to waive certain Medicaid state plan requirements for experimental, pilot, or demonstration projects); 42 U.S.C. 1396n(c)(3) (permitting states to waive certain Medicaid program requirements such as state wideeness and comparability for Home and Community Based Services waivers); 42 C.F.R. §§ 438.3(e)(2), 438.16 (enabling states and Medicaid managed care plans to expand settings options and provide medically appropriate and cost-effective substitutes for state plan covered services).

32. *See* Sandhu et al., *supra* note 10 (in describing three major Medicaid policy initiatives in the past decade, noting that “[g]iven Americans covered by Medicaid face greater socioeconomic challenges compared to Americans with private insurance, and are traditionally at highest risk for unmet social needs and societal inequities, the Medicaid program has been uniquely poised and motivated to integrate social care into health care delivery”).

33. 42 U.S.C. § 1315(a)(1); *see also* *About Section 1115 Waivers*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations> [https://perma.cc/D5SR-LYVV] (last visited Apr. 6, 2026).

34. 42 C.F.R. §§ 438.3(e)(2), 438.16. ILOSs can be utilized by state Medicaid programs and their managed care plans to strengthen access to care by expanding service and settings options as alternatives to traditional Medicaid benefits.; *see also* Diana Crumley, *Using In Lieu of Services to Address Health-Related Social Needs: Upshots from the Recent Federal Rule*, CTR. FOR HEALTH CARE STRATEGIES (June 2024), <https://www.chcs.org/resource/using-in-lieu-of-services-to-address-health-related-social-needs-upshots-from-the-recent-federal-rule/> [https://perma.cc/9YN3-M9HB] (explaining the use of ILOS to cover health-related social needs).

35. *See* Garfield, Koprak, & Haughton, *supra* note 14 (“Federal, state, and philanthropic grant and pilot programs are often time-limited”); CTR. FOR HEALTH L. & POL’Y INNOVATION OF HARV. L. SCH. & FOOD IS MED. COAL., *supra* note 20, at 36 (summarizing approval periods for five main pathways); *see, e.g.*, Knowles et al., *supra* note 29 (documenting organizational advocacy for long-term sustainable payment for CHWs given limitations of waivers and ILOS).

36. *See* 42 U.S.C. § 1315(f)(6); U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 33.

37. Demonstration waivers can typically be extended in three-to-five-year increments. *See id.*; *see, e.g.*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., RE: DESIGNATED STATE HEALTH PROGRAMS AND DESIGNATED STATE INVESTMENT PROGRAMS (2025), <https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf> [https://perma.cc/QT7X-YVQB] (determining that certain demonstration projects will no longer be approved nor renewed, given CMS’s concerns about the appropriateness of providing federal funding for such programs).

delivery and financing systems already in place.³⁸ As a result, many programs find themselves at the end of a grant or pilot period without a clear funding source or path to full integration.

The Strong Start for Mothers and Newborns Initiative serves as an apt example.³⁹ From approximately 2013 to 2017, this program tested enhanced prenatal care interventions, such as birth centers, for women at risk of having preterm birth.⁴⁰ Despite “exceptional” results in reducing racial inequalities, improving birth outcomes, and lowering costs, the initiative did not transition into a sustained, covered benefit.⁴¹ Multiple factors contributed to this outcome, including provider difficulties in contracting with MCOs, low Medicaid reimbursement rates, and lengthy Medicaid eligibility determination processes.⁴²

These challenges reflect a deeper structural issue, as many Strong Start interventions did not align with traditional Medicaid benefit categories or payment models. For example, the initiative followed a midwifery model of prenatal care, which, particularly at the time, differed significantly from the approach compatible with existing reimbursement structures.⁴³ Unlike discrete, billable services typically provided by obstetricians in hospital settings, birth centers offer comprehensive prenatal, delivery, and postpartum care, often requiring longer visits and extended support both pre- and post-delivery.⁴⁴

38. See, e.g., *North Carolina's Healthy Opportunities Pilots: Barriers and Pathways to Success*, REINVESTMENT PARTNERS 6–7, https://static1.squarespace.com/static/6525b3af3afe0f0c191f9b5f/t/675ab68693a5583f5ed9bbf6/1733998214541/NC+HOPS+Barriers+and+Pathways+to+Success_final.pdf [<https://perma.cc/QX2F-HQVK>] (last visited Apr. 28, 2025) (explaining the difference between assisting provider organizations in complying with pilot program requirements and preparing them to become vendors in the health care sector).

39. See generally *Strong Start for Mothers and Newborns: General Information*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/innovation-models/strong-start> [<https://perma.cc/8LSV-8UXH>] (last visited Apr. 6, 2026).

40. *Spotlight on Success: The Strong Start for Mothers and Newborns Initiative*, NAT'L P'SHIP FOR WOMEN & FAM. (Sep. 2020), <https://nationalpartnership.org/report/spotlight-on-success-the-strong-start-for-mothers-and-newborns-initiative/> [<https://perma.cc/B6JD-AMDL>]. There were three models of enhanced prenatal care: group prenatal care, birth centers, and maternity care homes. *Id.*

41. *Id.*; CTR. FOR MEDICARE & MEDICAID INNOVATION, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *STRONG START FOR MOTHERS AND NEWBORNS: EVALUATION OF FULL PERFORMANCE PERIOD 2* (2018), <https://www.cms.gov/priorities/innovation/files/reports/strongstart-prenatal-fg-finalevalrpt.pdf> [<https://perma.cc/48HS-X9P3>] (“Women who received prenatal care in Strong Start Birth Centers had better birth outcomes and lower costs relative to similar Medicaid beneficiaries not enrolled in Strong Start.”); see U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 39 (“The Strong Start initiative period of performance has concluded and is no longer active.”).

42. See IAN HILL ET AL., *STRONG START FOR MOTHERS AND NEWBORNS EVALUATION: YEAR 5 PROJECT SYNTHESIS VOLUME 1: CROSS-CUTTING FINDINGS* 143–44 (2018), <https://www.cms.gov/priorities/innovation/files/cmml/strongstart-prenatal-finalevalrpt-v1.pdf> [<https://perma.cc/G629-6NU6>].

43. See *id.* at 3.

44. See *id.* at 3–4.

Rather than emphasizing strictly medical interventions like pharmaceutically induced labor or continuous electronic fetal monitoring, Strong Start offered enhanced services such as peer counseling, health education, and psychosocial support—many of which were not reimbursable under Medicaid at all.⁴⁵ As a result, reimbursement rates for Strong Start providers were substantially lower.⁴⁶ For instance, one birth center in Charleston, South Carolina, reported receiving only \$1,600 from the state’s MCO despite the actual cost of care being approximately \$3,000.⁴⁷ Because Medicaid payments failed to cover the true cost of delivering care, many birth centers were unwilling or unable to serve Medicaid beneficiaries,⁴⁸ ultimately contributing to the program’s inability to transition into a sustained benefit.

The Strong Start example reflects a critical point: compatibility with existing coverage frameworks is not merely advantageous but essential. Without it, programs are stuck in short-term funding limbo, dependent on grants or pilot programs, in which even the most successful interventions may not access sustainable reimbursement mechanisms. Moreover, reliance on short-term funding can lead to service interruptions, high provider turnover, and wasteful reinvestment to meet shifting priorities.⁴⁹ Conversely, alignment with coverage structures and legal frameworks can unlock vital funding sources, allowing organizations and providers to deepen their impact while reducing the total cost of care and improving patient health.⁵⁰

45. *See id.* at 3–4, 42.

46. *See id.* at 42 (“birth centers paid as little as 15 percent of hospital rates for the same delivery, and between obstetricians and midwives’ reimbursement, with midwives paid 70 to 92 percent of physician rates for the same service”) (internal citation omitted).

47. *See id.* at 28.

48. *See id.*

49. *See, e.g.,* REINVESTMENT PARTNERS, *supra* note 38, at 1, 6–7 (explaining that failed pilots and unsuccessful integration into Medicaid managed care program will result in service disruption and loss of political and industry support); Knowles et al., *supra* note 29 (discussing provider turnover rates and service interruption); Rush, *supra* note 29 (identifying limits of short-term funding, including that it may be “subject to appropriations or private philanthropic decisions” which do “not afford CHWs or their employers the latitude to apply the full range of CHW capabilities to community needs”); *cf.* Georgia Health Policy Center, *Bringing the Future into Focus: A Step-by-Step Sustainability Planning Workbook* 4 (2011) (explaining how grant-funded programs may need to “scale back” the services provided or the coverage area in response to reduced financial support).

50. *See Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case*, KPMG 9 (Mar. 2018), <https://www.commonwealthfund.org/publications/other-publication/2018/mar/investing-social-services-core-strategy-healthcare> [<https://perma.cc/6F4X-LWQA>]; We acknowledge that coverage integration introduces new challenges, familiar to traditional health care interventions. For example, health insurance “churn” or the frequency with which individuals move in and out of different insurance plans remains an ongoing challenge for patient access, specifically in the context of maternity care. For example, pregnant people in non-Medicaid expansion states typically lose guaranteed Medicaid coverage just sixty days after the birth. As a result, their access to post-partum services, such as those offered through the Strong Start, is limited. *See generally* Kathy Gifford et al., *Medicaid Coverage*

C. Phase Three: Full Integration as a Covered Benefit

Some innovative interventions have transitioned into the third phase, which is full health care integration. For example, the Diabetes Prevention Program (DPP),⁵¹ non-emergency medical transportation (NEMT) services, and doula services have become covered health care benefits under several traditional insurance programs.⁵² For example, after several states successfully piloted Medicaid coverage for doula services, CMS provided technical assistance, including SPA templates, to encourage more states to add these services to their programs.⁵³ Now, several states cover doula services under various benefit categories, most commonly under the “preventive services” category.⁵⁴

To achieve success, innovators typically first demonstrate improved outcomes and cost savings during the grant-funding and pilot phases. Then, they show that their services are compatible with existing legal and administrative frameworks (e.g., for delivery, billing, and oversight). Finally, programs can be formally adopted as mandated or optional covered benefits through federal or state programs—or both. Once integrated, such services can become accessible

of Pregnancy and Perinatal Benefits: Results from a State Survey, KAISER FAMILY FOUND. 5–6 (2017), <https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-and-perinatal-benefits-introduction/> [https://perma.cc/6XAV-MLNE]. Policy changes that expand and encourage continued coverage have the potential to reduce these effects. *Id.* at 6.; *see also* Sachs, *supra* note 13, at 71.

51. The Diabetes Prevention Program is a value-based intervention program that works to prevent the progression of type 2 diabetes through a lifestyle change program. *See generally About Prediabetes and Type 2 Diabetes*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/diabetes-prevention/about-prediabetes-type-2/index.html>. [https://perma.cc/AG6L-WBJU] (last visited Apr. 6, 2026).

52. *See, e.g.*, 42 C.F.R. § 410.79 (DPP coverage under Medicare Part B); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 209, 134 Stat. 1182, 2986–89 (2020) (adding NEMT as a Medicaid requirement); *Commercial Coverage Landscape: Payer List*, NAT’L DPP COVERAGE TOOLKIT, <https://coveragetoolkit.org/commercial-coverage-landscape/> [https://perma.cc/HT3S-4SH3] (last updated July 30, 2025) (listing commercial health plans that cover DPP’s lifestyle change program); Anoosha Hasan, *State Medicaid Approaches to Doula Service Benefits*, NAT’L ACAD. FOR STATE HEALTH POL’Y (Mar. 31, 2026), <https://nashp.org/state-tracker/state-medicare-approaches-to-doula-service-benefits/> [https://perma.cc/59FM-CA4K] (showing doula coverage under state Medicaid programs); *see also* U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 21 (describing NEMT benefits); NAT’L HEALTH L. PROGRAM, *supra* note 27 (describing doula benefits).

53. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., SHO# 21-007 RE: IMPROVING MATERNAL HEALTH AND EXTENDING POSTPARTUM COVERAGE IN MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) 9–10, 22 (2021), <https://www.medicare.gov/federal-policy-guidance/downloads/sho21007.pdf> [https://perma.cc/W9QU-JH8K].

54. *See* Priti Khanal et al., *Covering Doula Services Under Medicaid: Design and Implementation Considerations for Promoting Access and Health Equity*, CTR. FOR HEALTH CARE STRATEGIES 12 (Dec. 2022), https://www.chcs.org/media/Covering-Doula-Services-Under-Medicaid-Brief_120822.pdf [https://perma.cc/KYT4-FUT9]; Hasan, *supra* note 52 (showing doula coverage under state Medicaid programs and listing coverage under “Preventive,” “Other Diagnostic, Screening, Preventive, and Rehabilitative Services,” and “Freestanding Birth Centers” benefit categories); *see also* 42 C.F.R. § 440.130.

to qualifying beneficiaries through standard reimbursement mechanisms, enabling sustainable support for scale and impact. Although processes and pathways vary across services and insurer types, in all cases, long-term coverage requires demonstration of both efficacy and legal fit.

III. UNDERSTANDING THE STRUCTURAL GAP: EXAMINING SERVICE MODELS AND LEGAL FRAMEWORKS TO ADDRESS BARRIERS TO HEALTH CARE INTEGRATION

On the path from community-based intervention to health care benefit, many services struggle to achieve sustainable integration into traditional insurance coverage. These difficulties often stem not from clinical inefficacy but from mismatches between how innovative services operate and how health care is structured.

Understanding this gap is essential to navigating the transition from innovation to integration. This section begins by comparing traditional and non-traditional service models to illustrate where and why misalignment occurs. These structural differences help explain why, despite demonstrated health and cost benefits, many services struggle to move beyond short-term funding and achieve long-term integration into health care. This section goes on to examine how these challenges emerge and how alignment with one or more of the country's three major health care coverage frameworks—Medicaid, Medicare, and the ACA—can serve as tools to design coverage-compatible models. As innovative services gain traction under value-based care, understanding structural and legal barriers and how programs have navigated them is essential to maximizing benefits, expanding access, and minimizing costs and waste.

A. Differences Between Traditional and Innovative Service Provision and Coverage

To contextualize the obstacles that arise during the transition from pilot to covered benefit, it is helpful to highlight some core differences between how traditional and innovative services are provided, covered, and reimbursed. A comparison between a routine service, such as a measles vaccination, and a non-traditional intervention, like doula care, helps illustrate the underlying structural differences.

When a patient seeks a measles vaccination, they will likely go to their local doctor's office. The provider administering the vaccine has likely attended and graduated from a professional school, such as medical school, been licensed by their state's medical board, and credentialed by the relevant specialty board. After the appointment, the doctor's office will submit a claim for the service to the appropriate insurer, private or governmental, using a set billing code for the vaccination. Then, the insurer will reimburse the provider at a predetermined rate or through a set pathway, such as a Medicaid managed care arrangement.

Service delivery, coverage, and reimbursement for innovative services can vary significantly from this familiar process. Take, for example, a patient seeking access to a doula for pregnancy support. Doulas are “non-medical professionals who provide emotional, physical, and informational support and guidance” before, during, and after labor and birth.⁵⁵ Patients are less likely to go to a doctor’s office to receive doula care, as doulas often make prenatal and postpartum home visits.⁵⁶ The doula is not a medical provider and is unlikely to have attended a professional school for their doula training or been licensed by a state medical board.⁵⁷ While the doula has likely undergone a formal training program, that training is not necessarily required or standardized.⁵⁸ After the appointment, the doula may be paid through out-of-pocket payments, grant- or pilot-funded organizations, or health care insurance reimbursement.⁵⁹ However, the reimbursement amount is unlikely to cover the entire cost of providing care, including time spent traveling, researching and gathering client resources, and completing administrative tasks.⁶⁰

In addition to differences between traditional and non-traditional services, innovative services often vary significantly among themselves, even within the same category. The disaggregated nature of funding and development leads to many providers and organizations operating without coordination or shared standards, despite delivering similar services. For example, Organization A may offer doula training, certification, and facilitate reimbursement under one model, while Organization B provides the same services using an entirely different approach.⁶¹ This fragmentation results in duplicative efforts, inconsistent implementation strategies, and divergent outcomes, all contributing to common integration pitfalls and undermining efforts to achieve integrated, sustainable coverage.⁶²

These inefficiencies compound at the system level. Organizations operating outside of a coverage scheme are more likely to work independently, requiring

55. NAT’L HEALTH L. PROGRAM, *supra* note 27.

56. See Amy Chen, Alexis Robles-Fradet, & Helen Arega, *Building A Successful Program for Medi-Cal Coverage for Doula Care: Findings from a Survey of Doulas in California*, NAT’L HEALTH L. PROGRAM 7–8 (May 2020), <https://healthlaw.org/resource/doulareport/> [<https://perma.cc/4DAQ-6L39>].

57. See Amy Chen, *Routes to Success for Medicaid Coverage of Doula Care*, NAT’L HEALTH L. PROGRAM 6 (Dec. 14, 2018), <https://healthlaw.org/resource/routes-to-success-for-medicaid-coverage-of-doula-care/> [<https://perma.cc/LZ22-5PBP>].

58. Chen, Robles-Fradet, & Arega, *supra* note 56 at 13; Chen, *supra* note 57.

59. See *supra* note 28 and accompanying text.

60. See, e.g., HILL ET AL., *supra* note 42, at 143; Alicia Camaliche et al., *Charting the Course for Community Health Workers*, FAMILIESUSA.ORG 8 (Sep. 2024), <https://familiesusa.org/wp-content/uploads/2024/10/CHW-Listening-Sessions-9-27-24.pdf> [<https://perma.cc/2VKN-L2SR>]; see generally Peters & Robles-Fradet, *supra* note 16.

61. See, e.g., Khanal et al., *supra* note 54 (comparing six states’ approaches to adopting the doula services Medicaid benefit across seven domains, including training, certification, and reimbursement).

62. See, e.g., *id.* at 6–8 (demonstrating, in the context of coverage for doula services, fragmented approaches and their resulting challenges).

each to resolve similar legal issues in isolation. For example, many community-based organizations—especially smaller ones—face challenges navigating the complexities of HIPAA, which is often a requirement for delivering services within health care systems.⁶³ This fragmentation increases inefficiency and diverts resources away from service delivery, undermining the goals of coordinated, value-based systems.

Comparisons across delivery, coverage, and infrastructure expose the structural gap between innovative services and existing insurance frameworks. The following section builds on this analysis by identifying the key legal and administrative challenges that arise from this misalignment.

B. Barriers to Sustainable Integration into Health Care Coverage

The structural gap between innovative services and the legal frameworks that govern them creates various barriers to smooth integration into health care reimbursement models. Innovators do not bear these challenges alone; regulators, payers, and health care systems must also grapple with how generally applicable principles interact with these non-traditional services. Stakeholders face challenges in defining the scope of services, credentialing providers, and creating appropriate systems for reimbursement. These barriers can limit scalability, undermine attempts to build longevity for these programs, decrease provider participation, and perpetuate disparities. However, aligning providers that deliver similar services with the same governing legal standards can promote stability and consistency. Moreover, as explained above, compatibility with existing coverage frameworks is essential for scaling access and securing sustainable reimbursement.

This section examines three core categories of barriers that stem from the structural gap: (1) limitations in benefit design; (2) rigid or unclear licensing and credentialing requirements; and (3) billing and reimbursement challenges.

1. Benefit Design

Benefit design—or the rules that structure insurance plans and determine which services will be covered, under what conditions, and by which providers—can derail successful health care integration of innovative services from the start. Each coverage program’s legal framework addresses benefit

63. See Rachel Landauer, Katie Garfield & Carmel Shachar, *Network Contracting to Address Health-Related Social Needs: Considerations for HIPAA Compliance*, HEALTH L. LAB & CTR. FOR HEALTH L. & POL’Y INNOVATION (Nov. 2023), <https://www.healthlawlab.org/wp-content/uploads/2023/11/Network-Contracting-to-Address-Health-Related-Social-Needs-HIPAA-2023.pdf> [<https://perma.cc/7UF3-QXZT>]; see, e.g., Letter from Ctr. for Health L. & Policy Innovation of Harvard L. Sch. et al., to Chiquita Brooks-LaSure, Administrator, U.S. Ctrs. For Medicare & Medicaid Servs., U.S. Dep’t of Health & Hum. Servs. 3 (Apr. 24, 2024), <https://www.healthlawlab.org/wp-content/uploads/2023/04/Letter-to-CMS-re-1115-Waiver-Survey-2023.pdf> [<https://perma.cc/M3TE-R4KL>].

design differently.⁶⁴

a. Medicaid benefit design rules

Although every state establishes and administers its own Medicaid program, the federal government sets broad rules and baseline standards that all state programs must follow.⁶⁵ All covered services must fit within one of the mandatory or optional benefit categories specified in § 1905(a) of the Social Security Act.⁶⁶ Each state lays out the details of its program, including services covered, in its “state plan,” which is an agreement between the state and the federal government that outlines how that state will administer its Medicaid program.⁶⁷ States can make changes to their programs by submitting state plan amendments (SPAs) and getting approval from CMS.⁶⁸ Through the state plan process, states have flexibility to define the type, amount, duration, and scope of each service so long as those interpretations are sufficient to “reasonably

64. *Health IT Playbook Glossary*, OFF. OF THE NAT’L COORDINATOR FOR HEALTH INFO. TECH., <https://playbook.healthit.gov/playbook/glossary/#b> [<https://perma.cc/V67T-G9AE>] (last updated Feb. 28, 2018) (defining “benefit design”); *see, e.g.*, 42 U.S.C. 1396d(a) (Medicaid covered benefits); 42 C.F.R. §§ 440.10–185 (Medicaid service definitions); 42 U.S.C. § 1395(k) (Medicare Part B scope of benefits); 42 C.F.R. §§ 410.10–175 (Medicare Part B service definitions); 42 U.S.C. § 18022 (ACA Essential Health Benefits); 45 C.F.R. § 156.100 (ACA benchmark plan process and scope of benefits).

65. *See* 42 U.S.C. § 1396a(a); 42 C.F.R. §§ 430.10–430.25 (requiring that state Medicaid programs meet federal standards to receive federal funding); *see also* *What’s the difference between Medicare and Medicaid?*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html> [<https://perma.cc/2SK5-M2MJ>] (last visited Apr. 8, 2026).

66. § 1905(a) of the Social Security Act, 42 U.S.C. § 1396d(a). Federal law requires states to provide certain “mandatory benefits,” such as inpatient hospital services, laboratory and X-ray services, and transportation to medical care. *Id.*; *see* 42 C.F.R. §§ 440.210–440.220. Additionally, states may choose to provide “optional benefits,” such as prescription drugs, preventive services, and rehabilitative services. 42 C.F.R. § 440.225; *see* 42 C.F.R. §§ 440.10–440.185 (service definitions); *see also* *Mandatory & Optional Medicaid Benefits*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html> [<https://perma.cc/FV63-Y56N>] (last visited Apr. 8, 2026).

67. *See* 42 U.S.C. § 1396a; 42 C.F.R. §§ 430.10–430.25; *Medicaid State Plan Amendments*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments> [<https://perma.cc/HB5J-8T3J>] (last visited Apr. 8, 2026); *see also* *State Plan*, MEDICAID & CHIP PAYMENT & ACCESS COMM’N (Aug. 14, 2019), <https://www.macpac.gov/subtopic/state-plan/> [<https://perma.cc/6QYT-4L4P>] (“The state plan: provides assurances that a state will abide by federal rules in order to claim federal matching funds; indicates which optional groups, services, or programs the state has chosen to cover or implement; and describes the state-specific standards to determine eligibility, methodologies for providers to be reimbursed, and processes to administer the program.”).

68. 42 C.F.R. § 430.12(c); *see* MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 67. For example, states can continue or discontinue coverage of an optional service or change a provider payment methodology by submitting a SPA. *Id.*

achieve [the service’s] purpose.”⁶⁹ States may also impose “appropriate” limits on covered services, which are often grounded in “medical necessity,” the requirement that services meet accepted clinical standards and be suitable for diagnosing or treating an individual’s condition.⁷⁰

Innovators seeking to gain Medicaid coverage of new services must first determine whether their service falls within an existing benefit category. Many innovative services likely fall within one or more existing categories; for example, community health workers (CHWs) have been included in several Medicaid SPAs under the preventive services, primary care case management, and dental categories.⁷¹ Innovators must also ensure that their services meet the state’s criteria, as defined by the relevant state’s definition, of medical necessity.⁷²

69. 42 C.F.R. § 440.230(a)–(b); see *Medicaid Benefits*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/benefits> [<https://perma.cc/R5QX-52TD>] (last visited Apr. 8, 2026). For example, one state could deem a ridesharing service to fit within the “transportation to medical care” mandatory benefit category or the “case management” optional benefit category, while another state might not cover a ridesharing service at all.

70. States cannot arbitrarily deny coverage solely because of the diagnosis, type of illness, or condition. 42 C.F.R. § 440.230(c). For example, a state cannot deny Medicaid coverage of X-rays for individuals presenting with chronic pain solely because of their diagnosis but may require that X-rays be ordered by a licensed provider in accordance with established criteria. See 42 C.F.R. § 440.230(d). Notably, the Medicaid Act does not define the term “medical necessity.” See 42 U.S.C. 1396d; 42 C.F.R. § 400.203; see also Melissa McCall, *Medical Necessity and the Law*, FINDLAW, <https://www.findlaw.com/healthcare/patient-rights/medical-necessity-and-the-law.html> [<https://perma.cc/B3ES-LNXW>] (last updated Jan. 23, 2025); see, e.g., *State Definitions of Medical Necessity under the Medicaid EPSDT Benefit*, NAT’L ACAD. FOR STATE HEALTH POL’Y (Apr. 23, 2021), <https://nashp.org/state-tracker/state-definitions-of-medical-necessity-under-the-medicaid-epsdt-benefit/> [<https://perma.cc/U8GA-RR66>] (collecting definitions of “medical necessity” for the EPSDT Medicaid benefit).

71. See, e.g., Colorado State Plan Amendment (SPA) 24-0025, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Sep. 17, 2024), <https://www.medicaid.gov/medicaid/spa/downloads/CO-24-0025.pdf> [<https://perma.cc/2PT3-92UW>] (authorizing reimbursement for CHW services as preventive health services); Maine State Plan Amendment (SPA) 24-0022, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Sep. 24, 2024), <https://www.medicaid.gov/medicaid/spa/downloads/ME-24-0022.pdf> [<https://perma.cc/3UXU-SDTA>] (authorizing reimbursement for CHW services as primary care services); California State Plan Amendment (SPA) 24-0016, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (July 25, 2024), <https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0016-Approval.pdf> [<https://perma.cc/2MCR-ZTUQ>] (authorizing reimbursement for CHW services in the dental setting); see generally NAT’L ACAD. FOR STATE HEALTH POL’Y, *supra* note 19.

72. CMS guidance may also help programs structure their services to align with medical necessity requirements. For example, CMS has emphasized that services be “evidence-based” and provided to Medicaid beneficiaries based on a documented need, rather than applied through a one-size-fits-all approach. See, e.g., ADDRESSING HEALTH-RELATED SOCIAL NEEDS IN SECTION 1115 DEMONSTRATIONS, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. 18–19 (Dec. 6, 2022), <https://www.medicaid.gov/medicaid/downloads/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf> [<https://perma.cc/9CVG-ZNYK>].

b. Medicare benefit design rules

Unlike Medicaid, Medicare is a purely federal program administered by CMS with little involvement from the states.⁷³ Medicare beneficiaries can receive coverage through two options: “Original Medicare” or “Medicare Advantage.”⁷⁴ Original Medicare encompasses Parts A and B, which include hospital insurance and medical insurance, respectively.⁷⁵ CMS identifies three criteria for Original Medicare coverage: a service must (1) fall within at least one defined benefit category established in § 1861 of the Social Security Act; (2) not be specifically excluded by the Act; and (3) be “reasonable and necessary.”⁷⁶

Original Medicare is a defined benefit program, meaning that a service must fall within one of the enumerated benefit categories to be considered for coverage.⁷⁷ If a service does not fall within one of the categories, Congress must amend the Social Security Act to add a new category that encompasses the service.⁷⁸ Certain services are explicitly excluded from Medicare coverage, such as routine dental care, cosmetic surgery, and custodial long-term care.⁷⁹ Moreover, statutory provisions forbid payment for services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”⁸⁰ A “reasonable and necessary” service that falls within a Medicare benefit category may be eligible for Original Medicare coverage, subject to an extensive, evidence-based determination process at the national, local, or claim level.⁸¹

73. U.S. DEP’T OF HEALTH & HUM. SERVS., *supra* note 65.

74. *Parts of Medicare*, MEDICARE.GOV, <https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare> [<https://perma.cc/JK9R-4RZL>] (last visited June 9, 2026); 42 U.S. Code §§ 1395c–1395i-5 (Medicare Part A); 42 U.S.C. §§ 1395j–1395w-6 (Medicare Part B); 42 U.S.C. §§ 1395w-21–1395w-29 (Medicare Part C or Medicare Advantage).

75. MEDICARE.GOV, *supra* note 74; 42 U.S. Code §§ 1395c–1395i-5 (Medicare Part A); 42 U.S.C. §§ 1395j–1395w-6 (Medicare Part B); 42 U.S.C. §§ 1395w-21–1395w-29 (Medicare Part C or Medicare Advantage).

76. *See* 42 U.S.C. § 1395x (defining benefit categories); 42 U.S.C. § 1395y(a)(1)(A) (excluding services not “reasonable and necessary”); 42 C.F.R. § 411.15(k) (excluding particular services from coverage); *see generally Medicare Coverage of Items and Services*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coverage/medicare-coverage-items-and-services> [<https://perma.cc/XH6G-VPSN>] (last updated Mar. 10, 2026, 8:33 PM).

77. *See* 42 U.S.C. 1395x. For example, covered categories include hospital services, certified nurse-midwife services, and diabetes screening tests. *Id.*

78. For example, Congress added medical nutrition therapy (MNT) services as a benefit category in 2000. *See* 42 U.S.C. 1395x(vv)(1) (2000).

79. *See generally* 42 U.S.C. 1395y(a). If a service falls within one of these exclusions, it cannot be covered absent a specific exception or a statutory amendment to remove or narrow the exclusion.

80. 42 U.S.C. 1395y(a)(1)(A).

81. There are three main coverage pathways under Original Medicare: national coverage determinations (NCDs), local coverage determinations (LCDs), and claim-by-claim review. *See*

As an alternative to Original Medicare, beneficiaries can opt into “Medicare Advantage,” or Part C, which is a Medicare-approved plan from a private company that bundles Parts A, B, and may include Part D (prescription drugs).⁸² While Medicare Advantage plans are still subject to regulation by CMS, they have greater flexibility in benefit design.⁸³ In addition to covering all Original Medicare benefits, Medicare Advantage plans may also offer “supplemental benefits,” which fall into three categories.⁸⁴ First are traditional, health-related benefits, such as vision, fitness, hearing, and dental, which have the primary purpose of preventing, curing, or diminishing an illness or injury.⁸⁵ Second, Expanded Primarily Health-Related Supplemental (EPHR) benefits are services that “ameliorate the effect of health conditions or reduce avoidable emergency and health care utilization.”⁸⁶ Examples of EPHRs include in-home support services and support for caregivers of enrollees.⁸⁷ Third, Special Supplemental Benefits for the Chronically Ill (SSBCI) can cover non-health-related services so long as they “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.”⁸⁸ This third pathway offers a promising avenue for coverage of innovative, non-traditional services that may not otherwise be able to meet the legal requirements of other insurance programs.⁸⁹

42 U.S.C. § 1395y (listing NCDs); 42 C.F.R. § 405.1060(a) (describing NCDs); 42 U.S.C. § 1395fff(f)(2) (describing LCDs); 42 U.S.C. § 1395y(a)(1)(A) (enabling case-by-case determinations where no NCD or LCD exists); *see generally* U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 72.

82. *See* 42 U.S.C. § 1395w-21(a)(1) (permitting enrollment in Original Medicare or “Medicare+Choice” (Medicare Advantage)); 42 U.S.C. § 1395w-22(a) (enumerating basic benefits); 42 C.F.R. § 422.2 (defining Medicare Advantage programs and their required coverage); *see also* SOC. SEC. ADMIN., MEDICARE 11 (Jan. 2025), <https://www.ssa.gov/pubs/EN-05-10043.pdf> [<https://perma.cc/5TYT-CGCG>].

83. *See generally* 42 U.S.C. § 1395w-22(a)(3) (allowing Medicare Advantage plans to provide enrollees with approved supplemental benefits, subject to limitations and requirements).

84. 42 U.S.C. § 1395w-22(a)(3). Medicare Advantage plans are required to cover all benefits and services that are covered under Original Medicare. 42 U.S.C. § 1395w-22(a)(1)(A). However, for some services, plans may use their own coverage criteria to determine medical necessity. *See* 42 C.F.R. § 422.101.

85. *Id.*; GAO, *Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization*, U.S. GOV’T ACCOUNTABILITY OFF. 6 (Jan. 2023),

<https://www.gao.gov/assets/d23/105527.pdf> [<https://perma.cc/N4X8-DXZU>]; *see* U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Reinterpretation of “Primarily Health Related” for Supplemental Benefits* 1 (Apr. 27, 2018), <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/CMS/hpms-memo-primarily-health-related-4-27-18.pdf>

[<https://perma.cc/2CW9-TATN>] (expanding definition to include additional benefits). These types of benefits have historically been defined as an item or service (1) not covered by Original Medicare, (2) that is primarily health related, and (3) for which the plan must incur a non-zero direct medical cost, *id.*

86. GAO, *supra* note 85; 42 U.S.C. § 1395w-22(a)(3)(A).

87. GAO, *supra* note 85.

88. 42 U.S.C. § 1395w-22(a)(3)(D); *see also* 42 C.F.R. § 422.102(f).

89. For example, nutrition support, subsidies for rent or utilities, and transportation for non-medical needs have all been covered under this type of benefit, *see* GAO, *supra* note 85, at 7.

c. Affordable Care Act benefit design rules

The ACA governs a significant portion of the private insurance market.⁹⁰ One of the ACA's key regulatory mechanisms is the requirement that non-grandfathered plans offered in the individual and small-group markets cover a standardized set of "essential health benefits" (EHBs).⁹¹ The statute enumerates ten categories of benefits, including "preventive and wellness services and chronic disease management" and "rehabilitative and habilitative services."⁹² The Act delegates the authority to further define these EHBs—within certain parameters⁹³—to the Secretary of the U.S. Department of Health and Human Services (HHS).⁹⁴ HHS has since delegated that responsibility to the states.⁹⁵

Through a "benchmarking" process, each state selects a model plan that serves as the state standard for EHBs and defines the specific items and services included in each EHB category.⁹⁶ Each state's process is different, but states often consider costs, clinical effectiveness, administrative feasibility, and public

90. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also* OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT: CURRENT ENROLLMENT TRENDS AND STATE ESTIMATES, 1–2 (Mar. 22, 2024), available at <https://aspe.hhs.gov/sites/default/files/documents/8e81cf90c721dbbf58694c98e85804d3/health-coverage-under-aca.pdf>. [<https://perma.cc/5HR2-RHKB>].

91. 42 U.S.C. §§ 18021–18022; *see generally* *Information on Essential Health Benefits (EHB) Benchmark Plans*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/marketplace/resources/data/essential-health-benefits> [<https://www.cms.gov/marketplace/resources/data/essential-health-benefits>] (last updated Mar. 13, 2026, 5:50 PM). A limited number of plans which were in existence before the ACA's enactment date and have not had major changes to their provisions are "grandfathered" into the law and are exempt from many ACA requirements, including the obligation to cover EHBs. *See* 45 C.F.R. § 147.140; 42 U.S.C. § 18011.

92. 42 U.S.C. § 18022(b).

93. 42 U.S.C. § 18022(b)(2)(A). For example, the scope of the EHBs must be "equal to the scope of benefits provided under a typical employer plan." *Id.* Additionally, EHBs must "reflect an appropriate balance among the categories . . . so that benefits are not unduly weighted toward any category." 42 U.S.C. § 18022(b)(4)(A). And benefits cannot be designed "in ways that discriminate against individuals because of their age, disability, or expected length of life." *See* 42 U.S.C. § 18022(b)(4)(B).

94. 42 U.S.C. § 18022(b)(1); *see generally* Héctor Hernández-Delgado & Wayne Turner, *Explainer: Proposed Changes to the Essential Health Benefits Standard in the 2025 Notice of Benefits and Payment Parameters*, NAT'L HEALTH L. PROGRAM, (Dec. 1, 2023), <https://healthlaw.org/wp-content/uploads/2023/12/EHB.-NBPP-Explainer-vAP.pdf> [<https://perma.cc/K99H-TB8V>]. HHS must also periodically review and update the EHBs "to address any gaps in access to coverage or changes in the evidence base." *See* 42 U.S.C. §§ 18022(b)(4)(G)–(H).

95. *See* 45 C.F.R. § 156.100, et seq.; *see generally* Stacey Pogue et al., *Enhancing Essential Health Benefits: How States Are Updating Benchmark Plans to Improve Coverage*, THE COMMONWEALTH FUND (Nov. 14, 2024), <https://www.commonwealthfund.org/publications/issue-briefs/2024/nov/enhancing-essential-health-benefits-states-updating-benchmark-plans> [<https://perma.cc/73VM-BX27>].

96. *See* 45 C.F.R. §§ 156.100, 156.111.

comments.⁹⁷ All Qualified Health Plans (QHPs) offered through the ACA's Health Insurance Marketplace must, at minimum, cover the services in their state's selected benchmark.⁹⁸ States can change their EHB benchmark plans subject to federal rules.⁹⁹ Because the ten EHB categories are broadly defined, the scope of covered services varies significantly from state to state.¹⁰⁰ However, plans offered on the ACA Marketplace must not discriminate in their benefit design based on age, expected length of life, disability, degree of medical dependency, quality of life, or other health conditions.¹⁰¹

Coverage of an innovative service will depend on whether that service is already included in a benchmark plan or whether it can be interpreted to fall within a category, like doula services as “maternity and newborn care” or produce prescriptions as “preventive and wellness services and chronic disease management.” Because states may update EHB benchmark plans and must consider public input when doing so, innovators have the opportunity to advocate for their service's inclusion.¹⁰²

d. Challenges and lessons learned in innovative service benefit design

While the legal frameworks above define benefit categories and eligibility rules, regulators, payers, and providers have faced challenges in applying these rules to many innovative services.¹⁰³ Often, these challenges stem from the

97. See, e.g., Madeline McBride et al., *State Flexibility to Add Adult Dental Care to Essential Health Benefits: An Update on State Action*, CTR. ON HEALTH INS. REFORMS (Apr. 8, 2025), <https://chirblog.org/state-flexibility-to-add-adult-dental-care-to-essential-health-benefits-an-update-on-state-action/> [<https://perma.cc/FGQ3-XY4T>] (citing several states' considerations of cost, public comments, administrative efficiency, and overall health when considering adding adult dental services as an EHB); see *EHB Benchmark Plan*, ME. BUREAU OF INS. (Nov. 7, 2024), <https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/EHB%20Benchmark%20Plan%20Initiative%20%28110724%29.pdf> [<https://perma.cc/SGE7-A88S>] (ensuring Maine's Benchmark plan offers comprehensive coverage that is affordable and in alignment with public comments).

98. See 45 C.F.R. § 156.115. Qualified Health Plans are insurance plans that are certified by the Health Insurance Marketplace. See 42 U.S.C. § 18021(a)(1); 45 C.F.R. § 155.20. QHPs must provide EHBs, follow established limits on cost sharing, and meet other outlined requirements. See 42 U.S.C. § 18021(a)(1); 45 C.F.R. § 156.200.

99. See 45 C.F.R. § 156.111.

100. 42 U.S.C. § 18022(b).

101. See 45 C.F.R. § 156.125(a).

102. See 45 C.F.R. § 156.111(c); see, e.g. ME. BUREAU OF INS., *supra* note 97; see generally Hayley Penan, *Step Guide to Updating Your State's Essential Health Benefits Benchmark Plan*, NAT'L HEALTH L. PROGRAM (May 9, 2018), <https://healthlaw.org/wp-content/uploads/2018/05/EHB-Step-Guide-BBP-5.9.182.pdf> [<https://perma.cc/FW3U-K4EZ>] (providing advocates with guide to effective EHB advocacy).

103. Cf. Erika Hanson et al., *Applying Legal and Clinical Quality Standards to 'Food Is Medicine'*, HEALTH AFFAIRS (Nov. 27, 2024), <https://www.healthaffairs.org/content/forefront/applying-legal-and-clinical-quality-standards-food-medicine> [<https://perma.cc/PZ4F-V7TL>]. For example, in the context of produce prescriptions, stakeholders must determine what groups of

innovative and non-traditional nature of the interventions, as insurers are uncertain about how to structure coverage and hesitant to provide the services at all.¹⁰⁴ Even when insurers cover these services, there is wide variation in the scope of coverage, leading to fragmented benefit definitions across insurance programs.¹⁰⁵

Poorly-defined benefit design can complicate efforts to ensure quality and accountability. For example, the Food is Medicine (FIM) movement has recently faced criticism due to uncertainty regarding coverage requirements.¹⁰⁶ While FIM programs are meant to provide “access to nutritious food through the health care system for patients with specific health conditions,”¹⁰⁷ some companies receiving health care reimbursement “fall far short” of providing interventions that meet generally accepted quality principles.¹⁰⁸ Due to the lack of universal standards as to what constitutes a high-quality, reimbursable FIM intervention, bad actors threaten to derail progress and distract from successful program development by receiving reimbursement for foods, such as Jimmy

people should be eligible for enrollment, available delivery methods (e.g. produce box, voucher for grocery store or farmers market), and the length of coverage. *Id.*

104. See, e.g., NORC MCO Learning Hub, *Key Findings from the Medicaid MCO Learning Hub Group Discussion Series and Roundtable – Focus on Social Determinants of Health*, UNIV. OF CHI. 5–6 (Oct. 2020), https://www.norc.org/content/dam/norc-org/pdfs/MCOLearningHub_KeyFindings_SDOHGroupRoundtableDiscussion_Formatted.pdf [<https://perma.cc/K4HS-XN3L>]; HILL ET AL., *supra* note 42 (explaining Strong Start program’s difficulty of contracting with Medicaid MCOs).

105. See, e.g., *Medicaid Coverage of Community Health Worker Services*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM’N 8 (Apr. 2022), <https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf> [<https://perma.cc/VQY6-ZJZT>] (discussing variation in state coverage of CHW services); Megan D’Alessandro et al., *Updates and FAQs: Developing and Implementing a Medicaid State Plan Amendment to Authorize Community Health Worker Reimbursement*, NAT’L ACAD. FOR STATE HEALTH POL’Y (Aug. 5, 2024), <https://nashp.org/updates-and-faqs-developing-and-implementing-a-medicaid-state-plan-amendment-to-authorize-community-health-worker-reimbursement/> [<https://perma.cc/K6UE-VGP7>] (compiling state definitions and scope of coverage for CHWs); *Doulas in Medicaid: Case Study Findings*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM’N 1, 2 (Nov. 2023), <https://www.macpac.gov/wp-content/uploads/2023/11/Doulas-in-Medicaid-Case-Study-Findings.pdf> [<https://perma.cc/GD7J-D5BZ>] (highlighting that while “[s]tates vary in the doula benefit design,” a standard scope of services has emerged to include “prenatal, labor and delivery, and postpartum services.”).

106. See, e.g., Nicholas Florko, *Medicaid is Paying Millions for Salty, Fat-laden ‘Medically Tailored’ Cheeseburgers and Sandwiches*, STAT (July 11, 2024), <https://www.statnews.com/2024/07/11/medicaid-food-is-medicine-medically-tailored-meals-quality-questioned/> [<https://perma.cc/M9YZ-EGX2>]; see also Letter from Sens. Thom Tillis & Ted Budd to Xavier Becerra, HHS Secretary (June 12, 2024), <https://nsjonline.com/wp-content/uploads/2024/06/Tillis-Budd-Letter-to-HHS-on1115-Renewal-NCCARES360.pdf> [<https://perma.cc/5HQM-JUBN>] (expressing concern regarding shared technology platform used in Medicaid demonstration program that provided select evidence-based, non-medical interventions to high-need Medicaid beneficiaries, including FIM services.).

107. Hanson et al., *supra* note 103.

108. See Florko, *supra* note 106.

Dean sandwiches, that do not meet the “nutritious” objectives of FIM.¹⁰⁹

In response to this scrutiny, leading FIM-focused nonprofits have worked independently and collaboratively with federal regulators to promulgate best practices, voluntary accreditation standards, and quality measurement frameworks.¹¹⁰ Many of these standards intentionally align with existing legal frameworks by, for example, requiring referrals from health care personnel, eligibility and needs assessments, and individualized care plans.¹¹¹ Through these efforts and others, FIM stakeholders are working to ensure that future health care coverage includes only clinically effective food-based interventions to ensure that the benefits received are compatible with existing benefit structures and their parameters for coverage.¹¹²

The Diabetes Prevention Program (DPP) offers valuable insights into how clear benefit design and standardization can facilitate a successful transition from community-based intervention to health insurance benefit. DPP is an evidence-based lifestyle program used to delay or prevent the onset of type 2 diabetes for people with prediabetes while also lowering health care costs over time.¹¹³ Following ongoing collaboration between providers, regulators, and insurers, the DPP established standardized eligibility criteria, a CDC-approved curriculum, and quality assurance protocols that align with traditional benefit definitions and have now become widely accepted as the standard DPP “health

109. See Colin M. Schwartz et al., *What Is ‘Food Is Medicine,’ Really? Policy Considerations on the Road to Health Care Coverage*, 44 HEALTH AFFAIRS 406, 409–10 (2025) (describing that the lack of a standard definition of FIM as a health care intervention makes the transition to coverage difficult); see, e.g., Florko, *supra* note 106 (describing a “a Jimmy Dean frozen sausage breakfast sandwich, biscuits and gravy, a cheeseburger” sold by one company providing Medicaid-funded services).

110. See, e.g., FOOD IS MED. COALITION, MED. TAILORED MEAL INTERVENTION ACCREDITATION CRITERIA AND REQUIREMENTS, Version 1.1 (2023), <https://fimcoalition.org/wp-content/uploads/2024/03/Food-is-Medicine-Coalition-Medically-Tailored-Meal-Intervention-Accreditation-Criteria-and-Requirements.pdf> [<https://perma.cc/5EBM-8MJV>]; OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, *Food is Medicine Analytic Framework*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://odphp.health.gov/foodismedicine/research-and-measurement/food-medicine-analytic-framework> [<https://perma.cc/BH49-NAYF>] (last updated Sep. 15, 2024); Health Care x Food, *Common Measures for AHA Health Care x Food Funded Studies*, AM. HEART ASS’N (Jan. 3, 2025), https://www.healthcarexfood.org/en/-/media/Files/HCFx/Common-Measures-Version-1-11.pdf?sc_lang=en [<https://perma.cc/YKG6-6FJV>] (offering required, preferred, and optional measure sets for studies into FIM interventions).

111. FOOD IS MED. COAL., *supra* note 110 (detailing standards for the Medically Tailored Meal intervention).

112. See Schwartz et al., *supra* note 109, at 410.

113. See U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 51; National Insts. of Health, *NIH Study Finds Interventions to Prevent Type 2 Diabetes Give Good Return on Investment*, U.S. DEP’T OF HEALTH & HUM. SERVS. (Apr. 18, 2024), <https://web.archive.org/web/20250201192711/https://www.nih.gov/news-events/news-releases/nih-study-finds-interventions-prevent-type-2-diabetes-give-good-return-investment> [<https://perma.cc/5R99-663R>].

care benefit.”¹¹⁴ These features enabled the program—which started as a demonstration project—to be adopted as a national Medicare benefit and by many state Medicaid programs.¹¹⁵ By aligning with existing legal frameworks, DPP’s clearly defined structure facilitated its widespread adoption by public and private insurers, thereby expanding access to this life-saving benefit.¹¹⁶

These examples demonstrate the pivotal role that benefit design plays in scaling innovative interventions. When stakeholders can settle on clearly defined benefits that are grounded in legal frameworks, programs are more likely to achieve sustainable coverage, promote quality, and expand access.¹¹⁷ As the health care system continues to evolve towards value-based care, which encourages coverage for non-traditional services that reduce costs through upstream interventions, purposeful benefit design will remain central to ensuring that innovation translates into long-term coverage and impact.

2. Licensing and Credentialing Providers

A second common barrier to successful health care integration is licensing and credentialing, which are verification processes intended to ensure a provider meets educational, training, and professional standards of conduct.¹¹⁸ Under all three legal frameworks, almost all health care services must be delivered by

114. *Diabetes Prevention Recognition Program: Requirements for CDC-Recognized Organizations*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (May 15, 2024), <https://www.cdc.gov/diabetes-prevention/php/program-provider/program-requirements.html> [https://perma.cc/7L9V-M46V] (defining eligibility criteria, service delivery requirements, and provider standards for DPP).

115. See C.F.R. § 410.79 (noting that the program is covered under Medicare Part B for eligible beneficiaries, enabling nationwide implementation); Nat’l DPP Coverage Toolkit, *Medicaid Coverage Landscape*, NAT’L ASS’N OF CHRONIC DISEASE DIR., <https://coveragetoolkit.org/medicaid-coverage-landscape/> [https://perma.cc/A4VK-EZVD] (last updated July 30, 2025) (state Medicaid coverage table); see also *Medicare Diabetes Prevention Program*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://www.medicare.gov/coverage/medicare-diabetes-prevention-program> [https://perma.cc/Y5WU-MNNR] (last visited May 18, 2025).

116. See *id.* It is important to note that DPP has faced criticism for its eligibility requirements, particularly those related to weight loss. See, e.g., Stephanie L. Fitzpatrick et al., *Soc’y for Health Psychol. (APA Div. 38) & Soc’y of Behav. Med. Joint Position Statement on the Medicare Diabetes Prevention Program*, 7 TRANS. BEHAV. MED. 385 (June 2017). Additionally, DPP’s structure and requirements, such as its capitated payment structure, have sometimes made it difficult for health systems and community-based providers to implement the program. See Inga Gruß et al., *Challenges with Implementing the Diabetes Prevention Program for Medicare Beneficiaries in an Integrated Health System*, 27 AM. J. MANAGED CARE 1 (Nov. 2021).

117. As the FIM program demonstrates, stakeholders can include, among other parties, regulators, payers, community-based organizations, and service providers.

118. See *Provider Credentialing in Healthcare*, ANDROS, <https://andros.co/insights/guide-to-provider-credentialing/> [https://perma.cc/EDH2-6ZXD] (last visited May 18, 2025); 42 C.F.R. § 422.204 (outlining credentialing requirements for Medicare Advantage providers and suppliers).

appropriately licensed or credentialed providers to qualify for reimbursement.¹¹⁹ While these requirements aim to promote patient safety and quality of care,¹²⁰ they also pose significant barriers to achieving widespread coverage of innovative services.¹²¹

In practice, many non-traditional providers lack clear, accessible pathways to licensure or certification.¹²² For instance, the Doula Medicaid Project reports that “there are currently no mandatory licensure, certification, or credentialing requirements for doulas to practice in the United States.”¹²³ Even when credentialing pathways exist, they are often designed for traditional clinical roles and are not readily transferable to contexts in which providers have varied training backgrounds, serve multiple functions, and operate in unique service settings.¹²⁴ Credentialing aside, many providers, such as doulas and CHWs, are non-medical professionals who are likely unfamiliar with the complexities of

119. *See, e.g.*, 42 C.F.R. § 422.204 (outlining credentialing requirements for Medicare Advantage providers and suppliers); 42 C.F.R. § 424.516 (outlining provider and supplier licensure, certification, and regulatory compliance requirements in Original Medicare); 42 C.F.R. § 455.410 (requiring “all ordering or referring physicians or other professionals providing services under the [Medicaid] State plan or under a waiver of the plan to be enrolled as participating providers”); 45 C.F.R. § 155.1045(a)(1)(vi) (requiring accreditation of QHP issuer). Notably, for benefits provided under Medicare Advantage EPHR and SSBCI benefits, plans have flexibility in determining provider qualifications. *See* U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., Pub. 100-16, MEDICARE MANAGED CARE MANUAL, ch. 4 (Benefits and Beneficiary Protections), § 30.1 (2016) (“Supplemental benefits need not be provided through Medicare providers nor at Medicare certified facilities.”); 42 C.F.R. § 422.204(b)(3) (requiring only “basic benefits” be furnished by providers who meet qualification requirements).

120. Ellis M. “Mac” Knight, *Credentialing — The Foundation for Quality and Safety*, 10 PHYSICIAN LEADERSHIP J. 22, 22–23 (2023); *see also* Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Medicare Providers’ and Suppliers’ Disclosure of Private Equity Companies and Real Estate Investment Trusts, 88 Fed. Reg. 80,141, 80,143 (Nov. 17, 2023) (describing the provider enrollment process as a “gatekeeper” intended to exclude unqualified providers and protect program beneficiaries from harm).

121. *See, e.g.*, NILUFER ISVAN ET AL., U.S. DEP’T OF HEALTH & HUM. SERVS., OFF. OF THE ASSISTANT SEC’Y FOR PLAN. & EVALUATION, CREDENTIALING, LICENSING, AND REIMBURSEMENT OF THE SUD WORKFORCE: A REVIEW OF POLICIES AND PRACTICES ACROSS THE NATION, 17–21, 39–40 (Nov. 2019), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/193271/CLRSUDWorkforce.pdf [<https://perma.cc/GUX7-RSN4>] (explaining how the lack of uniform credentials and use of non-standard requirements for practice bars entrance to the field of “Substance Use Disorder” counseling).

122. *See, e.g.*, Amy Chen & Kate Rohde, *Doula Medicaid Training and Certification Requirements: Summary of Current State Approaches and Recommendations for Improvement*, NAT’L HEALTH L. PROGRAM (Mar. 16, 2023), <https://healthlaw.org/doula-medicaid-training-and-certification-requirements-summary-of-current-state-approaches-and-recommendations-for-improvement/> [<https://perma.cc/EUA4-CT5K>]; *see Medicaid Coverage of Community Health Worker Services*, *supra* note 105, at 9–10 (explaining the lack of consensus on CHW certification and training requirements).

123. Chen & Rohde, *supra* note 122.

124. *Id.* (explaining how “states must balance protecting quality of care with ensuring fair access for doulas who want to serve, or who are already serving,” considering that “doulas as a profession have not historically sought licensing by state medical boards.”).

pursuing provider reimbursement.

These gaps in policy and infrastructure place heavy burdens on providers. First, those unable to navigate costly or administratively complex licensing or credentialing processes may be excluded from reimbursement altogether.¹²⁵ Absent reimbursement, providers may resort to offering their services for free or charging fees on a sliding scale, undermining the financial viability of their work and limiting patient access to care.¹²⁶ Second, even if providers are willing and able to meet licensure standards, unsettled and disparate licensing requirements across reimbursement types create confusion and administrative inefficiencies.¹²⁷ Some providers report that the heavy burden of complying with varying health plan requirements deters them from enrolling in any plan at all.¹²⁸

Thus, the barriers providers face are two-fold. On one hand, overly rigid, traditional licensing and credentialing models risk excluding essential providers and undermining the foundations of the services themselves. On the other, unclear rules and shifting expectations across jurisdictions and payers force providers to confront a fragmented, often unfamiliar, landscape without the promise of transferability from payer to payer. To understand how these challenges manifest in practice, it is helpful to examine how licensing and credentialing are structured across the major health coverage frameworks. Together, these regulatory schemes create a patchwork of overlapping and sometimes conflicting requirements that non-traditional providers must navigate to deliver care.

a. Licensing and credentialing across coverage frameworks

To be eligible for Medicaid reimbursement, providers must be officially enrolled in the Medicaid program.¹²⁹ State Medicaid agencies enroll providers and ensure they pass screening and license verification to protect patient safety and ensure quality care.¹³⁰ Although licensure is generally required, services provided by non-licensed individuals can sometimes be covered if

125. See, e.g., Chen, Robles-Fradet, & Arega, *supra* note 56, at 29, 32 (documenting doula's concerns that training and certification costs can be prohibitively expensive); *Medicaid Coverage of Community Health Worker Services*, *supra* note 105, at 10 (noting that "rigid standards for certification and training can be time-consuming or costly, and may exclude potential CHWs"); *Doulas in Medicaid: Case Study Findings*, *supra* note 105, at 7 (documenting doula concern of administrative complexity regarding credentialing may deter doulas from enrolling as Medicaid providers).

126. See, e.g., Peters & Robles-Fradet, *supra* note 16.

127. Chen & Rohde, *supra* note 122.

128. See, e.g., *Doulas in Medicaid: Case Study Findings*, *supra* note 105, at 7.

129. 42 C.F.R. § 455.410 (requiring "all ordering or referring physicians or other professionals providing services under the [Medicaid] State plan or under a waiver of the plan to be enrolled as participating providers").

130. 42 C.F.R. §§ 455.410, 455.412.

“recommended by a physician or other licensed practitioner.”¹³¹ States may establish provider screening methods that are in addition to, or more stringent than, those required by federal regulations.¹³² Providers are subject to monitoring and evaluation by state Medicaid agencies to enforce quality standards and ensure compliance with federal and state requirements.¹³³ Providers that fail to meet requirements face financial, legal, and operational risks, including investigation and prosecution for fraud by federal and state authorities.¹³⁴ State Medicaid agencies can withhold payments and terminate services from the program in cases of fraud.¹³⁵

For Original Medicare, providers and suppliers must enroll in the Medicare program and obtain a National Provider Identifier (NPI) to be eligible for reimbursement.¹³⁶ Enrolled providers must resubmit and revalidate their information every five years.¹³⁷ CMS contracts with Medicare Administrative Contractors (MACs) to screen and enroll providers.¹³⁸ Oversight is governed by

131. *See, e.g.*, 42 C.F.R. § 440.130 (permitting Medicaid coverage of preventive services provided by non-licensed providers); 42 U.S.C. § 1396d(a)(13) (defining Medicaid “rehabilitative services” as “any medical or remedial services . . . recommended by a physician or other licensed practitioner.”). The “recommended by” exception is not a silver bullet; innovative services such as CHWs, for instance, struggle to be meaningfully integrated into multidisciplinary care teams because providers are often unfamiliar with the scope of CHW services and are not financially incentivized to collaborate. As a result, CHWs’ ability to provide care is curtailed. *See* Camaliche et al., *supra* note 60, at 10.

132. 42 C.F.R. § 455.452. States may also rely on the result of screening performed by Medicare contractors or Medicaid agencies of other states. 42 C.F.R. §455.410.

133. *See, e.g.*, 42 C.F.R. § 431.107 (requiring “an agreement between the Medicaid agency and each provider or organization furnishing services” for recordkeeping, fraud control, and other compliance purposes).

134. State-based, jointly funded Medicaid Fraud Control Units (MFCUs) are primarily responsible for detecting, investigating, and prosecuting fraud, waste, and abuse. *See About the Medicaid Fraud Control Units*, NAT’L ASS’N OF ATTNY. GEN., <https://www.naag.org/about-naag/namfcu/about-the-medicaid-fraud-control-units/> [<https://perma.cc/JB82-X79C>] (last visited May 29, 2025). The federal government also retains authority to bring criminal, civil, or administrative legal actions in cases of fraud in both Medicaid and Medicare. 42 U.S.C. § 1320a-7a (discussing civil penalties); 42 U.S.C. § 1320a-7b (discussing criminal penalties for acts involving Federal health care programs); 31 U.S.C. §§ 3729–3733 (False Claims Act); *see also* Off. of Inspector Gen., *Enforcement Actions*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://oig.hhs.gov/fraud/enforcement/> [<https://perma.cc/RWW6-LH67>] (last visited May 28, 2025).

135. 42 C.F.R. § 455.23. The federal government can also bring enforcement actions for fraud or violations of the False Claims Act. 31 U.S.C. §§ 3729–3733.

136. 42 C.F.R. §§ 424.506 (requiring National Provider Identifier); 424.510 (discussing Medicare enrollment requirements); 424.516 (requiring compliance with state licensure, certification, and regulatory requirements).

137. 42 C.F.R. § 424.515.

138. *See* 42 U.S.C. § 1395kk-1(a). MACs are private insurers that have been awarded a regional geographic jurisdiction to administer claims under Original Medicare. *What’s a MAC*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/whats-mac> [<https://perma.cc/9BVH-YK8B>] (last visited July 20, 2025). CMS also contracts with Unified Program Integrity Contractors (UPICs)

the Medicare Integrity Program, which authorizes CMS to conduct provider education, monitor compliance, and prevent fraud.¹³⁹ If a provider or supplier fails to meet Medicare requirements, CMS may revoke their enrollment or limit their billing privileges.¹⁴⁰

These enrollment requirements, and the high stakes of noncompliance under Medicaid and Original Medicare, jeopardize the scalability of many promising interventions. For example, while doulas and CHWs may be well-established in their communities, the administrative complexity of maintaining Medicaid enrollment or obtaining an NPI can overwhelm providers who may lack the infrastructure to manage these processes.¹⁴¹ Without institutional support or administrative capacity, even highly effective service providers risk being excluded from formal health care reimbursement systems.

In Medicare Advantage (MA), providers are subject to similar requirements. Enforcement of the provider requirements, however, is typically carried out by the plans themselves, pursuant to applicable federal and state regulations. For example, 42 C.F.R. § 422.204 requires MA organizations to implement “a documented process” for the selection and evaluation of providers, including verification of licensure, credentialing, and accreditation.¹⁴² Plans must also re-credential at least every three years and consider provider performance indicators related to quality improvement, utilization management, and patient satisfaction.¹⁴³ Because MA plans have more flexibility in credentialing criteria, they may be more amenable to credentialing and contracting with non-traditional providers, so long as those providers comply with applicable state licensure requirements.¹⁴⁴

ACA QHPs must implement a provider credentialing process, but unlike in the federal health insurance programs, ACA plans are not required to formally “enroll” providers. Federal regulations require “QHP issuers”¹⁴⁵ to verify the credentials of participating providers, but they do not prescribe specific

to investigate potential fraud and abuse. *See* 42 U.S.C. § 1395ddd (authorizing contracts); U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PROGRAM INTEGRITY MANUAL (CH. 6), <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c06.pdf> [<https://perma.cc/VG4D-C3UY>]; *see generally* *Unified Program Integrity Contractor (UPIC)*, NORIDIAN HEALTHCARE SOLUTIONS, <https://med.noridianmedicare.com/web/jddme/cert-reviews/upic> [<https://perma.cc/P5G8-YRZW>] (last updated Aug. 22, 2025).

139. *See* 42 U.S.C. § 1395ddd.

140. *See* 42 C.F.R. § 424.535.

141. *See supra* note 125 and accompanying text.

142. *See* 42 C.F.R. § 422.204.

143. *See* 42 C.F.R. § 422.204(b)(2)(ii).

144. Because provider licensing is conducted at the state level, plans and providers are subject to applicable state regulations in that context. *See id.* § 422.204(b)(1)(i).

145. QHP issuers are health insurance issuers that offer QHPs in a state in accordance with a certification from an Exchange. 45 C.F.R. § 155.20. Issuers are required to be licensed to engage in the business of insurance in the state and are subject to state law that regulates insurance. *See* 45 C.F.R. § 144.103.

licensing or credentialing standards.¹⁴⁶ Instead, QHPs generally rely on standards set by recognized accrediting entities.¹⁴⁷ These organizations, such as the National Committee for Quality Assurance (NCQA) and URAC, require health plans to “establish the qualifications of their licensed medical professionals by assessing their background and legitimacy to provide care.”¹⁴⁸ Because QHPs typically focus on traditional medical professionals, providers may still be excluded from participation due to unclear or mismatched credentialing standards.

The fragmented structure across Medicaid, Medicare, and the ACA not only creates inefficiencies—it contributes directly to the uncertainty and exclusion that prevent promising care models from scaling. Fortunately, several state and federal initiatives demonstrate how flexible design can expand access without compromising health and safety.

b. Structuring credentialing pathways to support non-traditional providers

Stakeholders can develop appropriate yet accessible provider qualification standards that align with quality and safety goals while avoiding overburdening longstanding community providers who may struggle to meet rigid, overly prescriptive requirements. For example, some states have utilized alternative vetting processes and flexible licensing options that still meet federal requirements.¹⁴⁹ To develop these alternative models, regulators should collaborate with providers—who bring essential institutional knowledge—to ensure credentialing systems reflect best practices and preserve the core principles of the services themselves.¹⁵⁰ This approach supports broader

146. See 42 U.S.C. § 18031(c)(1)(D); 45 C.F.R. § 156.275 (requiring QHPs to be accredited on the basis of, *inter alia*, provider credentialing). QHPs must also maintain accurate provider directories. 45 C.F.R. § 156.230(b).

147. See 45 C.F.R. § 155.1045 (permitting state exchanges to use accreditation by recognized entities in certifying QHPs).

148. See *Credentialing Accreditation & Certification Programs*, NCQA, <https://www.ncqa.org/programs/health-plans/credentialing/> [<https://perma.cc/DYR3-BLYA>] (last visited May 29, 2025); see also *Credentials Verification Organization Accreditation*, URAC, <https://www.urac.org/accreditation-cert/credentials-verification-organization-accreditation/> [<https://perma.cc/7L7G-J4QT>] (last visited May 29, 2025).

149. See, e.g., Hasan, *supra* note 52.

150. See, e.g., *Expanding Doula Support Services in Massachusetts: Consideration for Successful Implementation*, BETSY LEHMAN CTR. 14 (Jan. 2022), https://betsylehmancenterma.gov/assets/uploads/DoulaSupportMA_Report.pdf [<https://perma.cc/7J7H-BX7Q>] (documenting concern that primarily recognizing westernized, white-dominant training programs can overshadow training programs run by Black and brown doulas); *Doulas in Medicaid: Case Study Findings*, *supra* note 105, at 7 (citing doula concerns that if training and certification organizations are not community-based, they may not sufficiently train doulas to meet the needs of their patients); see also Leticia Boughton Price et al., *Illinois Community Health Worker Roundtables*, CHWA & CTR. FOR HEALTH L. & POL’Y INNOVATION OF HARVARD L. SCH. 4, 8 (July 2022), <https://chlp.org/wp-content/uploads/2022/07/Illinois-Community-Health-Worker->

provider participation, enhances access to culturally competent care, and promotes more sustainable, equitable systems.

Growing state Medicaid coverage of doula services demonstrates how provider credentialing and licensing can be adapted to accommodate innovative service models while advancing value-based care objectives. Doula care has been shown to improve health outcomes, reduce costs, and mitigate the effects of racism and racial bias in health care settings.¹⁵¹ In Medicaid, in particular, pregnant people who received doula support during labor and delivery exhibited lower preterm birth rates and required fewer cesarean sections, decreasing the risk of costly and dangerous complications.¹⁵² According to the Doula Medicaid Project, states have adopted a range of certification approaches for doulas, with many relying on independent training organizations and/or offering multiple pathways to credentialing, including recognition of demonstrated field experience.¹⁵³ Leading advocates and policy experts argue that this flexibility is essential for reducing barriers to entry.¹⁵⁴

Like doulas, community health workers (CHWs) offer a compelling example of how stakeholders can adapt credentialing frameworks to support non-traditional providers. As introduced earlier, CHWs serve as culturally competent intermediaries between health systems and communities.¹⁵⁵ CHW interventions have consistently demonstrated positive outcomes, particularly in

Roundtables.pdf [https://perma.cc/2RXZ-KFKS] (advocating for CHW leadership in training programs and flexibility in training formats to credit highly qualified CHWs for their prior professional experience).

151. See Alexandria Sobczak et al., *The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review*, 15(5) CUREUS 1, 11 (May 24, 2023) (“... doulas have been found to reduce cesarean section frequency, low birth weight, and premature labor” and increase well-being and satisfaction rates); see Meghan A. Bohren et al., *Continuous Support for Women During Childbirth*, COCHRANE DATABASE OF SYS. REV. 1 (2017) (meta-analysis of 26 studies finding continuous, one-to-one intrapartum support may improve outcomes for women and infants compared with usual care); see also *Doulas and Midwives Are Key Partners in Improving Maternal and Infant Health Outcomes*, NAT’L ACAD. FOR STATE HEALTH POL’Y (Dec. 23, 2022), https://nashp.org/doulas-and-midwives-are-key-partners-in-improving-maternal-and-infant-health-outcomes/ [https://perma.cc/UP4E-X4WT].

152. Kathleen Knocke, *Doula Care and Maternal Health: An Evidence Review*, ASPE OFF. OF HEALTH POL’Y 5 (Dec. 13, 2022), https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf [https://perma.cc/LH62-RB4S].

153. Chen & Rohde, *supra* note 122; see, e.g., *Doula Application Information*, CAL. DEP’T OF HEALTH CARE SERVS., https://www.dhcs.ca.gov/provgovpart/Pages/Doula.aspx [https://perma.cc/EME4-AB77] (last visited May 19, 2025) (requiring doulas to either complete minimum hours of training or have at least five years of recent experience in doula care, supported by letters of recommendation). For more information about the Doula Medicaid Project, see *About the Doula Medicaid Project*, NAT’L HEALTH LAW PROG., https://healthlaw.org/doulamedicaidproject/ [https://perma.cc/97SJ-8J2T] (last visited May 19, 2025).

154. Chen, *supra* note 30.

155. See AM. PUB. HEALTH ASS’N, *supra* note 19; see also *Medicaid Coverage of Community Health Worker Services*, *supra* note 105, at 1 (“CHW services may include health promotion and education, patient outreach and follow-up, assistance in navigating the health care system, translation and interpretation services, and care coordination and case management.”).

increasing access to and adherence to care, enhancing patient satisfaction, and reducing racial disparities.¹⁵⁶ Many states certify CHWs after they complete specific training programs or a certain number of supervised practice hours.¹⁵⁷ States have also made efforts to avoid unnecessary credentialing barriers by, for instance, exempting CHWs with prior experience from such requirements or by recognizing licenses and certifications from other states.¹⁵⁸ This balance—setting clear, navigable guidelines that legacy providers can follow while maintaining the flexibility to accommodate diverse backgrounds and models of care—is essential to equitably expanding access and increasing provider enrollment.¹⁵⁹

While doula and CHW services illustrate how states can flexibly structure credentialing to support emerging services, non-emergency medical transportation (NEMT) demonstrates a different approach via federally mandated coverage that can ensure baseline standards while still preserving state flexibility. NEMT ensures that Medicaid beneficiaries can access medically necessary health care services by providing transportation to and from those services.¹⁶⁰ When Congress added NEMT as a mandatory Medicaid benefit through Section 209 of the Consolidated Appropriations Act in 2020, it

156. *Medicaid Coverage of Community Health Worker Services*, *supra* note 105, at 2–3 (collecting research); Emmett Ruff et al., *Advancing Health Equity through Community Health Workers and Peer Providers: Mounting Evidence and Policy Recommendations*, FAMILIES USA 19 (Nov. 2019), https://familiesusa.org/wp-content/uploads/2019/11/HEV_PCORI-CHW-Report_11-04-19.pdf [<https://perma.cc/DE73-4Q58>].

157. *See Medicaid Coverage of Community Health Worker Services*, *supra* note 105, at 9.

158. *See id.* (including an example from Oregon allowing documentation and experience certification requirements); *cf.* CALIFORNIA DEP'T OF HEALTH CARE SERVS., *MEDI-CAL COMMUNITY SUPPORTS, OR IN LIEU OF SERVICES (ILOS) POLICY GUIDE 55* (July 2023), <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf> (explaining how California FIM programs provide alternative vetting process for community-based providers); *see, e.g.*, Mass. Exec. Off. of Health & Hum. Servs., *Order Maximizing Available Health Care Providers* (Apr. 2020), <https://www.mass.gov/doc/order-maximizing-available-healthcare-providers-april-2020/download> [<https://perma.cc/8Z35-Q3KD>] (issuing Massachusetts licenses to health care providers “who are licensed in another State who present to the corresponding Massachusetts licensing authority verification that such license is in good standing in that other State” during the COVID-19 state of emergency).

159. *See* Ctr. for Health L. & Pol'y Innovation of Harvard L. Sch., Nat'l Council of La Raza & Am. Acad. of Family Physicians Found., *Recommended Model Guidelines for Credentialing Community Health Worker Programs and Community Health Workers* (2013), <https://chlp.org/wp-content/uploads/2013/12/PATHS-Credentialing-Guidelines-Final-070815.pdf> [<https://perma.cc/EUB7-UWJ5>]; *see, e.g.*, Emmett Ruff & Eliot Fishman, *Building Capacity for Community Health Worker Integration: Three Key Steps State Policymakers Should Take during the COVID-19 Crisis and Beyond*, FAMILIES USA 2–3 (July 2020), https://familiesusa.org/wp-content/uploads/2020/07/HE-267_Integrating-CHWs_Report_7-21-20.pdf [<https://perma.cc/D2PQ-2KMT>] (explaining how standardized certifications can create the infrastructure for Medicaid reimbursement and also lay out the scope of practice for CHWs, facilitating recruitment and contracting).

160. *See* 42 C.F.R. § 440.170(a); U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 21.

imposed minimum federal standards on NEMT providers and drivers.¹⁶¹ These requirements include that drivers hold valid licenses, that providers have procedures to address violations of state drug laws, and that driver histories be disclosed to state agencies.¹⁶² Although these requirements may seem simple, they provide greater legal clarity and opportunities for long-term system alignment while preserving state flexibility above a consistent floor.¹⁶³ In addition to improving access and consistency, federal provider qualification and enrollment standards have supported oversight efforts by reducing administrative confusion and reinforcing broader goals of program integrity and quality of care.¹⁶⁴

These case studies demonstrate that several approaches can help pull non-traditional providers out of regulatory gray areas and certification limbo, and into clear, navigable pathways that support access while advancing quality and safety goals.

3. *Billing and Reimbursement*

A final common barrier to sustainable health care integration involves billing and reimbursement, where limited administrative capacity and inadequate payment rates pose significant obstacles to incorporating innovative interventions into mainstream coverage frameworks.

161. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 209, 134 Stat. 1182, 1456 (2020).

162. *Id.* at 2988.

163. See 42 U.S.C. § 1396a(a)(87) (allowing states to impose more rigid requirements). A majority of states have amended their state plans to implement the new requirements, demonstrating the statute's effectiveness of promoting regulatory alignment. See *29 States Have CMS-Approved State Plan Amendments (SPAs) to Implement the New Non-Emergency Medical Transportation (NEMT) Requirements*, SIMON & CO. (Mar. 31, 2022), <https://mjsimonandcompany.com/non-emergency-medical-transport/mandatory-medicare-benefit-campaign/half-of-states-have-cms-approved-state-plan-amendments-spas-to-implement-the-new-non-emergency-medical-transportation-nemt-requirements> [<https://perma.cc/UU4D-8PY2>].

164. See Sharon Silow-Carroll et al., *Medicaid's Non-Emergency Medical Transportation Benefit: Stakeholder Perspectives on Trends, Challenges, and Innovations*, HEALTH MGMT. ASSOCS. 21 (Aug. 2021), https://www.healthmanagement.com/wp-content/uploads/HMA_NEMT_Report_MACPAC_Aug-21.pdf [<https://perma.cc/LF7J-WEMS>] (discussing how regulation and oversight can reduce fraud and abuse). Additional federal guidance further crystallizes expectations regarding state oversight responsibility, see U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUM. SERVS., STATE MEDICAID DIR. LETTER NO. 23-006, 26 (Sep. 28, 2023), <https://www.medicare.gov/federal-policy-guidance/downloads/smd23006.pdf> [<https://perma.cc/8MMJ-H5FX>], and provider expectations, see generally *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 2016), <https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf> [<https://perma.cc/JX9R-G6YT>].

a. Medicaid rate setting and reimbursement structure

Under Medicaid, services are reimbursed according to policies and methodologies that each state outlines in its state plan (subject to CMS approval).¹⁶⁵ Because there are no federal minimums, states have considerable flexibility to establish Medicaid provider payment rates for most provider types.¹⁶⁶ That flexibility, however, is bounded by several federal requirements designed to ensure adequate access and value.

For instance, § 1902(a)(30)(A) of the Social Security Act requires that payments for services be consistent with “efficiency, economy, and quality of care” while “safeguard[ing] against unnecessary utilization” of care and services.¹⁶⁷ This section also requires that rates be “sufficient to enlist enough providers so that care and services are available under the plan, at least to the extent that such care and services are available to the general population in the geographic area.”¹⁶⁸ If a state wants to reduce or restructure rates, it must consider stakeholder input—including from providers and beneficiaries—and the impact that the proposed change will have on access to the service.¹⁶⁹ While Medicaid MCOs are not subject to these exact payment provisions, state payments for MCO services must be actuarially sound, meaning that the rates are projected to provide “for all reasonable, appropriate, and attainable costs” required under the contract.¹⁷⁰ When determining those rates, states must consider utilization and cost data, trends, and demographic factors.¹⁷¹ Together, these structural safeguards are intended to promote access and payment adequacy.

b. Medicare rate setting and reimbursement structure

As with other barriers, reimbursement differs between Original Medicare and Medicare Advantage. In Original Medicare, CMS centrally administers payment and directly reimburses providers. CMS sets national Medicare payments through prospective payment systems for Part A (hospital insurance)

165. See 42 C.F.R. § 447.201.

166. See *Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation*, CTRS. FOR MEDICARE AND MEDICAID SERVS. 1, <https://www.medicaid.gov/medicaid/downloads/upl-instructions-qualified-practitioner-services-replacement-new.pdf> [<https://perma.cc/CBU2-C8KN>] (last visited Apr. 10, 2026); *Upper Payment Limit Supplemental Payments*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM’N 1 (Nov. 2021), <https://www.macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf> [<https://perma.cc/2QPW-YDJE>].

167. Codified at 42 U.S.C. § 1396a(a)(30)(A).

168. 42 U.S.C. § 1396a(a)(30)(A).

169. 42 C.F.R. § 447.204.

170. 42 U.S.C. § 1396b(m)(2)(A); 42 C.F.R. § 438.4.

171. 42 C.F.R. § 438.5.

and fee schedules for Part B (medical insurance).¹⁷² Providers are generally reimbursed on a fee-for-service basis, meaning they are paid a set amount based on the diagnosis, treatment, or service rendered.¹⁷³

By contrast, in Medicare Advantage, CMS pays plans a capitated, risk-adjusted monthly amount per beneficiary, not per service.¹⁷⁴ MA plans then negotiate rates and payment models directly with contracted providers.¹⁷⁵ Importantly, CMS does not regulate provider payment amounts offered by MA plans, but it does require that “benefits [be] available and accessible” to enrollees with “reasonable promptness” and “continuity.”¹⁷⁶

c. Affordable Care Act rate setting and reimbursement structure

Although federal law requires that all QHPs cover services included in the state’s EHB benchmark plan, the ACA does not establish a centralized federal reimbursement system.¹⁷⁷ Instead, QHP issuers negotiate payment rates directly with providers and can implement their preferred payment models, including those that forward value-based principles.¹⁷⁸ While there are no federal minimums or caps on these rates, plans must meet federal network adequacy standards, which may indirectly influence payment rates.¹⁷⁹

d. Challenges arising from billing and reimbursement

Problems with billing codes and processes create structural barriers to the

172. 42 U.S.C. § 1395ww(d) (establishing Inpatient Prospective Payment Systems (IPSS) methodology for Medicare Part A); 42 C.F.R. pt. 412 (detailing regulations for IPPS); 42 U.S.C. § 1395w-4 (requiring the HHS Secretary to establish Medicare Part B fee schedules based on several factors); 42 C.F.R. pt. 414 (implementing regulations for payment of Part B services).

173. *See supra* notes 169–70 and accompanying text.

174. *See* 42 U.S.C. § 1395w-23(a); *see also* 42 C.F.R. § 422.250–422.266. MA’s capitated payment model furthers the goals of value-based care by incentivizing providers to keep patients healthy within the fixed budget. *See generally* Margaret Lindquist, *Understanding Value-Based Care Models*, ORACLE HEALTH (Apr. 16, 2025), <https://www.oracle.com/health/value-based-care-models/> [<https://perma.cc/9MV2-ZE3Q>].

175. *See* 42 U.S.C. § 1395w-22(d); 42 C.F.R. § 422.112(a)(1).

176. *See* 42 U.S.C. § 1395w-22(d).

177. *See* 45 C.F.R. § 165.115 (requiring provision of benefits that are “substantially equal to the EHB-benchmark plan”); Letter from Ctr. for Consumer Info. & Ins. Oversight, U.S. Ctrs. For Medicare & Medicaid Servs. on 2024 Final Letter to Issuers in the Federally-facilitated Exchanges (May 1, 2023), <https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf> [<https://perma.cc/STN4-7WTK>] (clarifying that “states are the primary regulators of health insurers” in federally-funded exchanges and are responsible for reviewing rates for reasonableness and compliance with federal laws and regulations).

178. *See, e.g., Rate Justification for QHP Plans*, EMPIRE HEALTHCHOICE ASSURANCE, INC., 1 (Jan. 2023), https://www.anthembluecross.com/content/dam/anthem/us/global/pdf/2023_NY_G1921_SG_RateJustification.pdf [<https://perma.cc/8U3E-UV22>] (QHP issuer explaining how, despite a rate increase, it “continue[s] to negotiate the best possible rates for covered services” and to collaborate with providers through value-based payment models).

179. *See* 45 C.F.R. § 156.230.

scalability and sustainability of innovative services. Medical Nutrition Therapy (MNT), a “nutrition-based treatment provided by a registered dietitian”¹⁸⁰ that uses education and behavioral counseling to prevent or manage a medical condition, illustrates these challenges to integrating into the reimbursement systems.¹⁸¹ Although Medicare Part B and other insurers cover MNT for certain conditions,¹⁸² billing procedures often remain unclear, particularly in non-traditional settings. The lack of guidance has led to service caps, staffing shortages, and access limitations.¹⁸³ These problems, in turn, limit beneficiary access and exacerbate the underutilization of services.¹⁸⁴ Similar challenges have been reported in other innovative services, such as those involving CHWs; as researchers have noted, “when regulatory language lacks clarity, organizations struggle to translate regulations into [effectuating] service delivery, submitting claims, and successfully receiving payment.”¹⁸⁵

Beyond regulatory ambiguity, non-traditional providers and community-based organizations (CBOs) often lack the necessary infrastructure and expertise to manage the complexities of health care coding, billing, and payment systems.¹⁸⁶ Some CHWs have noted that navigating the billing process can be

180. See *Medical Nutrition Therapy*, U.S. CTRS. FOR DISEASE CTRL. & PREVENTION (May 15, 2024), <https://www.cdc.gov/diabetes-toolkit/php/reimbursement/medical-nutrition-therapy.html> [<https://perma.cc/E4RP-XJHG>]; see also 42 U.S.C. 1395x(vv)(1) (defining MNT services as “nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional”).

181. *Medical Nutrition Therapy*, U.S. CTRS. FOR DISEASE CTRL. & PREVENTION (May 15, 2024), <https://www.cdc.gov/diabetes-toolkit/php/reimbursement/medical-nutrition-therapy.html> [<https://perma.cc/E4RP-XJHG>]; see also 42 U.S.C. 1395x(vv)(1) (defining MNT services as “nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional”); *Medical Nutrition Therapy*, CLEVELAND CLINIC, <https://my.clevelandclinic.org/health/treatments/medical-nutrition-therapy-mnt> [<https://perma.cc/6EBB-CPW2>] (last updated Feb. 29, 2024).

182. 42 C.F.R. § 410.132; see also *Medical Nutrition Therapy Services*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/coverage/medical-nutrition-therapy-services> [<https://perma.cc/VY87-QKAU>] (last visited Apr. 10, 2026); Eat Right Pro, *Places of Service and Specific Healthcare Services*, ACAD. OF NUTRITION & DIETETICS, <https://www.eatrightpro.org/career/payment/coding-and-billing/places-of-service-and-specific-health-care-services> [<https://perma.cc/R9AG-B94W>] (last visited Apr. 10, 2026).

183. Eat Right Pro, *Academy Advocates for Sustainable Billing Practices for Medical Nutrition Therapy*, ACAD. OF NUTRITION & DIETETICS (Mar. 28, 2024), <https://www.eatrightpro.org/news-center/public-policy-news/academy-advocates-for-sustainable-billing-practices-for-mnt> [<https://perma.cc/8P39-QXZA>].

184. See, e.g., Letter from Jeanne Blankenship & Carly Leon, Acad. of Nutrition & Dietetics to Gift Tee, Director, Division of Practitioner Services, U.S. Ctrs. For Medicare & Medicaid Svcs., U.S. Dep’t of Health & Hum. Svcs. 2 (Mar. 22, 2024), https://www.eatrightpro.org/-/media/files/eatrightpro/about-us/about-us-regulatory-comments/3-28-24-academy-comments-to-cms-hopd_march-2024.pdf?rev=316fa3c4d7a54599afa33cf26165a547&hash=816F29BC6BEA3C9297212E98E97B7272 [<https://perma.cc/WUZ7-YM6W>].

185. Kathryn E. Gunter et al., *Barriers and Strategies to Operationalize Medicaid Reimbursement for CHW Services in the State of Minnesota: A Case Study*, 38 J. GEN. INT’L MED. S70, S71 (Mar. 2, 2023).

186. See, e.g., Camaliche et al., *supra* note 60, at 6–7.

“the equivalent of learning a whole new language from scratch.”¹⁸⁷ Thus, even when insurers technically cover services, many organizations struggle to operationalize and access reimbursement.¹⁸⁸ For instance, registered dietitian nutritionists (RDNs) delivering MNT report low reimbursement levels, primarily due to a limited understanding of the coding and billing processes.¹⁸⁹ The Academy of Nutrition and Dietetics has warned that RDNs providing clinical services “may be at risk for losing income and/or jobs to other, more business-savvy health care providers” who are better able to navigate payment systems.¹⁹⁰ However, technical assistance and training can meaningfully reduce these administrative barriers.¹⁹¹ For example, to facilitate Medicaid coverage of doula services in Oregon, liaisons were deployed to assist doulas with submitting Medicaid claims and billing.¹⁹²

Even when reimbursement is available and accessible, low payment rates for non-traditional services often fail to reflect the full scope of work required to deliver effective care.¹⁹³ A primary reason for this insufficiency is the

187. Camaliche et al., *supra* note 60, at 6–7.

188. See, e.g., Kathryn E. Gunter et al., *supra* note 185; CTR. FOR HEALTH L. & POL’Y INNOVATION OF HARV. L. SCH. & FOOD IS MED. COAL., *supra* note 20, at 33 (explaining that complicated billing and reimbursement processes in Medicaid nutrition programs “threaten the timely delivery of services and payments”).

189. See Bonnie T. Jortberg et al., *Trends in Registered Dietitian Nutritionists’ Knowledge and Patterns of Coding, Billing, and Payment*, 120 J. OF THE ACAD. OF NUTRITION & DIETETICS 134, 144 (July 2019). Underutilization of insurance can have broader negative impacts. Failure to log services can skew data needed to assess important metrics such as cost, volume, and utilization, making services “invisible” to rate-setting parties. Cf. KPMG, *Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case*, THE COMMONWEALTH FUND 9 (Mar. 2018), <https://www.commonwealthfund.org/publications/other-publication/2018/mar/investing-social-services-core-strategy-healthcare> [<https://perma.cc/C9TR-UFF3>] (describing how failing to log services due to a lack of payment codes makes expenses “invisible” to rate-setting parties). For instance, if registered dietitians are not billing for the MNT services they provide, then systems cannot evaluate their efficacy or credit the value that is being delivered. See Jortberg et al., *supra* note 189, at 144.

190. Jortberg et al., *supra* note 189, at 144.

191. See, e.g., Anna Mudumala et al., *Challenges and Strategies in Expanding Non-Traditional Pregnancy-Related Services: Findings from a Survey of State Medicaid Programs*, KFF (May 3, 2024), <https://www.kff.org/medicaid/challenges-and-strategies-in-expanding-non-traditional-pregnancy-related-services-findings-from-a-survey-of-state-medicaid-programs/> [<https://perma.cc/4VUY-VLMA>] (explaining how states such as New Mexico and Virginia have provided technical assistance and resources to help MCOs and providers navigate billing).

192. Cara B. Safon et al., *Access to Perinatal Doula Services in Medicaid: A Case Analysis of 2 States*, 2(3) HEALTH AFF. SCHOLAR 1, 7 (Mar. 4, 2024); see also A. J. Admon et al., *Assessing and Improving Data Quality from Community Health Workers: A Successful Intervention in Neno, Malawi*, 3(1) PUB. HEALTH ACTION 56, 58 (Mar. 2013) (shifting data collection and aggregation responsibilities away from community health workers, resulting in rapid improvements in data quality).

193. See *Doulas in Medicaid: Case Study Findings*, *supra* note 105, at 8; see also HILL ET AL., *supra* note 42. Low reimbursement is particularly prevalent in Medicaid, see *Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services*, MEDICAID AND CHIP

continued reliance on the fee-for-service payment model, which is built around discrete, quantifiable services typically performed by licensed medical professionals.¹⁹⁴ By contrast, many non-traditional interventions—such as those supplied by CBOs and non-medical providers—do not conform to this structure.¹⁹⁵ As a result, billing codes often undervalue the frequency, duration, cost, and/or complexity of these services, leading to low provider participation, workforce turnover, and diminished quality of care.¹⁹⁶ For instance, CBOs delivering DPP services report that “covering their full, ongoing costs is a primary challenge,” with many relying on supplemental funding sources such as grants to sustain operations.¹⁹⁷

e. Alternative payment models present new opportunities

While this Article focuses primarily on the legal and structural barriers inhibiting widespread adoption of innovative services, there remain additional factors, such as payer reluctance to expand coverage for preventive services, which constrain integration. As some researchers have noted, financial incentives do not always align to encourage insurers to cover preventive services.¹⁹⁸ The frequency with which patients rotate on and off different insurance plans, especially Medicaid, may disincentivize insurers from covering preventive treatments that increase short-term costs when a future insurer may reap the full benefits down the line.¹⁹⁹ However, the shift from volume-based to

PAYMENT AND ACCESS COMM’N 1–2 (Jan. 2025), <https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf> [<https://perma.cc/Z92A-P8E4>]. Making matters worse, in 2015, the Supreme Court held that providers cannot sue State Medicaid Agencies to enforce federal reimbursement rate standards. *Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. 320, 328–29 (2015).

194. Camaliche et al., *supra* note 60, at 8.

195. Several factors contribute to this misalignment, including the prevalence of non-medical providers (e.g., doulas), team-based models of care (e.g., CHWs), multi-touch engagements, and the time-intensive nature of the intervention.

196. Joseph Humphry & Jasmin Kiernan, *Insights in Public Health: Community Health Workers Are the Future of Health Care: How Can We Fund These Positions?*, 78 HAW. J. HEALTH & SOC. WELFARE 371, 371 (Dec. 2019); *see, e.g., Doulas in Medicaid: Case Study Findings*, *supra* note 105, at 8; *see also* HILL ET AL., *supra* note 42; Mudumala, *supra* note 191; Camaliche et al., *supra* note 60, at 8.

197. Nat’l Disease Prevention Program Coverage Toolkit, *Nat’l DPP Lifestyle Change Program Delivery Options*, NAT’L ASS’N OF CHRONIC DISEASE DIR. (Mar. 12, 2025), <https://coveragetoolkit.org/medicaid-agencies-delivery/program-delivery-options/> [<https://perma.cc/CN49-7F2Q>].

198. *See, e.g.,* Katherine Pryor & Kevin Volpp, *Deployment of Preventive Interventions — Time for a Paradigm Shift*, 378 NEW ENG. J. MED. 1761, 1761 (2018).

199. *See* Pryor & Volpp, *supra* note 198, at 1762; Sachs, *supra* note 13, at 76; *cf.* Musumeci et al., *supra* note 199 (discussing the same disincentives in the context of high-cost disease treatment). Medicaid enrollment “churn” is particularly high, “the typical enrollee is covered for less than 10 months, and 10 percent of enrollees lose and regain Medicaid within 12 months.”

value-based care offers promise to counteract this narrow cost-avoidance framing.

Alternative value-based payment models, which widen the scope of optimization to include long-term outcomes and system-wide efficiency, offer a critical opportunity to redesign reimbursement structures to better support the sustainability and scalability of innovative, community-based services. By tying payment to quality metrics and cost savings rather than to service volume, they allow for more flexible and comprehensive reimbursement.²⁰⁰ CMS is increasingly integrating value-based care models into both Original Medicare and Medicare Advantage.²⁰¹ Under Original Medicare's Shared Savings Program, Accountable Care Organizations (ACOs) can share in the savings they generate for the Medicare program by delivering high-quality, cost-effective care.²⁰² MA organizations, similarly, often incorporate value-based arrangements into their provider contracts to share financial risks and encourage efficient use of resources.²⁰³

As CMS continues its shift to value-based care across both systems, innovative services will have greater opportunities to access reimbursement, particularly where they improve quality and reduce costs through upstream interventions.²⁰⁴ Medicare's Accountable Care Organization Realizing Equity,

MaryBeth Musumeci et al., *Reducing Medicaid Churn: Policies to Promote Stable Health Coverage and Access to Care*, COMMONWEALTH FUND (June 11, 2025). These high rates are due, in part, to the income-based nature of Medicaid eligibility and the heightened barriers to renew enrollment. *Id.*

200. See, e.g., Camaliche et al., *supra* note 60, at 8.

201. See, e.g., Abe Sutton, CMS Innovation Center Strategy to Make America Healthy Again, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again> [<https://perma.cc/T6JS-GUDX>] (last updated May 13, 2025) ("Medicare Advantage models will be designed to increase high-value coverage options and to help beneficiaries select plans that best meet their health needs."); *Strategic Direction*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/about/strategic-direction> [<https://perma.cc/SF6K-8B56>] (last updated Mar. 16, 2026) (discussing strategy of increasing provider participation in and improving administration of value-based payment programs).

202. See 42 U.S.C. § 1395jjj (directing HHS Secretary to establish a shared savings program for ACOs under Original Medicare); 42 C.F.R. pt. 425. ACOs are "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve." See generally *Accountable Care Organizations (ACOs): General Information*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/innovation-models/aco> (last visited May 30, 2025); see also 42 C.F.R. § 425.20.

203. See *Value-based contracts: Evaluating Medicare Advantage*, AM. MED. ASS'N 3 (2025), <https://www.ama-assn.org/system/files/2019-04/medicare-advantage-value-based-contracts.pdf> [<https://perma.cc/NJ2E-55TT>] ("Because MA plans are at risk for the full cost of Medicare-covered health expenses [under the capitated payment model], they have incentives to 'push down' or delegate this risk to providers.")

204. Not all value-based models have been successful. For example, CMS terminated Medicare Advantage's Value-Based Insurance Design (VBID) Model early due to its "substantial and unmitigable costs." See *Medicare Advantage Value-Based Insurance Design (VBID) Model*

Access, and Community Health (ACO REACH) model provides for team-based care and bundled payments for sets of services, which better supports the delivery of innovative interventions.²⁰⁵ While the ACO REACH model is currently slated to sunset at the end of 2026, CMS has continued to refine the model, suggesting an intention to renew it. Similarly, Medicaid MCO contracts can be designed to operationalize the inclusion of non-traditional providers via specially designed payment methodologies.²⁰⁶

While these alternative payment models provide a necessary component, ensuring inclusion of innovative services in these existing structures still requires system-wide alignment with legal infrastructure. The examples of successful integration discussed above demonstrate that alignment with coverage frameworks is possible, particularly when stakeholders collaborate to adapt benefit definitions, credentialing pathways, and payment models to support scalability while preserving program integrity.

IV. CONCLUSION

The transition from community-based intervention to complete health care coverage often overwhelms longstanding providers and community-based organizations that may be unprepared or insufficiently resourced to meet newly imposed legal requirements. Late-stage barriers can delay implementation, incur unnecessary expenses, and push out legacy providers who have long served marginalized populations. Given that most CBOs “have very little experience with many of the processes used in the health care industry,”²⁰⁷ stakeholders must ensure that these organizations are brought into compliance, not left behind.

While short-term funding mechanisms, such as pilot programs and demonstration projects, offer valuable early support, innovators should treat them as bridges to full coverage opportunities, rather than as long-term financing solutions. Reliance on time-limited financing can inhibit the scaling and sustainability of many promising interventions and prohibit these programs from achieving “cruising altitude.” Instead, these programs should be optimized from the outset to align with public and private coverage frameworks, laying the groundwork for long-term integration.

On the road to this long-term integration, many innovative services

to End After Calendar Year 2025, CMS.GOV BLOG (May 15, 2024), <https://www.cms.gov/newsroom/blog/medicare-advantage-value-based-insurance-design-vbid-model-end-after-calendar-year-2025-excess-costs> [<https://perma.cc/U95S-467C>].

205. *ACO Reach*, U.S. CNTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/priorities/innovation/innovation-models/aco-reach> (May 1, 2025) (this model is authorized under Medicare’s Shared Savings Program, see 42 C.F.R. § 425.10 et seq.); see Humphry & Kiernan, *supra* note 196, at 372 (describing benefits of team-based care and bundled payment models for inclusion of CHWs in clinical payment structures).

206. See Ruff & Fishman, *supra* note 159, at 8.

207. See, e.g., NAT’L ASS’N OF CHRONIC DISEASE DIR., *supra* note 197.

encounter recurring obstacles that stem from mismatches between service design and legal requirements. Understanding the main requirements of the three major insurance coverage opportunities in the United States is a crucial first step to ensuring the legal compatibility necessary for integration. If innovators and providers do not understand the legal frameworks that apply to their services from the outset, they may struggle to incorporate legal requirements into their program design and delivery down the road. If payers and regulators lack insight into how innovative services operate, they may miss opportunities to collaborate with providers and legacy organizations in adapting legal and regulatory frameworks to support coverage in ways that maintain safety, promote quality, and expand access.

Stakeholders have the opportunity—and responsibility—to proactively guard against the sudden onslaught of legal requirements. By familiarizing themselves with these requirements early on, implementers will be better positioned to navigate the recurring challenges and achieve sustainable, scalable integration. Moreover, these frameworks can guide stakeholders in aligning best practices, developing workable guidelines, and building the infrastructure necessary for and compatible with sustainable coverage. With thoughtful planning and collaboration, stakeholders can ensure that integration is not only achievable but also preserves best practices that support program integrity, quality of care, and other value-based goals.

**CERTIFICATES OF PUBLIC ADVANTAGE (COPAs): A
PROVISIONAL, STATE-LED SOLUTION TO RURAL HOSPITAL
CLOSURES AND CONSOLIDATION—WHY RURAL HOSPITAL
MARKETS CURRENTLY NEED AN ALTERNATIVE TO BANKRUPTCY
AND ANTITRUST-SCRUTINIZED M&A**

JAY BAKER, JD, MBA*

Rural hospital markets' economics differ from urban hospital markets. Today's federal reimbursement structures and antitrust policies fail to account for the unique economic dynamics present in rural hospital markets. Consequently, these hospitals have experienced a record number of closures in recent years. Such risk of closures has contributed to the coinciding rise in hospital mergers and acquisitions. Both the closure of a rural hospital and the consolidation of a rural hospital presents problems for patients. Thus, there is a pressing need to address both the closure and consolidation of rural hospitals. This paper elaborates on both problems, then proposes a currently available, albeit provisional, solution that states should consider implementing until the underlying causes of these problems are rectified.

Although strict antitrust enforcement may preclude increased post-merger/acquisition prices, it does not address the unique differences in competition that rural hospital markets experience. Conversely, lenient antitrust enforcement may allow rural hospitals to stay open by affiliating with another health system, but that would fail to address the anticompetitive effects associated with consolidation.

A Certificate of Public Advantage (COPA) is the only readily available, precedentially sound framework that simultaneously—if temporarily—addresses the adverse effects of both rural hospital closure and rural hospital consolidation. States should utilize COPA laws where appropriate, as they can help promote healthcare access and improve the quality of healthcare delivery—provided the states effectively supervise the consolidation resulting from an approved COPA. This paper explains why and how states should use COPAs during this critical time in which rural hospitals' financial viability is at risk and there is no pragmatic alternative other than regulated consolidation. COPAs acknowledge the unique market dynamics rural hospitals face and offer a pragmatic alternative to closures and unregulated consolidations.

* Jay Baker received his J.D. and M.B.A. from the University of Montana in 2025. He served as Managing Editor of the Montana Law Review and as a Research Assistant and Teaching Assistant in Contract Law. He has eight years of healthcare industry experience and is currently completing an administrative fellowship at University of Utah Health. The author extends his sincere gratitude to Professors Craig Cowie and Alicia Gilbert for their thoughtful review of this article.

TABLE OF CONTENTS

I. INTRODUCTION

- A. Background*
- B. Premise of Argument*

II. HOSPITAL FINANCES

- A. Hospital Supply and Demand*
- B. Rural Hospitals' Financial Distress*

III. HOSPITAL INTEGRATIONS

- A. Vertical Integration: Hospitals and Physicians*
- B. Horizontal Integration: Hospitals and Hospitals*
- C. Cross-market Mergers: Economies of Scale for Hospitals*

IV. COPAS: ADDRESSING PRICE AND QUALITY IN RURAL HOSPITAL MARKETS

- A. Lowering Prices: Competition or Regulation?*
- B. Improving Quality: Competition or Self-regulation?*

V. COPA LAWS

- A. State-Action Doctrine*
- B. Analysis of COPA Laws' Compliance with the State-action Doctrine*
 - 1. State Authorization*
 - 2. State Supervision*

VI. COPA APPROVALS, REVIEWS, AND CHALLENGES

- A. Tennessee and Virginia: 2017 COPA Challenge*
- B. Louisiana: 2023 COPA Challenge*
- C. Indiana: 2025 COPA Challenge*

VII. RECOMMENDED COPA LAW PROVISIONS

- A. Application*
 - 1. General Information*
 - 2. Public Benefit and Antitrust Justification*
 - 3. Community Impact*
- B. Approval*
 - 1. Enhancement of Quality of Health Care*
 - 2. Access to Healthcare Services in Undeserved or Rural Areas*
 - 3. Gains in Cost Efficiency of Services*
 - 4. Improvements in Population Health or Public Health Outcomes*
 - 5. Avoidance of Duplication of Hospital Resources*
 - 6. Improvements in Access to Care*
 - 7. Extent of Reduction in Competition*
 - 8. Impact on Pricing, Innovation, or Patient Choice*
- C. Authorization*
- D. Supervision*
- E. Termination*

VIII. CONCLUSION

I. INTRODUCTION

On February 5, 2025, two hospitals serving rural Indiana—Union Hospital and Terre Haute Regional Hospital—submitted an application for a Certificate of Public Advantage (COPA), requesting the state authorize their proposed merger under Indiana’s COPA statutes.¹ At a town hall addressing the matter, 63% of public commentors supported the merger, with only 25% of public commentors opposing it.² However, this COPA was opposed by both the Federal Trade Commission (FTC)³ and Indiana’s Attorney General.⁴ Additionally, during its 2025 legislative session, the Indiana Legislature amended its COPA statutes to preclude hospitals from submitting any more COPA applications, effective May 13, 2025.⁵ Still, on November 9, 2025, the Indiana Department of Health approved this COPA, permitting the merger of these hospitals.⁶ The merger was finalized on December 13, 2025.⁷

Indiana’s need for its recent COPA typifies the condition of rural hospital markets nationally. “Given the role rural hospitals play in the health and well-being of their communities, both closures and mergers may have broad and deep impacts.”⁸ Having such “broad and deep impacts,” the closures and consolidations of rural hospitals nationwide have raised concerns about patient access to affordable, quality health care in rural areas. This article explores some of the economic and legal principles involved in rural hospital closures, consolidations, and COPAs.

A. Background

By the end of 2025, 756 rural hospitals—over 30% of all rural hospitals in the country—were at risk of closing, with 323 rural hospitals at *immediate* risk

1. Union Hospital, Inc. & Terre Haute Regional Hospital, L.P., *Application for Certificate of Public Advantage* (Feb. 5, 2025), <https://www.in.gov/health/cshcr/files/COPA-2025-Application-Reduced.pdf> [https://perma.cc/37CQ-6M3Y].

2. *Determination: Union Hospital, Inc. and Terre Haute Regional Hospital, L.P. Application for Certificate of Public Advantage*, IND. DEP’T OF HEALTH 2 (Nov. 9, 2025), <https://www.in.gov/health/cshcr/files/COPA.Determination.2025.pdf> [https://perma.cc/SGR3-7WS3].

3. Press Release, Fed. Trade Comm’n, FTC Staff Opposes Proposed Indiana Hospital Merger (Sep. 5, 2024), <https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-staff-opposes-proposed-indiana-hospital-merger> [https://perma.cc/9H58-WAU7]; Press Release, Fed. Trade Comm’n, FTC Staff Reaffirm Opposition to Proposed Indiana Hospital Merger (Mar. 17, 2025), <https://www.ftc.gov/news-events/news/press-releases/2025/03/ftc-staff-reaffirm-opposition-proposed-indiana-hospital-merger> [https://perma.cc/JP29-KB56].

4. Letter from Todd Rokita, Att’y Gen., Ind., to Lindsey Weaver, Comm’r, Ind. Dep’t of Health (Apr. 17, 2025), <https://image.subscription.in.gov/lib/fe2e11747364047b721071/m/1/19d30b17-7feb-46ca-838d-b6dbbea7afe6.pdf> [https://perma.cc/QJ2R-BNR5].

5. IND. CODE § 16-21-15-3 (2025).

6. IND. DEP’T OF HEALTH, *supra* note 2.

7. Madeline Ashley, *Union Health, HCA Indiana Hospital Finalize Merger*, BECKER’S HOSP. REV. (Dec. 15, 2025), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/union-health-hca-indiana-hospital-finalize-merger/> [https://perma.cc/U9JJ-H3RD].

8. Alison Coates et al., *The Impact of Rural Hospital Closures and Mergers on Health System Ecologies: A Scoping Review*, 82(5) MED. CARE RSCH. REV. 359, 360 (2025).

of closing.⁹ On average, these hospitals receive “less than half the median profit margins of urban hospitals,”¹⁰ making them prone to financial instability. This lack of solvency exacerbates their risk of bankruptcy.¹¹ In 2025, twenty-three hospitals closed¹² and twenty declared bankruptcy.¹³ Simply put, “[s]mall rural hospitals are being forced to close because they are not paid enough to cover the cost of delivering care to patients in rural areas.”¹⁴

From 2005 through 2025, 195 rural hospitals either closed or converted—152 of those having occurred since 2010.¹⁵ Except for a handful of exceptions, these hospitals had fewer than 100 beds.¹⁶ Coinciding with these hospital

9. Molly Gamble, *756 Hospitals at Risk of Closure, State by State*, BECKER'S HOSP. REV. (Dec. 26, 2025), <https://www.beckershospitalreview.com/finance/756-hospitals-at-risk-of-closure-state-by-state/> [<https://perma.cc/RU32-AECL>]; see also *Rural Hospitals at Risk of Closing*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM 1 (Apr. 2024), https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf [<https://perma.cc/7FKX-SSVU>] (citing Saving Rural Hospitals, *How to Prevent Rural Hospital Closures*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, <https://ruralhospitals.chqpr.org/Solutions.html#the-need-for-rapid-action-to-prevent-closures-and-sustain-rural-healthcare> [<https://perma.cc/YA6F-F827>] (last visited Feb. 5, 2026) (explaining hospitals are considered at immediate risk of closing when they have “inadequate revenues to cover expenses” and “very low financial reserves”)). Compare Letter from Edward J. Markey, U.S. Sen., et al., to Donald Trump, Pres. of the U.S., Mike Johnson, Speaker of the House, and John Thune, Majority Leader, U.S. Sen. (June 12, 2025), https://www.markey.senate.gov/imo/media/doc/letter_on_rural_hospitals.pdf [<https://perma.cc/D2M9-PQ8A>] (identifying 338 rural hospitals at risk of closure, using Medicaid payor mix and consecutive years realizing negative total margin as criteria).

10. Karl Stark, *The Plight of Rural Hospitals: They've Been Closing at a Faster Rate Than Urban Facilities for Years*, U. OF PA. LEONARD DAVIS INST. OF HEALTH ECON. (Nov. 8, 2022), <https://ldi.upenn.edu/our-work/research-updates/rural-hospitals-are-smaller-and-make-less-money-than-urban-facilities> [<https://perma.cc/8PQY-MS8H>].

11. Shayann Ramedani et al., *The Bystander Effect: Impact of Rural Hospital Closures on the Operations and Financial Well-Being of Surrounding Healthcare Institutions*, 17 J. OF HOSP. MED. 901 (Sep. 2022) (manuscript at 5), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9633382/pdf/nihms-1834590.pdf> [<https://perma.cc/AE5P-6C9Q>] (noting that “[a] hospital’s solvency is based on the amount of reimbursements Medicare gives for cash positive service lines. If a hospital cannot meet these requirements, they can be at a higher risk of bankruptcy.”).

12. Madeline Scheetz, *23 Hospital Closures in 2025*, BECKER'S HOSP. REV. (Nov. 17, 2025), <https://www.beckershospitalreview.com/finance/2-hospital-closures-in-2025/> [<https://perma.cc/RK99-B335>].

13. Madeline Scheetz, *20 Healthcare Bankruptcies in 2025*, BECKER'S HOSP. REV. (Dec. 18, 2025), <https://www.beckershospitalreview.com/finance/7-healthcare-bankruptcies-in-2025/> [<https://perma.cc/X79E-8MH4>].

14. Saving Rural Hospitals, *Problems and Solutions for Rural Hospitals*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, <https://ruralhospitals.chqpr.org/Overview.html#fn1> [<https://perma.cc/S4UG-9YEX>] (last visited Feb. 5, 2026) (noting that, although small rural hospitals comprise approximately one quarter of U.S. hospitals, “less than 3% of total national spending on hospitals” goes to these small rural hospitals).

15. The Cecil G. Sheps Ctr. for Health Serv. Rsch., *Rural Hospital Closures*, UNIV. OF N.C. CHAPEL HILL, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures> [<https://perma.cc/BZ2Z-XQT6>] (last visited Feb. 5, 2026) (“Closed hospitals” being described as hospitals that no longer provide any healthcare services; “converted hospitals” being described as hospitals that no longer provide in-patient care but continue to provide some healthcare services).

16. *Id.*

closures has been an increase in hospital mergers and acquisitions (M&A).¹⁷

To avoid bankruptcy, rural hospitals are often forced to affiliate or merge with larger health networks.¹⁸ Consequently, as of 2022, 72% of hospitals were affiliated with a health network.¹⁹ There were fifty-three hospital M&A deals in 2022, sixty-five in 2023, seventy-two in 2024, and forty-six in 2025.²⁰ Prior to 2023, the percentage of hospital M&A involving a financially distressed hospital decreased annually: 18.6% in 2019, 16.7% in 2020, 15.2% in 2021, and 15.0% in 2022.²¹ Then, for three consecutive years, from 2023 to 2025, financially distressed hospitals comprised a record-breaking share of each year's hospital M&A—27.7%, 30.6%, and 43.5%, respectively.²² This indicates a disconcerting trend of hospital M&A being increasingly fueled by hospitals' financial distress—a trend that is likely to continue and disproportionately affect rural hospitals.²³ Taken at face value, this gives cause for concern, and “the full extent of market stress is likely understated, particularly in rural and underserved communities.”²⁴

When a rural hospital closes, the “bystander” hospitals in that region raise their prices, for they are providing treatments to the patients who would have gone to the now-closed hospital.²⁵ This causes a “spillover effect,” which is the exacerbation of the region's already-scarce quantity of healthcare providers; this, in turn, increases the remaining providers' patient load—increasing the bystander hospitals' financial distress and resulting in a cycle that “tends to perpetuate itself until there is either a regional monopoly or no infrastructure exists.”²⁶

From 1998 to 2021, 1,887 hospital mergers were announced.²⁷ This resulted in a 25% reduction in the number of hospitals patients could choose from, as the

17. Anu Singh, *Hospital and Health System M&A in Review: Financial Pressures Emerge as Key Driver in 2023*, KAUFMANHALL (Jan. 18, 2024), <https://www.kaufmanhall.com/insights/research-report/2023-hospital-and-health-system-ma-review> [https://perma.cc/7MBQ-JG3D].

18. Ramedani et al., *supra* note 11, at 904; Coates et al., *supra* note 8, at 360 (“Financial distress is also reported to contribute to mergers or affiliations . . . as rural hospitals look to improve financial performance to survive.”).

19. Ramedani et al., *supra* note 11, at 904.

20. Kris Blohm et al., *Hospital and Health System M&A In Review: Uncertainty Transitions to Continued Momentum in 2025*, KAUFMAN HALL (Jan. 15, 2026), <https://www.kaufmanhall.com/insights/research-report/hospital-and-health-system-2025-ma-review-uncertainty-transitions-continue> [https://perma.cc/E4UW-79G9].

21. *Id.*, at 5; Anu Singh, *Hospital and Health System M&A in Review: Despite Industry Stabilization, Numbers Reveal Ongoing Distress in 2024*, KAUFMAN HALL (Jan. 9, 2025), <https://www.kaufmanhall.com/insights/research-report/hospital-and-health-system-ma-review-despite-industry-stabilization> [https://perma.cc/4QGV-JMT9].

22. Blohm et al., *supra* note 20, at 5.

23. *Id.* at 9.

24. *Id.*

25. Ramedani et al., *supra* note 11.

26. *Id.* at 905.

27. Hoag Levins, *Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality*, UNIV. OF PA. LEONARD DAVIS INST. OF HEALTH ECON. (Jan. 19, 2023), <https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/> [https://perma.cc/28FG-5NBT].

number of U.S. hospitals decreased from 8,000 to just over 6,000 during this time.²⁸ A mere two years before the first of these 1,887 hospital mergers occurred, the Department of Justice (DOJ) and the FTC were of the opinion that “[m]ost hospital mergers and acquisitions . . . do not present competitive concerns.”²⁹ Since then, though, it has become increasingly recognized that the lack of antitrust enforcement which sprung from these agencies’ opinion helped enable the rise of anticompetitive effects now associated with hospital M&A.³⁰

President Biden addressed hospital M&A’s anticompetitive effects in his executive order on competition in 2021, noting that “[t]hanks to unchecked mergers, the ten largest healthcare systems now control a quarter of the market.”³¹ In 2023, the DOJ and FTC responded by withdrawing some of their lenient policy statements.³² In 2025, President Trump revoked President Biden’s 2021 executive order on competition,³³ but “the FTC’s and DOJ’s joint 2023 Merger Guidelines [remain] in effect and are the framework for this agency’s merger-review analysis.”³⁴

“Like the FTC under the Biden administration, the FTC under the Trump administration is likely to continue to be skeptical of claims that mergers are necessary to prevent unprofitable hospitals and other businesses from closing” and, as seen in Indiana, will continue its skepticism of COPAs.³⁵ Speaking of

28. *Id.*

29. U.S. DEP’T OF JUST. & U.S. FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 1, 8 (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/2VYZ-9Z5M>].

30. Jaime S. King et al., *Antitrust’s Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power*, 74 HASTINGS L. J. 1057, 1063 (2023).

31. Promoting Competition in the American Economy, Exec. Order No. 14036, 86 Fed. Reg. 36987 (July 9, 2021); Fact Sheet: Executive Order on Promoting Competition in the American Economy, Briefing Room Statements and Releases, Exec. Order No. 14,036, 86 C.F.R. 36987 (2021) (citing Ion Skillrud et al., *The potential for rapid consolidation of health systems*, DELOITTE (Dec. 10, 2020), <https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html>).

32. Press Release, Fed. Trade Comm’n, Federal Trade Commission Withdraws Healthcare Enforcement Policy Statement (July 14, 2023), <https://www.ftc.gov/news-events/news/press-releases/2023/07/federal-trade-commission-withdraws-health-care-enforcement-policy-statements> [<https://perma.cc/L2LV-ZNEE>]; see also Union Hospital, Inc. & Terre Haute Regional Hospital, L.P., *supra* note 1 and accompanying text (noting that the DOJ withdrew the policy statements four months earlier, on Feb. 3, 2023).

33. Revocation of Executive Order on Competition, Exec. Order No. 14,337, 90 Fed. Reg. 40,227 (Aug. 13, 2025).

34. See Letter from Andrew N. Ferguson, Chairman, U.S. Fed. Trade Comm’n, to FTC Staff, Merger Guidelines (Feb. 18, 2025), https://www.ftc.gov/system/files/ftc_gov/pdf/ferguson-memo-re-merger-guidelines.pdf [<https://perma.cc/953H-V34H>]; see also Memorandum from Omeed Assefi, Acting Assistant Att’y Gen., U.S. Dep’t of Just., to Antitrust Division Staff, Use of the 2023 Merger Guidelines (Feb. 18, 2025), <https://www.justice.gov/atr/media/1389861/dl?inline> [<https://perma.cc/4BQ6-TRDZ>].

35. Herbert F. Allen, Nathan Richardson & Madeline Greathouse, *Deregulation, Actually: Why Health Care Will Remain a Prime Target of Antitrust Enforcement in Trump 2.0*, AM. HEALTH L. ASS’N (May 1, 2025), <https://www.americanhealthlaw.org/content-library/connections-magazine/article/ba0f0c22-afeb-417e-8e3c-895b87e54a19/deregulation-actually-why-health-care-will-remain> [<https://perma.cc/PFV5-BWH4>].

the COPA application in Indiana, FTC Chair Andrew Ferguson posited, “eliminating competition in healthcare markets rarely serves Americans well.”³⁶ This article holds a different perspective on COPAs, viewing them incapable of eliminating competition where no real competition exists—namely, in rural hospital markets.

B. Premise of Argument

Rigorously enforcing antitrust law is an intuitive response to the recently acknowledged harms of hospital consolidation, but it does not account for the fact that a growing percentage of hospital M&A activity is fueled by hospitals’ financial distress. Simply preventing rural hospital M&A will not benefit patients in the relevant markets because, although hospital consolidation is a problem contributing to consumer harm, it is also the only available solution to the problem of hospital closures which, too, is contributing to consumer harm.

In 2016, Judge John E. Jones III observed, “[w]e find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here.”³⁷ In other words, the FTC is using antitrust law in an attempt to counteract the inevitable necessity for rural hospitals to consolidate—a necessity which “the same federal government . . . has created” through, “among other changes, the institution of the Affordable Care Act, fluctuations in Medicare and Medicaid reimbursement, and the adoption of risk-based contracting.”³⁸ This “evolving landscape of healthcare” that Judge Jones III noted a decade ago has further evolved into a national market unfriendly to independent hospitals, as evidenced by the aforementioned statistics.

Government payors’ decreased and stagnant reimbursement rates³⁹ have further exacerbated rural hospitals’ financial difficulties, and the One Big Beautiful Bill Act⁴⁰ adds to the number of federal schemes effectively encouraging hospital consolidation,⁴¹ accelerating the timeline by which the

36. *Id.* n. 31.

37. *FTC v. Penn State Hershey Med. Ctr.*, 185 F. Supp. 3d 552, 564 (M.D. Pa. 2016), *rev’d*, 838 F.3d 327 (3rd Cir. 2016).

38. *Id.*

39. *Calendar Year (CY) 2025 Medicare Physician Fee Schedule Proposed Rule*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (July 10, 2024), <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-proposed-rule> [<https://perma.cc/FUC6-9XDA>].

40. Pub. L. No. 119-21, 119th Cong. (2025).

41. The One Big Beautiful Bill will reduce federal Medicaid spending in rural areas by an estimated \$137 billion over the next 10 years. Zachary Levinson, Scott Hulver & Tricia Neuman, *First-Year Rural Health Fund Awards Range From Less Than \$100 Per Rural Resident in Ten States to More Than \$500 in Eight*, KFF (Jan. 6, 2026), <https://www.kff.org/state-health-policy-data/first-year-rural-health-fund-awards-range-from-less-than-100-per-rural-resident-in-ten-states-to-more-than-500-in-eight/> [<https://perma.cc/MR43-6AAM>]. *See also* Letter from Edward J. Markey, et al., to Donald Trump, et al., *supra* note 9. Although the \$50 billion in funds allocated to states through the Rural Health Transformation Program may help offset this

underlying causes of rural hospitals' financial difficulties must be addressed.

Neither closures nor consolidations offer a sustainable solution to rural hospitals' current plight, as patients suffer from either option. Legislators and regulators should address the financial distresses incentivizing hospitals to merge or close at record numbers. Specifically, rural hospitals must be able to achieve economies of scale or gain rate-negotiating power without resorting to consolidation. Until independent hospitals are able to accomplish this through means other than consolidation, states should intercede and allow financially distressed, rural hospitals to consolidate subject to ongoing state supervision—as Indiana did in 2025 through the use of a COPA.

Albeit with a negative connotation, the FTC succinctly describes this regulatory measure available to states:

Certificates of Public Advantage (also known as “COPAs”) are regulatory regimes adopted by state governments that are intended to displace competition among healthcare providers. COPAs purport to immunize mergers and collaborations from antitrust scrutiny under the state action doctrine.⁴²

Since its origination in 1943, the state-action doctrine has repeatedly been upheld.⁴³ This doctrine exempts private parties from antitrust law, provided their consolidatory conduct is (1) “clearly articulated and affirmatively expressed as state policy” and (2) “actively supervised by the State itself.”⁴⁴

The FTC claims COPAs “intend[] to displace competition among healthcare providers.”⁴⁵ However, this claim overgeneralizes market dynamics and fails to consider rural hospital markets' unique economic challenges, which other industries, and even urban hospital markets, do not face. Where competition is nonexistent, there is no competition to displace. “[M]ost rural communities have

reduction in spending, it is less than half the estimated reduction in federal spending and is not likely to save rural hospitals from their upcoming financial struggles. Carole Johnson, *The “One Big Beautiful Bill,” Now Law, Does Not Protect Rural Hospitals*, HEALTH AFF. (July 23, 2025), <https://www.healthaffairs.org/content/forefront/one-big-beautiful-bill-now-law-does-not-protect-rural-hospitals> [<https://perma.cc/88FG-VH3V>]; see generally Alan Condon, *Will Hospitals Benefit from \$50B Rural Health Program? 8 Things to Know*, BECKER'S HOSP. REV. (July 28, 2025), <https://www.beckershospitalreview.com/finance/will-hospitals-benefit-from-50b-rural-health-program-8-things-to-know/> [<https://perma.cc/Q2ZM-63E7>].

42. *Certificates of Public Advantage (COPAs)*, U.S. FED. TRADE COMM'N, <https://www.ftc.gov/news-events/features/certificates-public-advantage-copas> [<https://perma.cc/S3M2-PBBG>] (last visited Apr. 13, 2026).

43. See, e.g., *Parker v. Brown*, 317 U.S. 341 (1943); *Hallie v. Eau Claire*, 471 U.S. 34 (1985); *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992); *FTC v. Phoebe Putney Health Sys.*, 568 U.S. 216 (2013); *N.C. State Bd. of Dental Exam'rs v. FTC*, 717 F.3d 359 (4th Cir. 2013), *aff'd*, 574 U.S. 494 (2015); *La. Children's Med. Ctr. v. AG of the United States*, 2023 WL 6293887 (E.D. La. 2023).

44. *N.C. State Bd. of Dental Exam'rs*, 717 F.3d at 366 (quoting *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)); *Phoebe Putney Health Sys.*, 568 U.S. at 225 (quoting *California Retail Liquor Dealers Ass'n*, 445 U.S. at 105 (1980)).

45. U.S. FED. TRADE COMM'N, *supra* note 42.

only one hospital that is easily accessible, if they have a hospital at all.”⁴⁶ Thus, rural hospitals are often already monopolies in their respective local markets; however, these hospitals do not enjoy monopolistic leverage over their supply and demand, for their prices are dictated by third-party payors—over which they have little to no bargaining power.⁴⁷

Along with being unable to achieve meaningful economies of scale,⁴⁸ rural hospitals’ inability to negotiate higher reimbursement rates has contributed to their financial distress,⁴⁹ leading to the large number of rural hospitals currently at risk of closure. Merging with another hospital or health system gives the rural hospital the two capabilities it currently lacks: better economies of scale and more negotiating power with payors.⁵⁰ Of course, this allows the hospital to capitalize on its monopolistic position in the market, which rightfully invokes antitrust scrutiny. Therefore, M&A activity does present anticompetitive concerns here—not because it displaces competition, but because it allows the rural hospital to take advantage of its existing monopolistic position in the local market.

If no consolidation occurs, rural patients may suffer from their only nearby hospital being financially distressed or closing; if consolidation does occur, rural patients may suffer from the consequential anticompetitive effects; COPAs were created to address this catch-twenty-two problem.

With COPAs, a state may help rural hospitals avoid closure by authorizing qualifying consolidations that are subject to active state supervision and contingent on the terms and conditions agreed to prior to the merger. This allows for consolidation, but it mitigates the anticompetitive effects associated with such consolidation. COPAs acknowledge and address today’s rural hospital markets’ unique, and even dire, economic needs. After addressing rural-hospital economics, this article reviews the state-action doctrine and COPA laws, then it identifies which statutory provisions should be included in states’ COPA statutes.

46. Saving Rural Hospitals, *The Importance of Rural Hospitals*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, <https://ruralhospitals.chqpr.org/Importance.html> [https://perma.cc/59PW-U27S] (last visited Feb. 5, 2026).

47. Jacob Dorn, Dynamic Bargaining Between Hospitals and Insurers 3–4 (Apr. 25, 2025) (unpublished manuscript), <https://jacobdorn.info/files/job-market-paper.pdf> [https://perma.cc/6PFE-TRZD]. The author points out that “[t]he estimated hospital and insurer demand functions are key inputs to the bargaining model,” *id.* at 3, and finds that “small hospitals receiv[e] roughly take-it-or-leave-it offers,” *id.* at 4.

48. Lawton R. Burns & Mark V. Pauly, *Transformation of the Health Care Industry: Curb Your Enthusiasm?*, 96 THE MILBANK Q. 57, 78–79 (2018), DOI: 10.1111/1468-0009.12312 [https://perma.cc/YJE7-ECV9]; *but see* Tengiz Verulava, *Economies of Scale, Efficiency and Optimal Size of the Hospital*, 9 GLOBALIZATION & BUSINESS 129, 132 (June 2024), DOI: 10.35945/gb.2024.17.012 [https://perma.cc/7CJP-FGPX] (concluding “there is an economy of scale in health care, but it is significantly lower (11–14%) than in other sectors of the economy (60–95%).”).

49. Yuvraj Pathak & David Muhlestein, *Hospital System Market Share and Commercial Prices: A Cross-Sectional Approach Using Price Transparency Data*, 14 HEALTH ECON. REV. 102 (2024).

50. Coates et al., *supra* note 8.

II. HOSPITAL FINANCES

In 2024, the U.S.'s healthcare expenditure accounted for 18% of the nation's gross domestic product (GDP), and it is projected to be a 20.3% contributor to the national GDP in 2033.⁵¹ Measured by revenue, the hospital industry is the second largest industry in the nation.⁵² As such, this industry is also the country's sixth largest employer.⁵³ Although rural hospitals are a part of this large industry, they face significant financial challenges due to their unique payment structures and economic dynamics.⁵⁴ Consolidation helps alleviate these financial challenges, but such consolidation is also correlated with increased prices and spending.⁵⁵ This section explores the economic environment driving the need for COPAs.

A. Hospital Supply and Demand

Hospital competition exists in two stages: The first stage entails hospitals competing to be "in network" with insurers; the second stage entails hospitals competing for patients under those insurers' coverage.⁵⁶ Defining relevant markets in health care is difficult because insurers pay most of the expenses patients incur, so patients are "largely insensitive to healthcare prices."⁵⁷ After selecting an insurer, patients are not incentivized to shop for the most cost-

51. *NHE Fact Sheet*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet> [https://perma.cc/ECC5-LGFW] (last visited Feb. 5, 2026).

52. *Top 10 Largest Industries in the U.S. by Number of Businesses & Revenue*, CLEARLY PAYMENTS (July 8, 2025), <https://www.clearlypayments.com/blog/top-10-largest-industries-in-the-u-s-by-number-of-businesses-revenue/> [https://perma.cc/WR2V-75FM] (noting the health and medical insurance industry is the largest US industry by revenue).

53. Zachary Levinson & Scott Hulver, *Mapping Hospital Employment By State*, KFF (May 21, 2025), <https://www.kff.org/medicaid/mapping-hospital-employment-by-state/> [https://perma.cc/DG2Q-S3LN].

54. Statement from the Am. Hosp. Ass'n. to the Committee on Finance's Subcommittee on Health Care of the U.S. Senate, *Improving Health Care Access in Rural Communities: Obstacles and Opportunities 4–5* (May 17, 2023), <https://www.aha.org/system/files/media/file/2023/05/aha-statement-to-senate-finance-committee-subcommittee-on-health-on-improving-rural-health-care-access-5-17-2023.pdf> [hereinafter *Statement from AHA to Subcommittee on Health Care*].

55. King et al., *supra* note 30, at 1061; CHERYL L. DAMBERG, *HEALTH CARE CONSOLIDATION: THE CHANGING LANDSCAPE OF THE U.S. HEALTH CARE SYSTEM 2–3* (RAND Corp. 2023) (Testimony Submitted to the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health).

56. *FTC v. Penn State Hershey Med. Ctr.* 838 F.3d 327, 342 (3rd Cir. 2016); Hankyul Song, *Blackouts and Holes: Analyzing Cross-Market Geographic Mergers in the Healthcare Services Market*, 28 CARDOZO J. EQUAL RTS. & SOC. JUST. 633, 642 (2022).

57. *Penn State Hershey Med. Ctr.*, 838 F.3d at 342; *see also* JULIAN O. VON KALINOWSKI ET AL., *ANTITRUST LAWS AND TRADE REGULATION 4* § 70.04(3)(b)(ii) (2d ed. 2023); Anne M. Helm, *Optimizing Private Antitrust Enforcement in Health Care*, 11 ST. LOUIS. U. J. HEALTH L. & POL'Y 5, 24 (2017) (citing *W. Penn Allegheny Health Sys., Inc.*, 627 F.3d 85, 104 (3rd Cir. 2010)).

effective hospital,⁵⁸ for they are unaware of competing hospitals' prices—not only before receiving treatment (due to a lack of pricing transparency and predictability), but also after receiving treatment (due to insurers paying the majority of healthcare bills).⁵⁹ Further, even if patients were aware of nearby hospitals' prices, the prices within that geographic market would likely not experience any notable changes as a result because, unlike most products and services in competitive markets, “the demand for hospital services . . . is highly inelastic under competitive conditions.”⁶⁰

In a free market, the more perfectly elastic the supply and demand, the more efficient the market, as its cost savings are passed to the consumers.⁶¹ If, though, a firm obtains enough market power to become monopolistic and dictate the supply, it will enjoy cost savings without passing those savings to the consumers.⁶² High pre-merger profit margins often indicate an inelastic demand because otherwise, if the demand were elastic, the firm would have to lower its prices to compete with other firms for the responsive consumer demand.⁶³ Thus, a firm with high pre-merger profit margins offering services with inelastic demands can raise its post-merger prices without suffering large predicted loss or large critical loss.⁶⁴ Therefore, because hospitals offer many services with inelastic demand, a hospital that has obtained a substantial share of its relevant market can raise its already high pre-merger prices to exorbitant post-merger prices without incurring economic loss.

B. Rural Hospitals' Financial Distress

More than 50% of U.S. hospitals operated at a financial loss in 2022.⁶⁵ Rural hospitals are especially prone to financial distress because a sizeable percentage of their patients are covered by Medicare⁶⁶ or Medicaid.⁶⁷ The Center for Medicare and Medicaid Services (CMS) reimburses hospitals less than what it

58. David Gaines, *Healthcare's Cost Problem: Lack of Price Elasticity of Demand*, CAREIGNITION (Jan. 18, 2023), <https://www.careignition.com/blog/the-driver-of-healthcares-cost-problem-lack-of-price-elasticity-of-demand> [https://perma.cc/R637-YVWC].

59. Helm, *supra* note 57, at 31–32.

60. Kalinowski et al., *supra* note 57, at 2 § 30.03(7)(b) (2d ed. 2023) (quoting *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1388 (7th Cir. 1986)); *see also* Gregory Day, *Anticompetitive Healthcare*, 101 WASH. U. L. REV. 1539, 1575–76 (2024).

61. Roger D. Blair et al., *Hospital Mergers and Economic Efficiency*, 91 WASH. L. REV. 1, 40 n.215 (2016).

62. *Id.* at 40.

63. *See* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *Merger Guidelines* 44 (2023).

64. *Id.*

65. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 5.

66. Gina Turrini et al., *Access to Affordable Care in Rural America: Current Trends and Key Challenges*, OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUM. SERVS. 4 (July 9, 2021), <https://aspe.hhs.gov/sites/default/files/2021-07/rural-health-r.pdf> [https://perma.cc/87D4-LZGV] (stating “1 in 3 rural adults is enrolled in Medicare.”).

67. *Medicaid and Rural Health*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N 1 (Apr. 2021), <https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf> [https://perma.cc/5GVB-FWH5] (noting nearly 25% of rural residents under the age of 65 are covered by Medicaid).

costs hospitals to provide care for Medicare and Medicaid patients,⁶⁸ resulting in billions of dollars in underpayments each year.⁶⁹ Exacerbating this cost-reimbursement discrepancy, “hospital expense increases between 2019 and 2022 [were] more than double the increases in Medicare reimbursement for inpatient care during that same time.”⁷⁰ In 2022, Medicare paid eighty-two cents for every dollar hospitals spent in caring for Medicare patients,⁷¹ and this reimbursement-to-cost ratio has continued to fall since.⁷² Hospitals cannot negotiate rates with Medicare or Medicaid, as those reimbursement rates are established by CMS every year.⁷³ Hence, hospitals must either accept or reject Medicare and Medicaid payments.

Rural hospitals also have lower patient volumes than urban hospitals, so there are fewer opportunities to subsidize government payors’ reimbursements with reimbursements from commercial payors.⁷⁴ Additionally, patients in rural areas are more likely to be uninsured and, thus, delay hospital visits due to costs, which often exacerbates their conditions and leads to higher hospital expenses.⁷⁵ Rural hospitals also endure significant staffing shortages, as “only 10% of physicians in the United States practice in rural areas and over 65% of primary care Health Professional Shortage Areas are located in rural or partially rural areas.”⁷⁶ Moreover, general inflation and increases in hospital expenses have outpaced hospital prices’ growth, and the costs to stay in compliance with industry regulations are more burdensome to rural hospitals than to larger hospitals.⁷⁷

These economic burdens impose serious financial distress on rural hospitals, which has prompted Congress to create a variety of rural-hospital categories.⁷⁸ CMS refers to these categories when determining how Medicare and Medicaid

68. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 3.

69. *Id.*; *Medicare Significantly Underpays Hospitals for Cost of Patient Care*, AM. HOSP. ASS’N 1 (Jan. 2024), <https://www.aha.org/system/files/media/file/2024/01/medicare-significantly-underpays-hospitals-for-cost-of-patient-care-infographic.pdf> [<https://perma.cc/C2LK-8237>].

70. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 4.

71. *Medicare Significantly Underpays Hospitals for Cost of Patient Care*, *supra* note 69, at 1.

72. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 40.

73. *Id.*

74. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 2; Alicia Gilbert, *Frenemies: Why the FTC Should Explore the Utility of State COPAs to Address Anticompetitive Consolidation in Healthcare*, 85 LA. L. REV. 51, 53 (2024) (stating “[rural] hospitals have challenging payor mixes and high populations of uninsured patients populations with worse health outcomes.”).

75. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 2; Gilbert, *supra* note 74, at 53 (stating “rural hospitals have challenging payor mixes and high populations of uninsured patients populations with worse health outcomes.”).

76. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 4.

77. *Id.* at 5; *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to Higher-quality, Affordable Care*, AM. HOSP. ASS’N 13–14 (Feb. 2019), <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf> [<https://perma.cc/4Y2F-4ES9>].

78. MARCO A. VILLAGRANA ET AL., CONG. RSCH. SERV., R47526, CLOSED, CONVERTED, MERGED, AND NEW HOSPITALS WITH MEDICARE RURAL DESIGNATIONS: JANUARY 2018–NOVEMBER 2022, 1 (2023).

will pay each rural hospital, as payments depend on the type of designation each rural hospital has received.⁷⁹ While Medicare and Medicaid have switched to cost-based reimbursements to account for rural hospitals' precarious financial situations, the primary reason why rural hospitals lose money is due to private insurers' inadequate payments.⁸⁰

Private insurers often pay rural hospitals less than they pay large hospitals for the same services.⁸¹ The smaller the hospital, the less likely that hospital is to earn a profit on privately insured patients.⁸² Because small hospitals treat fewer patients than large hospitals do, there is less opportunity for the small hospitals to receive enough payments to not only recover their fixed costs, but also to earn a profit on their variable costs.⁸³ Further still, "if a provider manages to deliver care more efficiently, Medicare and commercial payors' reimbursement system will pay that provider less."⁸⁴ Thus, due to its lack of bargaining power with commercial payors, rural hospitals experience difficulties maintaining financial viability.

A hospital can receive better reimbursement rates by merging with another hospital, as this increases its bargaining leverage with commercial payors.⁸⁵ These payors, in turn, pass on their higher costs to their insureds.⁸⁶ Thus, hospital consolidation can contribute to higher insurance premiums and deductibles.⁸⁷ If no consolidation occurs, though, the hospital could close—putting additional strain on the community's economy,⁸⁸ patients,⁸⁹ and surrounding hospitals.⁹⁰

To significantly reduce their risk of closure, rural hospitals often merge or

79. *Id.* at 1–2.

80. *A Better Way to Pay Rural Hospitals*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM 1 (Apr. 2024), https://ruralhospitals.chqpr.org/downloads/Better_Way_to_Pay_Hospitals.pdf [<https://perma.cc/P6N7-3C9Y>].

81. *Id.* at 2.

82. Saving Rural Hospitals, *The Causes of Rural Hospital Problems*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, https://ruralhospitals.chqpr.org/Problems.html#Differences_in_Payment_Amounts_from_Commercial_Insurance_Plans [<https://perma.cc/FGE5-AK6L>].

83. *A Better Way to Pay Rural Hospitals*, *supra* note 80, at 2.

84. Gaines, *supra* note 58.

85. THEODOSIA STAVROULAKI, HEALTHCARE, QUALITY CONCERNS AND COMPETITION LAW 130–32 (Hart Studies in Law & Health 2023) (citing *FTC v. Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522 (E.D. Pa. 2020)); Gregory S. Vistnes, *Cross-Market Hospital Mergers: Assessing Likely Harm and Implications for Government Action*, 86 ANTITRUST L. J. 251, 288 (2024) ("The [Common Linked Employer] theory predicts that cross-market mergers increase the merged system's overall bargaining power, which in turn implies that such mergers will lead to higher prices at both the acquired and acquiring hospitals.").

86. STAVROULAKI, *supra* note 85, at 118–19 (citing *Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522).

87. *Id.*

88. George M. Holmes et al., *The Effect of Rural Hospital Closures on Community Economic Health*, 41 HEALTH SERVS. RSCH. 467 (2006), <https://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2005.00497.x> [<https://perma.cc/QSV2-DRKG>].

89. U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-93, RURAL HOSPITAL CLOSURES: AFFECTED RESIDENTS HAD REDUCED ACCESS TO HEALTH CARE SERVICES (2020).

90. Ramedani et al., *supra* note 11.

affiliate themselves with a larger hospital or health system.⁹¹

III. HOSPITAL INTEGRATIONS

Consolidation within the hospital industry has been comprised of vertical integrations, horizontal integrations, and cross-market integrations—which, collectively, produce a market with no meaningful competition and, consequently, increased prices without corresponding increases in quality.⁹²

A. Vertical Integration: Hospitals and Physicians

In 2000, 57% of physicians practiced independently.⁹³ This ratio held fairly consistent through 2012, at which time 53% of physicians were either full or part owners of their respective practices.⁹⁴ The following twelve years were not like the previous twelve, though: By the start of 2024, only 22.4% of physicians remained independent.⁹⁵ From 2019 through 2023 alone, 44,200 physician practices were acquired.⁹⁶ Such vertical integrations have contributed to an increase in hospital prices:

[H]ospitals that have stronger affiliations with physicians have been found to have higher prices. Similarly, if a hospital or health care system had market power before it acquired a physician organization, the acquisition could increase physician market power if it foreclosed rival physician organizations from access to hospital services. The combined effect of higher hospital and physician prices results in health insurance premiums becoming even more unaffordable to many employers and consumers.⁹⁷

Nationally, corporate-owned practices nearly doubled from 2019 to 2024,⁹⁸ and private-equity acquisitions increased from seventy five deals in 2012 to 484

91. H. Joanna Jiang et al., *Risk of Closure Among Independent and Multihospital-Affiliated Rural Hospitals*, 3(7) JAMA 1 (2022), DOI: 10.1001/jamahealthforum.2022.1835 [<https://perma.cc/GA8W-R9LQ>]; see also Burns & Pauly, *supra* note 48, at 78–82 (“Not only are more hospitals now members of systems, but they are also members of larger-sized systems.”).

92. Day, *supra* note 60, at 1541, 1559–62.

93. Carol K. Kane & David W. Emmons, *New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shift Toward Hospital Employment*, AM. MED. ASS’N 1 (2013).

94. *Id.* at 4.

95. Avalere Health, *Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019–2023*, PHYSICIANS ADVOCACY INST. 13 (Apr. 2024).

96. *Id.* at 16.

97. Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, HEALTH AFF. 1535 (Sep. 2017), DOI: 10.1377/hlthaff.2017.0556 [<https://perma.cc/XYV3-D7CS>].

98. Avalere Health, *supra* note 95, at 18.

deals in 2021.⁹⁹ Private-equity firms' acquisitions of physician practices are correlated with statistically significant price increases across specialties.¹⁰⁰ They are also correlated with higher rates of clinician turnover.¹⁰¹ When a community's healthcare workforce is stable, its health outcomes and quality metrics are improved, and its used resources are reduced.¹⁰² These desirable outcomes are pursued differently by private-equity firms, which implement "a distinct business model for profit generation" that emphasizes a high volume of prescribed tests, procedures, and patients seen per day.¹⁰³ Physicians may complain about "the loss of autonomy, pressure to increase volume and coding intensity, and greater reliance on nonphysician practitioners that come with selling to a private equity investor,"¹⁰⁴ but they often sell their practices anyways for financial reasons¹⁰⁵—such as Medicare paying hospitals more than it pays physician offices for the same service.¹⁰⁶

As of April 2025, private-equity firms own approximately 488 hospitals—over a quarter of which serve rural populations.¹⁰⁷ Concerningly, recent data indicate that hospitals acquired by private-equity firms experience an increase in adverse hospital events and adverse patient outcomes.¹⁰⁸ Thus, private equity's involvement in hospital ownership may come at a cost to patients not only economically, but also clinically.¹⁰⁹

99. RICHARD M. SCHEFFLER ET AL., AM. ANTITRUST INST., PETRIS CTR., WASH. CTR. FOR EQUITABLE GROWTH, *MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKETS* 6 (July 10, 2023).

100. *Id.* at 24.

101. Joseph Dov Bruch et al., *Workforce Compensation in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices*, 42 HEALTH AFF. 121 (2023), <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00308> [<https://perma.cc/8P3E-U7UC>].

102. *Id.* at n.12–15.

103. *Id.* at n.30 (citing ERIN FUSE BROWN ET AL., USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y, *PRIVATE EQUITY INVESTMENT AS A DIVINING ROD FOR MARKET FAILURE: POLICY RESPONSE TO HARMFUL PHYSICIAN PRACTICE ACQUISITIONS* 8 (Oct. 2021)).

104. FUSE BROWN ET AL., *supra* note 103, at 6.

105. Dov Bruch et al., *supra* note 101, at n.9.

106. Brady Post et al., *Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments*, 56 HEALTH SERVS. RSCH. 7 (Jan. 2021), DOI: 10.1111/1475-6773.13613, [<https://perma.cc/YAZ9-TPZJ>].

107. *PESP Private Equity Hospital Tracker*, PRIVATE EQUITY STAKEHOLDER PROJECT, <https://pestakeholder.org/private-equity-hospital-tracker> [<https://perma.cc/YW4U-8UGE>] (last visited Feb. 5, 2026).

108. Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition*, 330 JAMA 2365 (Dec. 26, 2023) ("Medicare patients at private equity-owned hospitals suffered a 25% increase in hospital-acquired complications compared to Medicare patients at hospitals not owned by private equity."); see also Maya Brownstein, *Private Equity's Appetite for Hospitals May Put Patients at Risk*, HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Dec. 16, 2024), <https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/> [<https://perma.cc/HEL5-MF9J>].

109. King et al., *supra* note 30, at 1061.

B. Horizontal Integration: Hospitals and Hospitals

A hospital that merges with a larger hospital gains access to more capital¹¹⁰ with which the smaller hospital may purchase equipment and offer services it was unable to provide prior to the merger. With this increased capital and additional service offerings, the hospital can hire more employees, which is particularly significant in rural communities, where hospitals are typically the largest or second-largest employer.¹¹¹

The Patient Protection and Affordable Care Act (ACA) encourages consolidation among healthcare providers because such consolidation can enhance hospital efficiency, streamline care delivery, and improve patient outcomes.¹¹² Findings from the American Hospital Association's analyses on the subject supports this hypothesis, concluding that "hospital acquisitions benefit patients by providing access to higher-quality care at a lower cost."¹¹³ This statement is supported by the finding that "acquisitions [are] associated with a statistically significant 3.3 percent reduction in annual operating expense per adjusted admission at the acquired hospitals" and that "[r]evenue per admission at acquired hospitals also declines relative to non-merging hospitals by a statistically significant 3.7 percent," which indicates merged hospitals' savings are passed to health plans and patients.¹¹⁴

One explanation for this positive spillover effect is that integrated health care can be delivered more efficiently and, consequently, more affordably than care delivered by non-consolidated healthcare providers.¹¹⁵ This should result in economies of scale for the integrated providers, which could reduce costs by up to 30%.¹¹⁶ For non-integrated providers, however, economies of scale remain elusive due to geographical constraints.¹¹⁷ Cross-market mergers help resolve this issue.

110. *The Impact of Hospital Consolidation on Medical Costs*, NAT'L COUNCIL ON COMP. INS. (July 11, 2018), https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx# [<https://perma.cc/NQ3C-CMF4>].

111. *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to Higher-quality, Affordable Care*, *supra* note 77, at 3.

112. Gilbert, *supra* note 74, at 53; Matthew G. Gibson, *Exceptional Efficiencies: A Valuable Defense for Healthcare Mergers*, 122 COLUM. L. REV. 1957, 1959 n.21 (2022); NAT'L COUNCIL ON COMP. INS., *supra* note 110, at n.7; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

113. Sean May, Monica Noether & Ben Stearns, *Hospital Merger Benefits: An Economic Analysis Revisited*, AM. HOSP. ASS'N 1 (Aug. 2021), <https://www.aha.org/system/files/media/file/2021/08/cra-merger-benefits-revisited-0821.pdf> [<https://perma.cc/3F7C-GJCU>].

114. *Id.*

115. NAT'L COUNCIL ON COMP. INS., *supra* note 110.

116. *Id.*

117. Verulava, *supra* note 48, at 133 (noting that the demand for a hospital's services decreases as the geographical distance between the patient and hospital increases); *see also* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 67, at 4.

C. Cross-market Mergers: Economies of Scale for Hospitals

“Cross-market mergers refer to consolidation in seemingly different markets.”¹¹⁸ In the context of hospital markets, cross-market mergers mean mergers that “involve hospitals located far enough apart that, from an antitrust perspective, they would be viewed as competing in separate geographic markets.”¹¹⁹ Approximately 50% of U.S. hospital mergers are cross-market mergers.¹²⁰ This prevalence in cross-market mergers may be attributed to hospitals’ need for economies of scale.¹²¹

Due to the physical nature of healthcare delivery, a patient typically must physically visit the hospital to receive care, so the patient’s options in hospitals are limited by their geographic proximity.¹²² Likewise, a hospital’s potential patient pool is limited by the number of individuals living in close proximity to the hospital.¹²³ Thus, a hospital’s potential for economies of scale is restricted because its relevant market is confined to the patients within its geographic vicinity.¹²⁴ Consequently, unless these geographic restrictions are eliminated, “there are no scale economies in hospital systems.”¹²⁵ Moreover, a hospital system may even experience scale diseconomies as it grows.¹²⁶

Cross-market consolidation is necessary to achieve scalable financial success because large health systems can expand across geographical regions, which diversifies its payor mix and spreads both its financial risks and revenues across multiple markets.¹²⁷ For this reason, “[b]y 2019, 59% of hospital systems in the United States . . . had facilities in more than one geographic market.”¹²⁸ This economic development has led to increased prices: “nonprofit hospitals that were members of national or regional systems” were more aggressive in their pricing than nonprofit hospitals that were independent or members of a local system.¹²⁹

Acknowledging the evidence suggesting that cross-market mergers cause

118. Gilbert, *supra* note 74, at 68.

119. Vistnes, *supra* note 85, at 252.

120. *Id.*

121. STAVROULAKI, *supra* note 85, at 100; Gilbert, *supra* note 74, at 54 (“All of these challenges have encouraged rural hospitals to consolidate to achieve economies of scale through increased volume, better collaboration of services, and decreased costs.”).

122. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 67, at 4.

123. Verulava, *supra* note 48, at 133 (noting that the demand for a hospital’s services decreases as the geographical distance between the patient and hospital increases).

124. *Id.*

125. *Id.* at 79, 132 (concluding “there is an economy of scale in health care, but it is significantly lower [11–14%] than in other sectors of the economy [60–95%].”).

126. *Id.*

127. STAVROULAKI, *supra* note 85, at 99–101.

128. King et al., *supra* note 30, at 1061 (citing Brent D. Fulton et al., *The Rise of Cross-Market Hospital Systems and Their Market Power in the US*, 41 HEALTH AFFS. 1652, 1654–55 (2022) (“defining a geographic market using commuting zones to better capture where individuals would be willing to drive in between their homes and places of employment for healthcare.”)).

129. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 3, 16 (2004).

consumer harm,¹³⁰ the antitrust agencies have grown increasingly concerned by such consolidation.¹³¹ Historically, however, the antitrust agencies have not challenged hospital cross-market mergers,¹³² and some legal scholars even contend that the agencies are unable to address such mergers under current antitrust law because defining the relevant market—an integral step in antitrust analyses—is difficult where third-party payors are involved.¹³³

This lack of antitrust enforcement has contributed to health systems' expansion across markets: "By 2017, in most markets, a single hospital system had more than a 50-percent market share of hospital discharges."¹³⁴ On a national scale, from 2014 to 2018, the ten largest health systems controlled nearly a quarter of the market share and realized twice as much revenue growth as their competitors.¹³⁵ According to "conventional economic wisdom," such threat to competition and consumer harm is exacerbated by the market's barriers to entry, with which hospital markets are replete.¹³⁶

Cross-market mergers allow hospitals to achieve economies of scale,¹³⁷ but the corresponding decrease in localized hospital markets poses significant patient harms.¹³⁸ In response, for the sake of health care accessibility in rural areas, state legislatures should enact laws that allow rural hospitals to consolidate and, thus, maintain financial viability—but the state should authorize such consolidation and supervise its post-merger prices. COPA laws are such laws.

IV. COPAS: ADDRESSING PRICE AND QUALITY IN RURAL HOSPITAL MARKETS

In competitive markets, competition can improve quality and lower

130. Gilbert, *supra* note 74, at 69.

131. Vistnes, *supra* note 85, at 253.

132. *Id.*

133. Gilbert, *supra* note 74, at 69 n.117.

134. Damberg, *supra* note 55, at 2.

135. Ion Skillrud et al., *The potential for rapid consolidation of health systems*, DELOITTE (Dec. 10, 2020), <https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html> [<https://perma.cc/7YZM-48EW>].

136. Matthew C. Baker & Thomas Stratmann, *Barriers to entry in the healthcare markets: Winners and Losers from certificate-of-need laws*, SOCIO-ECONOMIC PLANNING SCIENCES (Oct. 2021) (acknowledging the prevalence of barriers to entry in the hospital market but identifying the advantages to such barriers, consistent with the ACA's intent to minimize duplicative healthcare services within a geographic market); *see also* United States v. Oracle Corp., 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004) ("In addition to market concentration, probability of consumer harm in that case was established by factors such as legal barriers to new entry, low elasticity of consumer demand, inability of consumers to move to distant hospitals in emergencies, a history of collusion and cost pressures creating an incentive to collude.").

137. STAVROULAKI, *supra* note 85, at 99–101; Gibson, *supra* note 112, at Section I.B n.74; Coates et al., *supra* note 8 ("Mergers or affiliations may allow rural hospitals to achieve efficiencies of scale that they cannot as small, standalone entities.").

138. Vistnes, *supra* note 85, at 259 ("[E]conomic theory predicts—and evidence is emerging—that cross-market hospital systems raise price by exerting market power across markets." (quoting Fulton, *supra* note 97, at 1652, 1655)).

prices.¹³⁹ In rural hospital markets, though, where no such competition exists, quality improvements are not entirely dependent on competition, so antitrust law may be insufficient: “when market power is not the source of harm, antitrust enforcement is insufficient to foster an affordable, accessible, and high-value health system.”¹⁴⁰ Thus, price reduction in rural hospital markets may only be achievable through regulated consolidation.

Antitrust law is a regulatory tool used to benefit consumers by promoting competition—the expected outcomes of which are lowered costs and improved quality.¹⁴¹ In their own attempt to lower costs and improve quality, hospitals use a transactional tool—consolidation.¹⁴² Regardless of which tool is used, its effectiveness should be measured by its ability to (a) lower prices and (b) improve quality. When used responsibly, COPAs offer the benefits of consolidation without the anticompetitive harms correlated with consolidation. In other words, they can help lower prices and improve quality.

The ACA encourages consolidation and aims to avoid duplicative—or, in other words, competitive—services within a geographic market,¹⁴³ yet the antitrust agencies scrutinize hospital consolidation.¹⁴⁴ Judge John E. Jones III of the Third Circuit also acknowledged this tension, noting that “the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances.”¹⁴⁵ That is to say, although the FTC discourages hospital consolidation, the ACA and other federal schemes encourage it.¹⁴⁶ The reason for these fundamentally different perspectives on hospital consolidation is this: Although they both consider competition effective for lowering costs, they differ on whether competition or consolidation improves quality.

On one hand, *decreased* consolidation is thought to increase competition and,

139. *Competition Counts: How Consumers Win When Businesses Compete*, FED. TRADE COMM’N 2 (May 2015), https://www.ftc.gov/system/files/attachments/competition-counts/pdf-0116_competition-counts.pdf [<https://perma.cc/5LPH-H9ZD>].

140. Yash Singh, *The Antitrust Antidote to Hospital and Nursing Home Corporatization—Promises and Pitfalls*, 393 N. ENGL. J. MED. 1761 (2025), <https://pubmed.ncbi.nlm.nih.gov/41181922/> [<https://perma.cc/T7BU-SGQT>].

141. *Mergers and Competition*, U.S. FED. TRADE COMM’N, <https://www.ftc.gov/news-events/topics/competition-enforcement> [<https://perma.cc/39W7-XHUN>] (last visited Mar. 13, 2026); *Health Care Competition*, FED. TRADE COMM’N, <https://www.ftc.gov/news-events/topics/competition-enforcement/health-care-competition> [<https://perma.cc/MZH2-836P>] (last visited Apr. 13, 2026).

142. Gibson, *supra* note 112, at 1958 n.11.

143. Gilbert, *supra* note 74, at 53; Gibson, *supra* note 112, at 1959 n.21; NAT’L COUNCIL ON COMP. INS., *supra* note 110, at n.7.

144. Press Release, Fed. Trade Comm’n, *supra* note 32; see Union Hospital, Inc. & Terre Haute Regional Hospital, L.P., *supra* note 1 and accompanying text (noting that the DOJ withdrew the policy statements four months earlier, on Feb. 3, 2023); see also Letter from Andrew N. Ferguson to FTC Staff, *supra* note 34, at 1–2.

145. *FTC v. Penn State Hershey Med. Ctr.*, 185 F. Supp. 3d 552, 564 (M.D. Pa. 2016), *rev’d*, 838 F.3d 327 (3rd Cir. 2016).

146. *Id.*

consequently, increase quality.¹⁴⁷ On the other hand, *increased* consolidation is thought to increase efficiencies and, consequently, increase quality.¹⁴⁸ The FTC adopts the former rationale; the ACA adopts the latter. While the former should be adopted for competitive hospital markets, the latter should be adopted for rural hospital markets. This is the underlying reason for COPAs.

Most rural hospitals are monopolies,¹⁴⁹ yet many are at risk of closure because they cannot capitalize on their monopolistic position in the market. Thus, preventing consolidation through enhanced antitrust enforcement does not increase competition, which means there is no increase in competition to benefit patients financially.¹⁵⁰ Simultaneously, although “health system advocates have argued that integration can yield operational efficiencies and quality-of-care enhancements, research suggests that hospital consolidation leads to increased costs and prices without a corresponding improvement in care quality.”¹⁵¹ Thus, consolidation also does not benefit patients financially. Therefore, neither the regulatory tool nor the transactional tool is lowering costs, so patients are harmed either way.

A third tool should be considered: COPAs. COPAs facilitate improved quality of care by allowing hospitals to consolidate and improve quality through increased efficiencies, while relying on medical professionals’ motivation to improve the quality of their care regardless of whether competition exists. COPAs facilitate lowered costs by implementing state regulation of prices.¹⁵² In competitive hospital markets, the existing competition may effectuate lower prices and quality improvements. In rural hospital markets, though, where there is no meaningful competition either before or after an acquisition, medical care must be improved through consolidation and prices lowered through localized regulation.

147. GAO, *Antitrust: DOJ and FTC Jurisdictions Overlap, but Conflicts are Infrequent*, GAO-23-105790 (Jan. 3, 2023) (“Competition in a free market benefits American consumers through lower prices, better quality and greater choice.”).

148. Zachary Levinson et al., *Ten Things to Know About Consolidation in Health Care Provider Markets*, KFF (Apr. 19, 2024) <https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/> (“[C]onsolidation could allow providers to operate more efficiently. . . . These potential efficiencies could in turn benefit patients, for example, if they lead to higher quality care or reduced costs. . . .”).

149. ERIN C. FUSE BROWN, MILBANK MEM’L FUND, *HOSPITAL MERGERS AND PUBLIC ACCOUNTABILITY: TENNESSEE AND VIRGINIA EMPLOY A CERTIFICATE OF PUBLIC ADVANTAGE* 6 (Sep. 26, 2018) (“Most rural areas struggle to support even one major health care provider, let alone multiple competitors.”); Saving Rural Hospitals, *supra* note 46 (stating “most rural communities have only one hospital that is easily accessible, if they have a hospital at all.”).

150. See Singh, *supra* note 140 (stating “when market power is not the source of harm, antitrust enforcement is insufficient to foster an affordable, accessible, and high-value health system”).

151. Suhui (Evelyn) Li et al., *How Do Hospitals Exert Market Power? Evidence From Health Systems and Commercial Health Plan Prices*, 3(1) HEALTH AFFS. SCHOLAR 1,1 (2025), DOI: 10.1093/haschl/qxae179 [<https://perma.cc/2HK4-HWKR>].

152. TEX. HEALTH & SAFETY CODE ANN. § 314A.102 (2025).

A. Lowering Prices: Competition or Regulation?

The FTC anticipates that promoting competition within the healthcare market will, as is expected in other markets, reduce costs, incentivize innovation, and improve the quality of services rendered.¹⁵³ “Competition is always about the existence and availability of alternatives.”¹⁵⁴ Contrarily, concentration is the prevalence of combination within a market, caused by the merging of two or more previously independent undertakings, or by the acquiring of one or more undertakings—whether in part or in whole.¹⁵⁵ In concentrated markets, few firms hold significant market power, with which they can negotiate “higher-than-competitive payment rates.”¹⁵⁶ Under the standards set in the DOJ and FTC’s horizontal merger guidelines, “more than 80% of hospital markets are considered ‘highly concentrated.’”¹⁵⁷

Non-coordinated effects are defined as “the removal of important competitive constraints on one or more firms, which gain increased market power, without resorting to coordinated behavior.”¹⁵⁸ Such effects are more probable in markets with only a few “significant competitors,”¹⁵⁹ who can increase their market power without resorting to coordinated behavior because they have leverage over the market supply, so they can raise demand—and, thus, prices—by artificially decreasing the supplies in circulation, which saves them money in supply purchases without compromising sales.¹⁶⁰ This describes most rural hospital markets, where there are few competitors, which offer the same or similar services and can increase demand of a service by restricting the available quantity of that service. However, a standalone rural hospital cannot capitalize on its monopolistic position in the market, for it has insufficient bargaining power in its reimbursement-rate negotiations with commercial insurers.¹⁶¹

Monopolies can substantially control the available supply in the market, and

153. *Health Care Competition*, *supra* note 141.

154. Herbert J. Hovenkamp, *Competitive Harm from Vertical Mergers* 21 (UNIV. OF PA. INST. FOR L. & ECON. Research Paper, Paper No. 20-51, 2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3683386 [<https://perma.cc/T4SB-SRCX>].

155. Kalinowski et al., *supra* note 57, at 1 § 203.07(1)(a) (2d ed. 2023).

156. PAUL B. GINSBURG, *WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES EVIDENCE OF PROVIDER MARKET POWER* 1 (2010).

157. Maryclaire M. Farrington, *Stuck Between a Doc and a Hard Place: How Hospital Price Transparency and Other Regulatory Statutes Fail Against Ever-Growing Monopolistic Hospital Systems*, 17 *Health. L. & Pol’y Brief* 47, 51 (2022) (citing Zack Cooper & Martin Gaynor, *Addressing Hospital Concentration and Rising Consolidation in the United States*, 1% Steps for Health Care Reform 1, <https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/> [<https://perma.cc/WST2-UJQK>] (last visited Apr. 14, 2026)).

158. Kalinowski et al., *supra* note 57, 1 § 203.07(3).

159. *Id.* at 1 § 203.07(3)(b)(i)(I).

160. *See id.*

161. Dorn, *supra* note 47, at 3–4 (“The estimated hospital and insurer demand functions are key inputs to the bargaining model.”) (finding that “small hospitals receiv[e] roughly take-it-or-leave-it offers”).

in a market with an inelastic demand, they can raise their prices without concern that consumers will choose to forego the service or product entirely.¹⁶² For many of the services offered by hospitals, there is an inelastic demand.¹⁶³ However, unlike most other monopolists, hospitals are not able to independently dictate their own prices.¹⁶⁴ Rather, they must negotiate the reimbursement rates that private insurers will pay.¹⁶⁵ This means a hospital can only enjoy its monopolistic position within a market if it also has enough negotiating leverage over these third-party payors.¹⁶⁶

Absent an affiliation with a larger health system, rural hospitals do not have the bargaining power needed to negotiate profitable reimbursement rates from private insurers.¹⁶⁷ Thus, in rural hospital markets, being a monopoly does not equate to being profitable. For a hospital to be profitable, it must have sufficient negotiating power. Therefore, even if there were two competitors within a rural hospital market, this would not necessarily result in lower prices, for the prices are not dictated by either hospital—they are dictated by the negotiations between a hospital and the insurers. Notably, insurers have been gaining bargaining power through consolidation of their own, which further decreases the little leverage small hospitals have had in these negotiations.¹⁶⁸

Large health systems with a heterogenous payor mix have greater bargaining power to dictate their own prices.¹⁶⁹ When such a health system

162. Blair et al., *supra* note 61, at 40.

163. *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1388 (7th Cir. 1986) (stating “the demand for hospital services by patients and their doctors is highly inelastic under competitive conditions.”).

164. Dorn, *supra* note 47, at 3–4 (“The estimated hospital and insurer demand functions are key inputs to the bargaining model.”); Kate Ho & Robin S. Lee, *Insurer Competition in Health Care Markets*, 85 *ECONOMETRICA* 379, 384–85 (2017) (assuming in its predictive modeling that “[Employers bargain] over premiums with the insurers that it offers, and that these insurers also bargain with hospitals over reimbursement prices.”).

165. Dorn, *supra* note 47, at 3–4; Ho & Lee, *supra* note 164, at 384–85.

166. Dorn, *supra* note 47, 4 (finding that “small hospitals receiv[e] roughly take-it-or-leave-it offers”).

167. *Id.*

168. JOSÉ R. GUARDADO & CAROL K. KANE, AMA, *COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS* 9–10 (2025), <https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf> [<https://perma.cc/J8T9-KDHT>]; Leemore Dafny, *Health Insurance After Corporatization—What Next?*, 394 *N. ENGL. J. MED.* 521, 522 (2026), <https://www.nejm.org/doi/abs/10.1056/NEJMp2415746> [<https://perma.cc/R4J9-PDPT>] (“Larger insurers can threaten to disfavor or exclude provider organizations from their networks unless they agree to lower rates — and this threat is credible particularly in relation to organizations without substantial countervailing market power.”).

169. Kate Ho & Robin S. Lee, *Insurer Competition and Negotiated Hospital Prices* 3, 2 (Sep. 2013) (Nat’l Bureau of Econ. Rsch., Working Paper No. 19401), https://www.nber.org/system/files/working_papers/w19401/revisions/w19401.rev1.pdf [<https://perma.cc/XJ76-EB8R>] (expecting “the most attractive hospitals to have the greatest ability to negotiate higher prices when insurer market power is low; other hospitals may see smaller price increases, or even price reductions, because the effect of insurer competition on premiums outweighs the offsetting effect,” and noting that “changes in [negotiated hospital] prices . . . may encourage further provider consolidation, benefit some hospitals more than others, and lead to potential distortions in investment incentives.”).

acquires a standalone rural hospital, it can take advantage of that hospital's monopolistic position in the rural market, resulting in higher reimbursement rates,¹⁷⁰ which then results in higher insurance premiums and deductibles for patients.¹⁷¹ Therefore, because competition is nonexistent in rural hospital markets both before and after antitrust enforcement, competition cannot be the answer for lower prices here. Moreover, consolidation is often the only alternative to bankruptcy or closure for rural hospitals. Thus, states should allow these hospitals to affiliate with larger health systems, then turn to localized regulation—not competition—to lower post-merger prices. COPAs allow states to do exactly this.

B. Improving Quality: Competition or Self-regulation?

The FTC has consistently taken positions aligning with the idea that “quality will improve only to the extent that rigorous competition, information and choices are ensured.”¹⁷² The rural hospital market, however, is different.

The healthcare market generally is incapable of ensuring information and choices are available to patients in the same way they are available to consumers in other markets. As consumers seeking to purchase medical care, patients must receive information and choices that are personalized and that require expert opinions.¹⁷³ Thus, patients receive information and are offered choices from licensed medical providers, who are both the gatekeepers and catalysts for consumers in the market for healthcare services.¹⁷⁴ Due to this information asymmetry, patients have little choice but to rely on their provider's professional advice regarding their consumer choices in this market.¹⁷⁵ Physicians are knowledgeable of the services and insurers are knowledgeable of the prices, but patients are not equipped with the knowledge necessary for them to explore and choose higher-quality services.¹⁷⁶ Therefore, competition does not improve the

170. STAVROULAKI, *supra* note 85, at 118, 130–32 (citing *FTC v. Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522 (E.D. Pa. 2020)); Vistnes, *supra* note 85, at 252 (“The [Common Linked Employer] theory predicts that cross-market mergers increase the merged system's overall bargaining power, which in turn implies that such mergers will lead to higher prices at *both* the acquired and acquiring hospitals.”).

171. STAVROULAKI, *supra* note 85, at 118–19 (citing *Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522). See Robin S. Lee & Kyna Fong, Markov-Perfect Network Formation: An Applied Framework for Bilateral Oligopoly and Bargaining in Buyer-Seller Networks 32–33 (Sep. 2013) (unpublished manuscript), <https://robinlee.sites.fas.harvard.edu/papers/MPNENetworkFormation.pdf> [<https://perma.cc/ZZA5-GFBK>] (“[I]f hospitals possessed greater bargaining power and hence captured a larger share of industry rents, they would have an incentive to lower negotiated per-patient rates in order to increase total patient volume. Nonetheless, for those mergers in which hospitals find it profitable to merge, this effect does not often occur; in general, mergers seem to predominantly lead to higher premiums and fewer patients insured.”).

172. STAVROULAKI, *supra* note 85, at 86.

173. *Id.* at 29–33.

174. *Id.* at 29–33.

175. *Id.* at 87.

176. *Id.* at 84–85; Day, *supra* note 60, at 1543.

quality of medical care in the same way it improves quality in other markets.¹⁷⁷

Rather than improving through competition alone, the quality of medical care may improve only insofar as healthcare providers function as a self-regulated profession.¹⁷⁸ Unlike other markets—which experience improvements in quality through competition, information, and choices—the hospital market, in which information asymmetry is inherent, may experience quality improvements because medical professionals hold themselves to a professional standard that entails a consistent effort to improve the quality of their services, regardless of whether competition exists in the market.¹⁷⁹

In rural hospital markets, little to no competition exists.¹⁸⁰ If a hospital in a rural area is acquired by a larger health system, competition still does not exist in that geographic area. However, unlike in other industries, this lack of competition may not disincentivize healthcare providers from improving the quality of their services. To the contrary, such consolidation will likely improve the quality of services due to the decreased financial distress and increased efficiencies associated with provider integration.¹⁸¹ Therefore, in rural hospital markets, consolidation—not competition—is likely the more effective method for improving the quality of medical care. COPAs allow for such consolidation.

V. COPA LAWS

Certain consolidations may implicate antitrust laws: Although the existence of a monopoly is not inherently illegal,¹⁸² “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce” is illegal.¹⁸³ To simultaneously prevent antitrust scrutiny while promoting hospital consolidation in rural areas, state legislatures can exercise the state-action doctrine, which is the legal theory under which COPAs operate.¹⁸⁴

The “leading indicator of monopoly power” is a firm’s market share.¹⁸⁵ When bringing a monopolization claim, the plaintiff must “prove (1) the defendant had a specific intent to monopolize; (2) the defendant engaged in predatory or anticompetitive conduct; and (3) there is a dangerous probability

177. STAVROULAKI, *supra* note 85, at 29–33.

178. *Id.* at 86; Gibson, *supra* note 112, at 1959 n.21; *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets*, U.S. FED. TRADE COMM’N 7–9 (June 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session1_transcript_copa.pdf [<https://perma.cc/3FMT-3FZR>].

179. STAVROULAKI, *supra* note 85, at 86; Gibson, *supra* note 112, at 1959 n.21; U.S. FED. TRADE COMM’N, *supra* note 178.

180. FUSE BROWN, *supra* note 149, at 6 (“Most rural areas struggle to support even one major health care provider, let alone multiple competitors.”).

181. Gilbert, *supra* note 74, at 53; Gibson, *supra* note 112, at 1959 n.21 (2022); NAT’L COUNCIL ON COMP. INS., *supra* note 110, at n.7.

182. *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko*, 540 U.S. 398, 407 (2004) (“The mere possession of monopoly power, and the concomitant charging of monopoly prices, is not only not unlawful; it is an important element of the free-market system.”).

183. 15 U.S.C. § 1 (2024).

184. U.S. FED. TRADE COMM’N, *supra* note 42.

185. Kalinowski et al., *supra* note 57, at 4 § 70.04(6)(a).

that the defendant will achieve monopoly power.”¹⁸⁶ When firms enter agreements that do not readily appear to have adverse economic effects from restrained trade, courts “analyz[e] the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed.”¹⁸⁷ Where “the procompetitive effects outweigh the anticompetitive effects of the restraint at issue,” courts may allow the arrangement.¹⁸⁸ COPA laws have existed since 1993 and use the state-action doctrine to immunize anticompetitive hospital M&A from this antitrust scrutiny.¹⁸⁹ For this immunity to attach to a COPA merger or acquisition, the hospital consolidation must satisfy the state-action doctrine’s requirements—which, in effect, ensure the anticompetitive activity accomplishes the same result that the courts look for in antitrust litigation: “the procompetitive effects outweigh the anticompetitive effects of the [hospital consolidation].”¹⁹⁰

Understanding the state-action doctrine’s requirements allows legislators to draft COPA laws in a way that maximizes their effectiveness. In this section, the state-action doctrine is analyzed, then states’ COPA laws are evaluated against the doctrine’s two requirements.

A. State-action Doctrine

Under the state-action doctrine, M&A transactions may be immune from federal antitrust law.¹⁹¹ This immunity is sometimes referred to as “*Parker* immunity.”¹⁹² In *Parker v. Brown*, the Supreme Court held that the Sherman Act was not “intended to restrain state action or official action directed by a state.”¹⁹³

186. *Id.* (citing *Spectrum Sports v. McQuillan*, 506 U.S. 447, 458–59, (1993); *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883, 893 (9th Cir. 2008)).

187. Danielle Beth Rosenthal, *Are Independent Pharmacies in Need of Special Care? An Argument Against an ANTITRUST EXEMPTION FOR COLLECTIVE NEGOTIATIONS OF PHARMACISTS*, 13 YALE J. HEALTH POL’Y L. & ETHICS 198, 206 (quoting *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 692 (1978)).

188. *Id.*

189. Amy Y. Gu, *Updated: States with Certificates 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/5AS7-93D6]; U.S. FED. TRADE COMM’N, *supra* note 42.

190. *See* Rosenthal, *supra* note 187, at 206; *see, e.g.*, W. VA. CODE § 16-29B-28(c) (2025); NEB. REV. STAT. § 71-7706(1) (2025); TENN. CODE ANN. § 68-11-1303(b) (2025); OHIO. REV. STAT. § 3727.22(B) (2025); WASH. REV. CODE § 43.72.010(6) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314.002(a), (d) (2025).

191. *Parker v. Brown*, 317 U.S. 341, 352 (1943); *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 42–43 (1985); *FTC v. Phoebe Putney Health Sys.*, 568 U.S. 216, 217 (2013) (explaining that, under the state-action doctrine, “immunity from federal antitrust law may extend to nonstate actors carrying out the State’s regulatory program”).

192. *Day*, *supra* note 60, at 1583.

193. *Parker*, 317 U.S. at 351 (“In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state’s control over its officers and agents is not lightly to be attributed to Congress.”); *But see* Gregory Day, *Antitrust Federalism and the*

Therefore, although seemingly contradictory to the concept of preemption,¹⁹⁴ “federal antitrust laws are subject to suppression by state regulatory programs.”¹⁹⁵ The purpose of the state-action doctrine is “to respect the federal balance and to ‘embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution.’”¹⁹⁶

The Supreme Court has explained that the promotion of competition should not come “at the expense of other values a State may deem fundamental.”¹⁹⁷ The Court has further reasoned that the state-action doctrine is permissible because, “[w]here the actor is a municipality, there is little or no danger that it is involved in a *private* price-fixing arrangement.”¹⁹⁸ Based on this rationale, courts presume that municipalities act in the public’s interest.¹⁹⁹ Moreover, municipalities are “checked to some degree through the electoral process.”²⁰⁰ Thus, *Parker* immunity may apply “when it is clear that the challenged anticompetitive conduct is undertaken pursuant to the ‘State’s own’ regulatory scheme.”²⁰¹ Specifically, there are three scenarios in which *Parker* immunity may apply:

- (1) The state itself takes an action, for a “state’s own actions ‘ipso facto are exempt’ from the antitrust laws.”²⁰²
- (2) The private parties’ conduct is “clearly articulated and affirmatively expressed as state policy” and their actions are “actively supervised by the State itself.”²⁰³
- (3) The municipalities “act pursuant to state policy to displace

Prison-Industrial Complex, 107 Minn. L. Rev. 2193 (2023) (arguing that “federalism cannot support *Parker*’s broad scope”).

194. See Gilbert, *supra* note 74, at 55.

195. *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 632–33 (1992).

196. *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 574 U.S. 494, 503 (2015) (quoting *Cnty. Cmms’ns Co. v. Boulder*, 455 U.S. 40, 53 (1982)). (The state-action doctrine has now “been expanded to apply to all of the federal antitrust laws.” See Hunnicutt v. Tafoya-Lucero, No. CV21-00867 JCH/JFR, 2022 WL 832566, at *4 (D.N.M. Mar. 21, 2022)).

197. *N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 503 (citing generally *Exxon Corp. v. Governor of Maryland*, 437 U.S. 117, 133 (1978)); Frank H. Easterbrook, *Antitrust and the Economics of Federalism*, 26 J. LAW & ECON. 23, 24 (1983)).

198. *Hallie v. Eau Claire*, 471 U.S. 34, 47 (1985) (emphasis in original). *But see* Day, *supra* note 60, at 1583 (contending “it’s increasingly apparent that states restrain trade to bestow monopoly profits on favored corporations”).

199. *Hallie*, 471 U.S. at 45.

200. *Id.* at 45 n.9.

201. *F.T.C. v. Phoebe Putney Health Sys.*, 568 U.S. 216, 217 (2013) (quoting *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 635 (1992)).

202. *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 717 F.3d 359, 366 (4th Cir. 2013), *aff’d*, 574 U.S. 494 (2015) (quoting *Hoover v. Ronwin*, 466 U.S. 558, 568 (1984)).

203. *Id.* (quoting *California Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)); *Phoebe Putney Health Sys.*, 568 U.S. at 225 (quoting *Midcal Aluminum, Inc.*, 445 U.S. at 105).

competition with regulation or monopoly public service.”²⁰⁴

The second scenario is the focus of this analysis. In the second scenario, where *Parker* immunity attaches to private parties’ conduct, there need not be an expressed statement from the legislature for a clearly articulated state policy to be found.²⁰⁵ If no such expressed statement exists, though, “the anticompetitive effect must have been the ‘foreseeable result’ of what the State authorized.”²⁰⁶ Additionally, the state supervisor must consider the substance of the anticompetitive conduct, and “the supervisor must not be an active market participant.”²⁰⁷ The state cannot merely defer to a private party’s price-fixing arrangement; rather, for *Parker* immunity to apply, there must be “[a]ctual state involvement.”²⁰⁸

Over the last eight decades, the Supreme Court has repeatedly reaffirmed the state-action doctrine,²⁰⁹ allowing states to “suppress competition as ways of promoting the public’s welfare and regulating local markets.”²¹⁰ However, it has also noted that, “given the antitrust laws’ values of free enterprise and economic competition, ‘state-action immunity is disfavored.’”²¹¹ Similarly, the FTC views the state-action doctrine negatively:

Hospital mergers subject to COPAs can result in higher prices for patients without improvements in quality of care, reduced patient access to healthcare services, and lower wages for hospital employees who face fewer employment options.²¹²

Regulatory oversight under COPAs is administered by state agencies, and such oversight—which may include regulating the hospital’s price controls, cost-saving mechanisms, and contractual terms with private insurers—may place a burden on state resources.²¹³ Additionally, if a COPA expires or is repealed, a monopolist hospital could be left without supervision.²¹⁴ This, among other reasons, has prompted the FTC to recommend states avoid COPAs, explaining there is insufficient evidence to suggest that such state-sponsored

204. *N. C. State Bd. of Dental Exam’rs*, 717 F.3d at 367 (quoting *Phoebe Putney Health Sys.*, 568 U.S. at 225).

205. *Id.*

206. *Phoebe Putney Health Sys.*, 568 U.S. at 217 (quoting *Hallie v. Eau Claire*, 471 U.S. 34, 42–43 (1985)); *City of Columbia v. Omni Outdoor Advertising*, 499 U.S. 365, 372–73 (1991).

207. STAVROULAKI, *supra* note 85, at 69 (citing *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 574 U.S. 494, 497 (2015)).

208. *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 633 (1992).

209. *See N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 503.

210. *Day*, *supra* note 60, at 1584.

211. *Phoebe Putney Health Sys.*, 568 U.S. at 217 (quoting *Ticor Title Ins. Co.*, 504 U.S. at 621, 636).

212. U.S. FED. TRADE COMM’N, *supra* note 42.

213. FED. TRADE COMM’N, *FTC POLICY PERSPECTIVES ON CERTIFICATES OF PUBLIC ADVANTAGE* 1 (Aug. 15, 2022), available at https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf [<https://perma.cc/6BVA-GPKQ>].

214. *Id.* at 3–4.

consolidations “produce better results than market-based competition.”²¹⁵

However, COPAs’ efficacy should not be compared to market-based competition’s efficacy, for both the third-party-payor system and the information asymmetry inherent in rural hospital markets compromise the economic advantages typically associated with market-based competition in other industries.²¹⁶ Regulated consolidation, not competition, is the paradigm under which rural hospitals are more likely to decrease prices and improve quality²¹⁷—while also maintaining accessibility to health care by preventing hospital closures.²¹⁸ Thus, COPAs’ potential benefits address the known failures of the United States’ rural hospital markets, which Professor Erin C. Fuse Brown has aptly summarized:

[H]ealth care payment reforms have spurred a wave of industry consolidation. Providers argue that consolidation is necessary to achieve the scale and scope needed to assume greater financial risk in the shift to value-based payment, to invest in information technology infrastructure, and to take on population health improvement. As a result of widespread consolidation, hospital market concentration in the United States has increased by 40% in the past 30 years. No hospital market in the United States remains “highly competitive,” nearly half of all hospital markets in the nation are “highly concentrated,” and most rural areas struggle to support even one major health care provider, let alone multiple competitors. As competition diminishes, prices rise because monopoly providers are able to negotiate with payers on an all-or-nothing basis, and payers lose the ability to walk away from negotiations with dominant providers when building their provider networks.²¹⁹

Professor Brown further explains that state governments, especially in rural areas, “are also contending with the closure of rural hospitals,” so they are turning to COPAs as a tool “to allow health system integration to support their rural health care infrastructure and direct resources toward population health, while controlling the adverse effects of consolidation on health care costs, quality, and access.”²²⁰ Therefore, although COPAs are a “risky solution” because the underlying transaction would fail antitrust scrutiny if *Parker* immunity were not conferred to it by the state, “COPAs may be the only alternative states face to denying monopoly-creating provider consolidations” while also preventing hospital closures in rural areas.²²¹

When planning to use COPAs to prevent both the closure of rural hospitals

215. *Id.* at 1.

216. *See supra* Part IV.A–B.

217. *See supra* Part IV.A–B.

218. *See supra* Part I–III.

219. FUSE BROWN, *supra* note 149, at 6.

220. *Id.* at 7.

221. *Id.* at 2, 5.

and the price-raising acquisitions of those hospitals, states should realize that *Parker* immunity is an affirmative defense, so the transacting parties bear the burden of proof.²²² Thus, state legislators should carefully craft their COPA laws to ensure the participating hospitals meet the state-action doctrine's requirements.

B. Analysis of COPA Laws' Compliance with the State-action Doctrine

Currently, seventeen states have codified exercisable COPA laws for hospitals.²²³ Prior to 2025, nineteen states allowed hospitals to apply for COPAs, but Colorado repealed its COPA statutes,²²⁴ and Indiana amended its statute to disallow hospitals from applying for COPAs.²²⁵ COPA laws immunize qualifying hospital consolidations from antitrust laws, so long as the consolidation meets the statutory guidelines and the two-prong test for *Parker* immunity.²²⁶ For *Parker* immunity to apply, the consolidating hospitals' conduct must be (i) authorized and (ii) supervised by the state.²²⁷

1. State Authorization

To authorize a party's anticompetitive conduct, the state must have "articulated a clear and affirmative policy to allow the anticompetitive conduct."²²⁸ Ensuring they have "clearly articulated" a state policy that COPAs serve to advance, most state legislatures have included an explanation of their intentions for COPA laws.²²⁹ A state that has not clearly articulated such a policy may nevertheless satisfy this requirement if the "the inherent, logical, or ordinary result" of the conduct that the state is authorizing has foreseeable anticompetitive effects that are "consistent with its policy goals."²³⁰ This "implicit endorsement" constitutes state authorization as required for *Parker* immunity.²³¹

222. *Yeager's Fuel, Inc. v. Pennsylvania Power & Light Co.*, 22 F.3d 1260, 1266 (3rd Cir. 1994) (citing generally *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 625 (1992)).

223. *Health System Consolidation*, NAT'L CONF. OF STATE LEGISLATURES, <https://www.ncsl.org/health/health-system-consolidation> [<https://perma.cc/7RE4-5U5H>] (last updated Feb. 7, 2024) (assertion supported by information available via permalink).

224. *See* COLO. REV. STAT. §§ 25.5-1-501–516 (repealed 2025).

225. IND. CODE § 16-21-15-3(a) (2025) (stating "a hospital may not submit an application under this chapter after May 13, 2025").

226. Gilbert, *supra* note 74, at 54–55.

227. *N.C. State Bd. of Dental Exam'rs v. F.T.C.*, 717 F.3d 359, 367 (4th Cir. 2013), *aff'd*, 574 U.S. 494 (2015) (citing *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)); *F.T.C. v. Phoebe Putney Health Sys.*, 568 U.S. 216, 225 (2013) (citing *Midcal Aluminum, Inc.*, 445 U.S. at 105); *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 631 (1992).

228. *Ticor Title Ins. Co.*, 504 U.S. at 631.

229. *Phoebe Putney Health Sys.*, 568 U.S. at 225 (quoting *Midcal Aluminum, Inc.*, 445 U.S. at 105).

230. *N.C. State Bd. of Dental Exam'rs v. FTC*, 574 U.S. 494, 506–07 (2015) (quoting *Phoebe Putney Health Sys.*, 568 U.S. at 229).

231. *Id.*; *Phoebe Putney Health Sys.*, 568 U.S. at 229.

Corroborating the positions taken in this article related to the economic realities of today's rural hospital markets, the State of Washington has provided one of the most comprehensive explanations for its COPA laws' purpose:

(1) The legislature recognizes that competition among health care providers, facilities, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care services, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. However, the legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature therefore intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for activities approved under this chapter that might otherwise be constrained by such laws and intends to displace competition in the health care market: To contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, uniform package of health care benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents. To these ends, any lawful action taken pursuant to chapter 492, Laws of 1993 by any person or entity created or regulated by chapter 492, Laws of 1993 are declared to be taken pursuant to state statute and in furtherance of the public purposes of the state of Washington.²³²

232. WASH. REV. CODE § 43.72.300(1)–(2) (2025).

Florida's legislature has specified that its COPA laws are intended "to foster the development of rural health networks."²³³ Acknowledging that rural hospital markets need unique market intervention, it specifies that, pursuant to its COPA laws, these markets' "competitive market forces shall be replaced with state regulation."²³⁴ The Florida Legislature stipulated that rural hospitals' consolidation under these laws are only exempt from antitrust law if they "improve the quality of health care, moderate cost increases, and are made between members of rural health networks," for it "is within the public policy of the state to facilitate the provision of quality, cost-efficient medical care to rural patients."²³⁵

Texas likewise focuses on rural hospital markets, but it goes a step further and narrows the applicability of its COPA laws to hospitals within certain low-population counties.²³⁶ The Texas legislature expressly immunizes qualifying hospital mergers from antitrust laws, stating "it is in the state's best interest to supplant state and federal antitrust laws with a process for regulatory approval and active supervision by the designated agency."²³⁷ Similarly to Florida, Texas notes that these COPAs are intended to be used "to address unique challenges in providing health services in rural areas."²³⁸ Mississippi also aims for COPAs to be used in rural communities, but it does not restrict non-rural hospitals from applying for COPAs.²³⁹

Rather than focusing on rural hospitals, West Virginia has authorized state-action immunity for COPAs involving academic medical centers.²⁴⁰ Like other states with COPA laws, West Virginia has concluded that "it is in the state's best interest to supplant [antitrust laws] with regulatory approval and oversight" when the merger's benefits are likely to outweigh the disadvantages associated with the decrease in competition.²⁴¹ Unlike most other states with COPA laws, West Virginia may approve a COPA only if the anticipated benefits include not only enhanced economies of scale, improved quality of care, and increased accessibility to care, but also enhanced medical-education opportunities and affordability.²⁴²

Other states have used broader language in their COPA laws, focusing primarily on COPAs' intended benefits rather than the settings under which they may be authorized by the state. Wyoming notes that the state policy underlying

233. FLA. STAT. § 381.04065(1) (2025).

234. *Id.*

235. *Id.*

236. TEX. HEALTH & SAFETY CODE ANN. § 314A.002 (2025) (applying COPA laws exclusively to hospital mergers "within a county that: (1) contains two or more hospitals; and (2) has a population of: (A) less than 100,000 and is not adjacent to a county with a population of 250,000 or more; or (B) more than 100,000 and less than 150,000 and is not adjacent to a county with a population of 100,000 or more.").

237. TEX. HEALTH & SAFETY CODE ANN. § 314A.003 (b) (2025).

238. *Id.* at § 314A.003 (a) (2).

239. MISS. CODE ANN. § 41-9-307 (1)–(2) (2024).

240. W. VA. CODE § 16-29B-28 (a)–(d) (2025).

241. *Id.* at (c).

242. *Id.* at (d).

its COPA laws serves to promote (i) health care quality, (ii) health care access, (iii) health care affordability, and (iv) “[a] comprehensive health care system in the state.”²⁴³ Tennessee states that the use of regulation instead of competition furthers its state policy “to promote cooperation and coordination among hospitals,” as it believes this approach can result in benefits that “outweigh any disadvantages attributable to a reduction in competition.”²⁴⁴

A COPA—regardless of its intended benefits (whether they be for rural healthcare access, medical education, or an entirely different public benefit)—may receive *Parker* immunity if it advances a clearly articulated state policy.²⁴⁵ Because these legislatures have clearly articulated and affirmatively expressed a state policy being advanced by COPAs under their respective state statutes, COPA-qualifying hospital M&A transactions may be exempt from antitrust laws.

Conversely, some states—such as Wisconsin, South Carolina, Oregon, Nebraska, Kansas, and Louisiana—have not expressly identified which of their state policies is intended to be advanced through COPAs.²⁴⁶ However, the absence of an expressed state policy in the COPA laws does not preclude a COPA from satisfying the state-authorization requirement for *Parker* immunity, provided that the state has “foreseen and implicitly endorsed the anticompetitive effects” of the hospital consolidation.²⁴⁷

For example, a New York statute satisfied the state-authorization requirement when it contained language that indicated “the legislature clearly foresaw that [the state-established healthcare corporation] could be party to anticompetitive contractual arrangements with private parties.”²⁴⁸ In 2023, the language in Louisiana’s COPA laws was deemed sufficient to demonstrate that the state has a “policy in favor of COPA-approved mergers regardless of their anticompetitive effects.”²⁴⁹

Because implicit endorsement can satisfy the “clearly articulated”

243. WYO. STAT. ANN. § 35-24-101 (2025).

244. TENN. CODE ANN. § 68-11-1303 (a)–(b) (2025).

245. See *F.T.C. v. Phoebe Putney Health Sys.*, 568 U.S. 216, 217 (2013) (holding that *Parker* immunity applies only where the challenged restraint is the foreseeable result of a clearly articulated and affirmatively expressed state policy to displace competition); *City of Columbia v. Omni Outdoor Advertising*, 499 U.S. 365, 372–73 (1991) (explaining the clear-articulation requirement).

246. See WIS. STAT. §§ 150.84–150.86 (2025); S.C. CODE ANN. § 44-7-530 (2025); OHIO REV. STAT. § 3727.21 (2025); NEB. REV. STAT. § 71-7701–03 (2025); KAN. STAT. ANN. § 65-4957 (2024).

247. *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 574 U.S. 494, 506–07 (2015); *Phoebe Putney Health Sys.*, 568 U.S. at 228.

248. *LaFaro v. New York Cardiothoracic Group, PLLC*, 570 F.3d 471, 478 (2nd Cir. 2009).

249. *Louisiana Children’s Med. Ctr. v. Att’y Gen. of the United States*, No. 23-1305, 2023 WL 6293887 at *7 (E.D. La. 2023) (quoting Louisiana’s COPA law: “It is the intent of the legislature that supervision and control over the implementation of these agreements, mergers, joint ventures, and consolidations substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements, mergers, joint ventures, or consolidations state action immunity for actions that might otherwise be considered to be in violation of state antitrust laws, federal antitrust laws, or both.”); LA. STAT. ANN. § 40:2254.1 (2025).

requirement, states likely satisfy the clear-articulation test simply by enacting COPA laws—even if the legislature declines to explicitly identify which state policy the COPAs will be advancing.

2. *State Supervision*

Ensuring the state actively supervises every COPA, as is necessary for *Parker* immunity, legislatures promulgate the supervision processes in COPA laws.²⁵⁰

The supervision requirement compels the state to “exercise ultimate control” of the anticompetitive acts that it has authorized, ensuring that the antitrust-exempted business conduct is indeed advancing the articulated state policy.²⁵¹ This means the stage agency must “have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.”²⁵² In other words, “[t]he mere presence of some state involvement or monitoring does not suffice.”²⁵³

For active supervision to exist, the state must “exercise[] sufficient independent judgment and control so that the details of the challenged action have been established as a product of deliberate state intervention.”²⁵⁴ If it merely provides “generic oversight” instead of a “review and approval of the ‘particular anticompetitive acts,’” the state is not actively supervising the COPA.²⁵⁵ However, “[a]ctive supervision need not entail day-to-day involvement.”²⁵⁶

The Supreme Court has held that “active supervision is flexible and context dependent.”²⁵⁷ Regardless of the context, though, a state’s supervision plan should give “realistic assurance” that the private party’s “anticompetitive conduct ‘promotes state policy, rather than merely the party’s individual interests.’”²⁵⁸ To this end, there are three “constant requirements of active supervision” courts should enforce:

- (1) The supervisor must review the substance of the anticompetitive decision;
- (2) The supervisor must have the power to veto or modify particular

250. *N.C. State Bd. of Dental Exam’rs v. FTC*, 717 F.3d 359, 367 (4th Cir. 2013), *aff’d*, 574 U.S. 494 (2015); *Phoebe Putney Health Sys.*, 568 U.S. at 225.

251. *Patrick v. Burget*, 486 U.S. 94, 100–101 (1988) (citing *Hallie v. Eau Claire*, 471 U.S. 34, 46–47 (1985)).

252. *N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 507 (quoting *Patrick*, 486 U.S. at 101).

253. *Patrick v. Burget*, 486 U.S. 94, 101 (1988) (citing generally *324 Liquor Corp. v. Duffy*, 479 U.S. 335, 345 n.7 (1987)).

254. *N.C. State Bd. of Dental Exam’rs*, 717 F.3d at 369 (quoting *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 634 (1992)) (original brackets omitted).

255. *Id.* (quoting Interlocutory Order In re North Carolina State Bd. of Dental Exam’rs, 151 F.T.C. 607, 630, 2011 WL 3568990 (FTC Feb. 3, 2011) (quoting *Patrick*, 486 U.S. at 101)).

256. *N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 515.

257. *Id.* at 497.

258. *Id.* (quoting *Patrick*, 486 U.S. at 100–101).

- decisions to ensure they accord with state policy; and
- (3) The “mere potential for state supervision is not an adequate substitute for a decision by the State.”²⁵⁹

In most COPA-issuing states, the health department has been tagged as the supervising authority.²⁶⁰ Louisiana instead designates the Department of Justice as the supervising entity.²⁶¹ Other states, such as Tennessee and Texas, blend these two approaches, giving their attorneys general investigatory powers and advisory roles.²⁶² The health departments possess rulemaking authority,²⁶³ can modify the terms of a COPA,²⁶⁴ and may revoke or terminate COPAs if the hospital fails to comply with the COPA’s terms²⁶⁵—which are set by the supervising agency after it has reviewed and approved the COPA.²⁶⁶ These statutory provisions allow the supervisor to review the hospitals’ decision to consolidate, and modify the COPA’s terms to reflect the state policy they are intended to advance. Thus, they satisfy the three “constant requirements of active supervision.”

By enacting COPA statutes, legislatures provide a realistic assurance that, under the state’s supervision, consolidated hospitals’ conduct will advance a state policy. Thus, states with COPA laws have reduced the likelihood of the FTC successfully challenging a COPA on the basis that it fails to meet the supervision criteria necessary for *Parker* immunity. This was recently demonstrated in Louisiana.

In December 2022, the Louisiana Department of Justice (LADOJ) approved the acquisition of three hospitals and granted the COPA applied for by the transacting parties.²⁶⁷ The Louisiana district court, when discussing the second prong of the test for *Parker* immunity, determined that the agency met the three constant criteria: the supervising agency reviewed “the substance of the

259. *Id.* at 515 (quoting *Ticor Title Ins. Co.*, 504 U.S. at 638) (reformatted with enumeration); *accord*, *Teladoc, Inc. v. Tex. Medical Bd.*, 2015 U.S. Dist. LEXIS 166754 at *8 (W.D. Tex. 2015) (holding that the state medical board failed to meet the supervision prong of the state-action doctrine because it did not have any veto or modification authority over the private party’s decisions).

260. *See, e.g.*, TENN. CODE ANN. § 68-11-1302(3) (2025); W. VA. CODE § 16-29B-30(a) (2025); NEB. REV. STAT. § 71-7702(3) (2025); MISS. CODE ANN. § 41-9-305(f) (2024); WASH. REV. CODE § 43.72.310(6) (2025); WYO. STAT. ANN. § 35-24-102(a)(vi) (2025).

261. LA. STAT. ANN. § 40:2254.2 (2025).

262. TENN. CODE ANN. § 68-11-1303(f) (2025); TEX. HEALTH & SAFETY CODE ANN. §§ 314.002(g), 314.003 (2025).

263. *See, e.g.*, LA. STAT. ANN. § 40:2254.9 (2025); WYO. STAT. ANN. § 35-24-103 (2025).

264. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(g) (2025); WASH. REV. CODE § 43.72.310(6) (2025); WYO. STAT. ANN. § 35-24-115(d) (2025).

265. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(g) (2025); NEB. REV. STAT. § 71-7707 (2025); KAN. STAT. ANN. § 65-4958 (2024); LA. STAT. ANN. § 40:2254.6 (2025); MISS. CODE ANN. § 41-9-307(7) (2024); WASH. REV. CODE § 43.72.310(6) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314A.004 (2025).

266. *See, e.g.*, W. VA. CODE § 16-29B-28(e)(2)(i) (2025); LA. STAT. ANN. § 40:2254.10 (2025); WYO. STAT. ANN. § 35-24-101(b) (2025).

267. *Louisiana Children’s Med. Ctr. v. Att’y Gen. of the United States*, No. 23-1305, 2023 WL 6293887 at *1–2 (E.D. La. 2023).

acquisition,” “had the power to veto or modify the acquisition,” and actually approved and actively supervises the COPA, as opposed to merely having the potential for supervision.²⁶⁸ Moreover, the state’s COPA laws contain additional supervisory mechanisms, and the COPA’s terms and conditions further “empower the LADOJ to ‘actively supervise’ both the transaction itself and the new health system on an ongoing basis.”²⁶⁹ Because the three “constant requirements of active supervision” were met here, and because “the adequacy of supervision . . . depend[s] on all the circumstances of a case,”²⁷⁰ the court held that the supervision requirement for *Parker* immunity was satisfied.²⁷¹

The FTC has offered guidance on what constitutes active supervision.²⁷² Adding to the factors laid out by the courts, the FTC claims that “active supervision must precede implementation of the allegedly anticompetitive restraint.”²⁷³ This is consistent with the courts’ requirement that the agency must review the substance of the acquisition because, to effectively supervise a COPA-holding hospital, the state agency must first receive adequate information to determine whether it should approve the COPA. Therefore, to facilitate the state’s supervision, a COPA’s application, approval, and review processes should be documented with specificity.

VI. COPA APPROVALS, REVIEWS, AND CHALLENGES

Just as the LADOJ, all supervising agencies should analyze the anticipated effects of a COPA before deciding whether to approve it.²⁷⁴ For this reason, the COPA application, and any resulting agreement between the parties and the state, should be as comprehensive as is practicable.

Most COPA-issuing states prioritize public engagement, asking for public comments and making applications open to the public.²⁷⁵ Typically, a state may approve a COPA only if its “likely benefits . . . outweigh any disadvantages

268. *Id.* at *8 (internal quotations omitted).

269. *Id.* at *9 (brackets omitted) (quoting the COPA Terms and Conditions, R. Doc. No. 75-14, ¶¶12–14, 30–37).

270. *N.C. State Bd. of Dental Exam’rs v. FTC*, 574 U.S. 494, 515 (2015).

271. *La. Children’s Med. Ctr.*, No. 23-1305, 2023 WL 6293887 at *8–9.

272. *See generally*, *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*, FED. TRADE COMM’N (Oct. 2015), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf [<https://perma.cc/2GZ9-9ZHT>].

273. *Id.* at 10.

274. *La. Children’s Med. Ctr.*, No. 23-1305, 2023 WL 6293887 at *8 (noting the “extensive analysis by LADOJ attorneys and staff regarding the transaction, the facilities, and the likely effects on health care and competition in the state, which also included input from expert consultants who reviewed the COPA application”).

275. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(d) (2025); OHIO REV. STAT. § 3727.23 (2025); W. VA. CODE § 16-29B-28(e)(2) (2025); LA. STAT. ANN. § 40:2254.4(B) (2025); WYO. STAT. ANN. §§ 35-24-106 (2025); TEX. HEALTH & SAFETY CODE ANN. §§ 314.002(c), (g), 314.004(b) (2025).

attributable to a reduction in competition.”²⁷⁶ Nebraska, Tennessee, and Texas also require the applicants demonstrate with clear and convincing evidence that this outweighing-benefits standard is met.²⁷⁷

A. Tennessee and Virginia: 2017 COPA Challenge

In 2017, the FTC challenged a COPA application submitted by hospitals in Tennessee and Virginia.²⁷⁸ After considering the FTC’s protests against the COPA application, the Tennessee Department of Health nevertheless decided to approve the COPA.²⁷⁹ It determined, based on its knowledge of the local market and the fifty page COPA Terms of Certification to which it would hold the merging hospitals accountable, that this state-supervised hospital consolidation would result in a net benefit for local patients.²⁸⁰

This COPA primarily involved rural hospitals, of which there were nineteen, spanning across twenty one counties in both Tennessee and Virginia.²⁸¹ To be effective, such a COPA “may require stringent state oversight of prices, quality, and access.”²⁸² This was a worthwhile tradeoff for the hospitals, though, as they had been experiencing financial and public-health difficulties akin to those that most rural hospitals currently face.²⁸³ Tennessee has extensive COPA-application requirements, and both Tennessee and Virginia weighed specific advantages and disadvantages when considering whether to approve the application.²⁸⁴ The states’ departments of health provided their bases for approving the COPA, along with the supervisory responsibilities each would take.²⁸⁵

This type of COPA, where there are sufficient state resources and clear regulatory guidelines, allows local governments to continuously supervise consolidated hospitals in an attempt to further the public’s wellbeing—which is

276. W. VA. CODE § 16-29B-28(c) (2025); *accord.* NEB. REV. STAT. § 71-7706(1) (2025); TENN. CODE ANN. § 68-11-1303(b) (2025); OHIO REV. STAT. § 3727.22(B); TEX. HEALTH & SAFETY CODE ANN. § 314.002(a), (d) (2025).

277. NEB. REV. STAT. § 71-7706(1) (2025); TENN. CODE ANN. § 68-11-1303(e)(1) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314.002(d) (2025).

278. *See* FED. TRADE COMM’N, FED. TRADE COMM’N STAFF’S THIRD SUBMISSION TO THE TENNESSEE DEP’T OF HEALTH REGARDING THE CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF MOUNTAIN STATES HEALTH ALLIANCE & WELLMONT HEALTH SYS. (July 18, 2017), available at https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc_-_third_comment_to_tennessee_-_final_public_version.pdf [https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc_-_third_comment_to_tennessee_-_final_public_version.pdf].

279. *Tennessee Approves Ballard Health COPA Over FTC Protests*, MANATT (Oct. 23, 2017), <https://www.manatt.com/insights/newsletters/antitrust-law/tennessee-approves-ballad-health-copa-over-ftc-pro> [<https://perma.cc/U7D2-9QE7>].

280. *Id.*

281. FUSE BROWN, *supra* note 149, at 8–9.

282. *Id.* at 8.

283. *Id.* at 9.

284. *See id.* at 12–15.

285. *See id.* at 21–29.

the primary purpose underlying COPAs and the state-action doctrine.

B. Louisiana: 2023 COPA Challenge

In 2023, the FTC challenged a COPA acquisition in Louisiana.²⁸⁶ The FTC challenged this hospital acquisition after the transaction had occurred, bringing suit to contest the state-action doctrine which exempted the acquisition from antitrust laws.²⁸⁷ The FTC, the State of Louisiana, and the hospitals included in the case filed motions for summary judgment.²⁸⁸ The Eastern District Court of Louisiana granted the state and the hospitals' motions, and denied the FTC's motion, holding that the private parties' transaction met the requirements for *Parker* immunity.²⁸⁹

Louisiana's COPA statute allows the LADOJ to approve a COPA application, which it did in this case.²⁹⁰ The LADOJ and the acquiring hospital agreed to terms and conditions by which the agency was to supervise the hospital.²⁹¹ The state agency may "revoke the COPA" not only if the hospital fails to comply with these terms and conditions, but also if it "determines that the transaction is not resulting in lower health care costs or greater access to or quality of health care."²⁹²

This case reaffirms the legitimacy of COPAs under the state-action doctrine, and it demonstrates how a state agency may effectively supervise hospital consolidation by repeatedly reassessing whether it is advancing the state's articulated policy.

C. Indiana: 2025 COPA Challenge

In March of 2025, the FTC challenged a COPA application in Indiana.²⁹³ Indiana's legislature had included a date by which no more COPA applications would be considered—July 1, 2026.²⁹⁴ In its 2025 legislative session, it amended this expiration date, changing it to May 13, 2025.²⁹⁵ However, this amendment was likely not intended to signal a disapproval of COPAs.²⁹⁶ Rather, the Indiana

286. *See* La. Children's Med. Ctr. v. AG of the United States, No. 23-1305, 2023 WL 6293887 (E.D. La. 2023).

287. *Id.* at *1.

288. *Id.*

289. *Id.* at *1, 7–8, 12.

290. *Id.* at *2.

291. *Id.* (stating that the hospitals closed the transaction after its approval).

292. *Id.* (quoting the COPA Terms and Conditions, R. Doc. No. 75-17, at 3).

293. *See* FED. TRADE COMM'N, FED. TRADE COMM'N SUPPLEMENTAL STAFF SUBMISSION TO INDIANA HEALTH DEP'T REGARDING 2025 CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF UNION HEALTH & TERRE HAUTE REG'L HOSP. (Mar. 17, 2025), https://www.ftc.gov/system/files/ftc_gov/pdf/in-copa-comment-3-17-2025-public-redacted.pdf [<https://perma.cc/DQ6T-NAL3>].

294. IND. CODE § 16-21-15-3(a) (2024).

295. IND. CODE § 16-21-15-3(a) (2025).

296. *See Hearing on S.B. 119 Before the H. Comm. on Pub. Health*, 124th Gen. Assemb. (Ind. Apr. 1, 2025) (video recording available at https://iga.in.gov/session/2025/video/committee_public_health_1500, at 22:50) [hereinafter *Hearing on S.B. 119*].

General Assembly's discussion surrounding the amendment indicates that the statute was enacted to facilitate the COPA application submitted and approved in 2025, and should another hospital pursue a COPA in the future, the statute may once again be amended to allow for such an application.²⁹⁷

In its decision to approve the COPA merging Indiana's Union Hospital and Terre Haute Regional Hospital, the Indiana Department of Health considered the forty-five proposed commitments to which the hospitals would be held accountable by the health department.²⁹⁸ To ensure this COPA "[m]erger would benefit the population's health outcomes, health care access, and quality of care in a manner that outweighs the disadvantages of the Proposed Merger's anticompetitive effects," these commitments related to "[q]uality, [p]ricing, [p]reservation of [a]ccess, [e]nhancement, [e]mployment and [e]conomic [i]mpact, [p]opulation [h]ealth, and [o]ther" miscellaneous matters.²⁹⁹ The health department articulated with specificity these commitments in the COPA's terms and conditions.³⁰⁰

At first glance, Indiana's 2025 amendment to its COPA statute may look like an attempted course correction following the approval of a COPA in the face of opposition from the FTC³⁰¹ and state Attorney General.³⁰² However, after considering the town hall's public comments, the Indiana Department of Health's determination, and the Indiana General Assembly's discussion, it becomes evident that Indiana enacted its COPA statutes for this specific merger, for which the COPA application took two years to complete.³⁰³ Indiana's amendment to preclude future hospital COPA applications should not be inferred as a stance against COPAs; instead, other states should look to Indiana's 2025 COPA as an example of how to apply for, review, and approve a COPA for rural hospitals.

This COPA's two-year application process, along with the terms and conditions governing this COPA, give onlooking states and hospitals a strong example of how to use a COPA to address rural hospital markets' unique economic challenges. To build on this example and provide a resource for state legislators considering proposing COPA laws, the next section will consider all currently enacted COPA statutes and provide recommendations on which key provisions should be included in a state's COPA laws.

297. *Id.*

298. IND. DEP'T OF HEALTH, UNION HOSP., INC. & TERRE HAUTE REG'L HOSP., L.P. APPLICATION FOR CERTIFICATE OF PUBLIC ADVANTAGE 2 (Nov. 9, 2025).

299. *Id.*

300. *Id.* at Ex. 1.

301. FTC Staff Opposes Proposed Indiana Hospital Merger, *supra* note 3; FTC Staff Reaffirm Opposition to Proposed Indiana Hospital Merger, *supra* note 3.

302. Letter from Todd Rokita, *supra* note 4.

303. IND. DEP'T OF HEALTH at n. 23, *supra* note 298; *Hearing on S.B. 119*, *supra* note 296 (expressing apprehension toward disallowing future COPA applications and discussing a willingness to amend the statute at a later date, allowing future COPA applications once another COPA is being pursued).

VII. RECOMMENDED COPA LAW PROVISIONS

A model COPA statutory scheme for state legislatures to enact will entail the core tenants found below.

A. Application

The information required in a COPA application should, at minimum, include the following:

1. General Information

- a. Name and contact information of all applying parties;³⁰⁴
- b. Description of the proposed cooperative agreement;³⁰⁵ and
- c. Geographic area(s) impacted.³⁰⁶

2. Public Benefit and Antitrust Justification

- a. Explanation of how the agreement improves quality of or access to health care;³⁰⁷
- b. Description of expected cost savings or efficiencies;³⁰⁸ and
- c. Demonstration that the likely benefits outweigh the potential harms to competition.³⁰⁹

3. Community Impact

- a. Public hearing and community input.³¹⁰

B. Approval

The supervising agency should be permitted to approve a COPA application only if specific factors consistent with its articulated state policy have been met. These factors should help the supervising agency determine whether the likely benefits outweigh any potential disadvantages resulting from the possible reduction in competition.³¹¹ Such factors may include the following:

304. *See, e.g.*, WYO. STAT. ANN. § 35-24-104(a) (2025).

305. *See, e.g.*, NEB. REV. STAT. § 71-7703 (2025); WIS. STAT. § 150.85(2) (2026).

306. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(e)(2)(B) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314A.056(b)(2) (2025).

307. *See, e.g.*, LA. STAT. ANN. § 40:2254.4(B) (2025).

308. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 314A.056(b)(3) (2025); W. VA. CODE § 16-29B-28(d)(3).

309. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(b) (2026).

310. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(d); W. VA. CODE § 16-29B-28(e) (2025).

311. *See e.g.*, TENN. CODE ANN. § 68-11-1303(e–g); NEB. REV. STAT. § 71-7706 (2025); W. VA. CODE § 16-29B-28(c); KAN. STAT. ANN. § 65-4957(a) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314.002(e)–(f).

1. *Enhancement of Quality of Health Care*,³¹²
2. *Access to Healthcare Services in Underserved or Rural Areas*,³¹³
3. *Gains in Cost Efficiency of Services*,³¹⁴
4. *Improvements in Population Health or Public Health Outcomes*,³¹⁵
5. *Avoidance of Duplication of Hospital Resources*,³¹⁶
6. *Improvements in Access to Care*,³¹⁷
7. *Extent of Reduction in Competition*,³¹⁸ and
8. *Impact on Pricing, Innovation, or Patient Choice*³¹⁹

C. Authorization

To ensure it meets the “clear articulation” test for *Parker* immunity, COPA laws should contain language expressly identifying the state policy intended to be advanced by COPAs. Washington’s introduction to its COPA laws³²⁰ may be the most comprehensive statutory language to emulate when the legislature’s intent is to address the needs of rural hospital markets. If the state would like to restrict its COPAs exclusively to rural hospitals, it should consider Texas’s statutory language.³²¹ If the state intends to allow COPAs for a purpose other than to address rural hospitals’ needs, it may look to West Virginia’s statutory provisions.³²²

D. Supervision

To ensure it meets the state-supervision requirement for *Parker* immunity, COPA laws should contain language granting the supervising agency the “power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.”³²³ The statute’s provisions should give a “realistic assurance” that the supervision will hold the hospital accountable to actually advancing the articulated state policy.³²⁴ Specifically, it should mandate the supervising agency “review the substance of the anticompetitive decision,”

312. See e.g., TENN. CODE ANN. § 68-11-1303(e)(1); NEB. REV. STAT. § 71-7706(2)(a); KAN. STAT. ANN. § 65-4957(e)(1).

313. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(g).

314. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(c); NEB. REV. STAT. § 71-7706(2)(c); KAN. STAT. ANN. § 65-4957(e)(3); TEX. HEALTH & SAFETY CODE ANN. § 314A.056(a)(1)(A).

315. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(f).

316. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(e); KAN. STAT. ANN. § 65-4957(e)(5); W. VA. CODE § 16-29B-28(f)(4)(G).

317. See e.g., W. VA. CODE § 16-29B-28(d)(2)(A); TEX. HEALTH & SAFETY CODE ANN. § 314A.056(a)(1)(A).

318. See, e.g., TENN. CODE ANN. § 68-11-1303(e)(3); KAN. STAT. ANN. § 65-4957(f).

319. See, e.g., TENN. CODE ANN. § 68-11-1303(e)(3)(C).

320. WASH. REV. CODE § 43.72.300(1)–(2) (2025). See *supra* Part V.B.1.

321. See TEX. HEALTH & SAFETY CODE ANN. § 314A.002 (2025). See *supra* Part V.B.1.

322. W. VA. CODE § 16-29B-28(c). See *supra* Part V.B.1.

323. N.C. State Bd. of Dental Exam’rs v. F.T.C., 574 U.S. 494, 507 (2015) (quoting *Patrick v. Burget*, 486 U.S. 94, 101 (1988)).

324. *Id.* at 497 (quoting *Patrick*, 486 U.S. at 100–01).

and grant the agency the authority to “veto or modify particular decisions to ensure they accord with state policy.”³²⁵ The drafters may also want to note that the agency has actual supervisory authority—not merely the potential for supervision.³²⁶

Every state ought to require the hospital submit a report on an annual or biannual basis.³²⁷ The state should include information similar to the information found in the COPA application. That way, the supervising agency can decide each year or every other year whether, by a showing of clear and convincing evidence, the COPA’s benefits are still likely to outweigh any disadvantages from any reduction in competition caused by the COPA.³²⁸

To help fund the supervision of a COPA, states should mimic Texas and charge the hospital an annual fee consistent with the reasonable costs the agency incurs from supervising the COPA.³²⁹ Like Tennessee, states may consider giving their supervising departments the right to periodically conduct onsite inspections of the COPA-holding hospital.³³⁰ For additional supervisory mechanisms, states may look to the FTC’s guidance on state-action supervision.³³¹

E. Termination

Much like Tennessee requires, states should mandate the hospital submit a “plan of separation” before the agency’s supervision of that COPA can be discontinued—which will only occur if the agency deems that the plan of separation is completed.³³²

VIII. CONCLUSION

Rural hospital closures and consolidations have garnered significant attention in recent years, and both scenarios pose significant access issues for patients in rural communities. Consolidation may prevent a hospital from closing, helping it achieve economies of scale and gain reimbursement-bargaining power. Consequently, though, patients may experience post-merger price increases. However, such anticompetitive effects do not occur because competition has been displaced, for competition is already nonexistent in most rural hospital markets; consolidation simply allows the

325. *Id.* at 515; *accord.* *Teladoc, Inc. v. Tex. Medical Bd.*, 2015 U.S. Dist. LEXIS 166754 at *8 (W.D. Tex. 2015) (holding that the state medical board failed to meet the supervision prong of the state-action doctrine because it did not have any veto or modification authority over the private party’s decisions).

326. *See Id.*

327. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(g) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314A.059.

328. TENN. CODE ANN. § 68-11-1303(g) (2025).

329. *See* TEX. HEALTH & SAFETY CODE ANN. § 314A.105 (assessing “an annual supervision fee in an amount that is at least \$75,000 but not more than \$200,000”).

330. Tenn. Comp. R. & Regs. R. 1200-038-01-.06(7) (2025).

331. *See generally*, FED. TRADE COMM’N, *supra* note 272.

332. TENN. CODE ANN. § 68-11-1303(g); *see also* TENN. CODE ANN. § 68-11-1306(b).

hospital to take advantage of its existing monopolistic position in the market. Therefore, using antitrust law to preclude M&A activity may prevent anticompetitive effects, but it does not drive competition. Thus, in rural hospital markets, antitrust enforcement does not engender the benefits of competition, and it does not lead to lower costs or higher quality.

While the FTC attempts to prevent consolidation in these markets, other federal policies incentivize consolidation—whether directly or indirectly. Because urban hospital markets can support multiple competitors, antitrust enforcement may lead to lower costs and higher quality in those markets. Conversely, though, rural hospital markets are typically home to one hospital, and they do not offer a high enough demand for would-be competitors to enter this market. Because no meaningful competition exists in most rural hospital markets, local healthcare providers' delivery of care is not currently being incentivized by competition. Thus, the quality of the care they deliver is not tied to the amount of competition they face. Likewise, their motivation to improve the quality of their care may not be diminished if their employer hospital consolidates. In fact, such consolidation may alleviate the hospital's financial distress, allowing more opportunities to invest in patient services rather than financial survival. To ensure such consolidation results in better care at lower cost for patients, states may use COPAs to supervise the hospital's post-merger conduct.

COPAs permit hospital consolidation, implement post-consolidation ongoing regulatory oversight, account for rural hospital markets' unique economic dynamics, and create a third option for rural hospitals that may be choosing between closing their doors or entering a merger that may lead to higher costs for their patients. Using COPAs is not an ideal or long-term solution, but rather, the most readily available and viable option for rural hospitals to avoid closure, receive the benefits of consolidation, and provide their patients with accessible health care. Therefore, to provide financially distressed, rural hospitals with this option, states should consider enacting COPA statutes.

Indiana Health Law Review

Volume XXIII

2026

Number 2

NOTES

SURROGACY: A LOOK INTO THE EXCLUSIONARY ADVANCES IN ASSISTED REPRODUCTIVE TECHNOLOGY

CATERINA CARESS*

I. INTRODUCTION

“Every time I got pregnant, I would look at the world with rose-colored glasses, and I would imagine what life was going to be like on the other side. And every time I lost a pregnancy, to have that taken away was so tough.”¹ This is the story of Rebecca Jarvis, ABC News’ Chief Business, Technology, and Economics Correspondent, who turned to surrogacy to grow her family after a demoralizing battle with infertility.² Rebecca is not alone in her story: it is estimated that between “8% and 12% of reproductive-aged couples worldwide struggle with infertility.”³ The percentage of married women struggling with infertility increased from 6.7% between 2011 and 2015 to 8.7% between 2015 and 2019.⁴ Couples dealing with infertility have higher instances of anxiety and emotional distress; in a study of 200 couples visiting a fertility clinic, approximately “half of the women and 15% of the men said that infertility was the most upsetting experience of their lives.”⁵ For many, infertility is only the beginning of a long and costly plight to have a family—one that often requires medical intervention and the use of Assisted Reproductive Technologies

* J.D. Candidate, 2026, Indiana University Robert H. McKinney School of Law. Caterina would like to thank Professor Aila Hoss, J.D., Brooke Salazar, J.D., Dr. Josefa Ippolito-Shepherd, her husband, and family for their invaluable feedback and support throughout the Note drafting and editing process, as well as the many researchers, doctors, and advocates supporting the advancement of Assisted Reproductive Technology.

1. *Rebecca Jarvis Opens up on Infertility and Surrogacy Journey to Becoming a Family of 4*, ABC NEWS (Nov. 29, 2023, 8:12 AM), <https://abcnews.go.com/GMA/Family/rebecca-jarvis-opens-infertility-surrogacy-journey-becoming-family/story?id=105214194> [<https://perma.cc/95RU-CJZY>].

2. *Id.*

3. Mélodie Vander Borgh & Christine Wyns, *Fertility and Infertility: Definition and Epidemiology*, 62 CLINICAL BIOCHEM, 2, 2–3 (2018), <https://www.sciencedirect.com/science/article/pii/S0009912018302200?via%3Dihub> [<https://perma.cc/XEF7-7TSS>].

4. Colleen N. Nugent & Anjani Chandra, *Infertility and Impaired Fecundity in Women and Men in the United States*, NAT’L HEALTH STAT. REPORTS (Apr. 24, 2024), <https://www.cdc.gov/nchs/data/nhsr/nhsr202.pdf> [<https://perma.cc/8V9U-RNS4>].

5. *Infertility and Mental Health*, CEDARS SINAI (Sep. 8, 2020), <https://www.cedars-sinai.org/blog/infertility-mental-health.html> [<https://perma.cc/UBX4-TTVZ>].

(“ART”) to start their family.

Luckily for many, recent advancements in the development of ARTs have made the impossible possible, given those unable to conceive naturally the ability to grow their family, and substantially reduced the biological constraints and fears felt by older-aged couples and post-menopausal women starting their family later in life.⁶ In 2021 alone, 86,146 infants, or 2.3% of all infants born in the United States were conceived through ART.⁷ Even with these advancements, when ART does not work and a woman is unable to carry her own child, she is left with two options: surrogacy or adoption. Adoption has long been the most accessible option for nontraditional couples and couples struggling with infertility, and although millions of couples are waiting to adopt in the United States, a vast majority of these individuals will not share a genetic link with their adoptive child.⁸ For many, surrogacy is their only remaining option if they want to build a family that shares their genetic identity.

Although federal and state regulations of ARTs have become more sophisticated to keep up with this growing demand, surrogacy is often excluded from these ART regulatory policies.⁹ It is advantageous for health insurers and employers to race to keep up with legislation and policies that address this growing market, yet no such shift has occurred.¹⁰ As surrogacy rates continue to rise, the need to enact comprehensive legislation and regulation will only become more necessary; this is a real, urgent problem that needs to be met with comprehensive legislation and regulation.

Why is there so much pushback to regulating surrogacy? Part II will discuss the modern usage, global regulation of, and risks accompanying ART; Part III will provide an overview of the surrogacy process, a discussion of the accompanying costs of domestic and international surrogacy, moral and ethical dilemmas, and seminal surrogacy legal cases; Part IV will provide an analysis of the current federal and state regulations of ART and the exclusion of surrogacy, the inconsistencies in current regulations, exclusionary health

6. Brittany Harrison et al., *Advanced Maternal Age: Ethical and Medical Considerations for Assisted Reproductive Technology*, INT’L. J. WOMEN’S HEALTH 561, 561–62 (2017), <https://pmc.ncbi.nlm.nih.gov/articles/PMC5566409/> [<https://perma.cc/D4H4-24CW>]; see also Sudhaa Sharma & Neelam Aggarwal, *In Vitro Fertilization in Older Mothers: By Choice or By Law?*, 7 J. MID-LIFE HEALTH 103, 103–04 (2016) (noting that by the time a woman is 30 years old she will have lost about 90% of her egg supply, and as she grows older, the risk for dangerous complications arising from birth and pregnancy increase significantly).

7. *Fact Sheet: In Vitro Fertilization (IVF) Use Across the United States*, U.S. DEP’T HEALTH AND HUM. SERV. (Mar. 13, 2024), <https://www.hhs.gov/about/news/2024/03/13/fact-sheet-in-vitro-fertilization-ivf-use-across-united-states.html> [<https://perma.cc/Z78Z-V4EZ>].

8. See *Shining a Light on Waiting Children and Aspiring Adoptive Families*, ADOPTION & BEYOND, <https://adoption-beyond.org/how-many-babies-in-america-are-waiting-to-be-adopted/> (last visited Nov. 21, 2024) [<https://perma.cc/BX9F-8FPJ>]; see also *Debating Between Adoption and Surrogacy? 5 Questions to Ask Yourself*, AM. ADOPTION NEWS (Nov. 11, 2019), <https://www.americanadoptions.com/blog/adoption-or-surrogacy/> [<https://perma.cc/XY6D-6PXG>].

9. See discussion *infra* Part III.A.

10. See discussion *infra* Part IV.C.

policies across private, public, and TRICARE insurance, the exclusionary tax policies that make surrogacy largely unaffordable and inaccessible, and the economic, human rights, and employer-employee implications that create an urgent need to regulate; and finally, Part V, will discuss a proposed pathway of changes to the law that will increase affordability and accessibility.

II. OVERVIEW OF ASSISTED REPRODUCTIVE TECHNOLOGY

A. Modern Usage of Assisted Reproductive Technology

ARTs are used to treat infertility and encompass a “range of medical procedures used to address infertility and assist individuals and couples in achieving pregnancy.”¹¹ ART treatments include fertility treatments handling both eggs and sperm, and involve removing eggs from the ovaries, mixing eggs and sperm to make embryos, and implanting embryos.¹² ART procedures often use donor eggs, donor sperm, previously frozen embryos, surrogates, or gestational carriers.¹³ The Centers for Disease Control and Prevention (“CDC”) reported that in 2021, over 238,000 patients had over 413,000 rounds of ART cycles performed across 453 reporting clinics in the United States, resulting in over 91,000 live births.¹⁴ Approximately 2.3% of all infants born in the United States annually are conceived using ART.¹⁵

IVF treatment is the most common and effective type of ART and involves laparoscopically retrieving female cells developing into an egg, fertilizing in vitro, and transferring embryos into the women’s uterus to carry and birth.¹⁶ It is believed that over 4,000,000 individuals have been born following IVF.¹⁷ Intrauterine Insemination (“IUI”) is another commonly used form of ART, and involves stimulating a woman’s ovaries for a more active production of eggs,

11. *Assisted Reproductive Technology*, MEDLINEPLUS, <https://medlineplus.gov/assisted-reproductivetechnology.html> [<https://perma.cc/R7FB-JKX7>] (last visited Nov. 21, 2024); Meaghan Jain et al., *Assisted Reproductive Technology (ART) Techniques*, NAT’L INST. HEALTH, <https://www.ncbi.nlm.nih.gov/books/NBK576409/> [<https://perma.cc/WDG7-FD55>] (last updated Dec. 13, 2025).

12. Meaghan Jain et al., *Assisted Reproductive Technology (ART) Techniques*, NAT’L INST. HEALTH, <https://www.ncbi.nlm.nih.gov/books/NBK576409/> [<https://perma.cc/WDG7-FD55>] (last updated Dec. 13, 2025); MEDLINEPLUS, *supra* note 11.

13. Jain et al., *supra* note 12; MEDLINEPLUS, *supra* note 11.

14. *ART Success Rates*, CDC, <https://www.cdc.gov/art/artdata/index.html> [<https://perma.cc/P2NX-EP2D>] (last visited Nov. 21, 2024).

15. *Id.*

16. Jain et al., *supra* note 12.

17. Press Release, The Nobel Prize, The Nobel Assembly at Karolinska Institute has today decided to award the Nobel Prize in Physiology or Medicine 2010 to Robert G. Edwards for the development of in vitro fertilization (Oct. 4, 2010), <https://www.nobelprize.org/prizes/medicine/2010/press-release/> [<https://perma.cc/2W5D-RUAV>]

and then injecting sperm into the uterus.¹⁸ Intracytoplasmic sperm injection (“ICSI”) involves injecting a single sperm into the egg and is often used in combination with IVF.¹⁹ Frozen embryo transfer (“FET”) is the process in which frozen embryos created during a previous IVF cycle are placed in a woman’s uterus.²⁰ These are all the most common forms of ART, but if a woman is unable to carry a pregnancy to term using these methods, gestational surrogacy is the only remaining option for those that are not interested in adoption.²¹

B. Risks of Assisted Reproductive Technologies

The use of ART does not come without risk associated with pregnancy, delivery, and childhood.²² Risks include hyper stimulation of ovaries, ovarian torsion, infection, bleeding, death, failure to conceive, multiple gestation, premature and “small for gestational age” infants, birth defects, later in life health risks for children born after ART, epigenetic imprinting disorders, risks from handling gametes and embryos, risks of culture, risks associated with cryopreservation, and gamete and embryo “mix ups.”²³ Sepsis, pre-eclampsia, hemorrhage, and maternal death are all risks associated with childbirth, and the hormonal changes faced after pregnancy exacerbate mental health conditions like postnatal depression or postnatal psychosis.²⁴

III. OVERVIEW OF SURROGACY

A. Surrogacy Process

Surrogacy is the process in which a gestational carrier, also known as a surrogate, carries and births the baby of a couple or individual, also referred to as intended parents.²⁵ There are two types of surrogacies: gestational and

18. Andrew J. Levi, *Overview of the Types of Assisted Reproductive Techniques (ART)*, PARK AVE. FERTILITY, <https://parkavefertility.com/overview-of-the-types-of-assisted-reproductive-techniques-art/> [https://perma.cc/GQJ5-8A9E] (last visited Nov. 21, 2024).

19. MEDLINEPLUS, *supra* note 11.

20. *Id.*

21. *Surrogacy*, YALE MED., <https://www.yalemedicine.org/conditions/gestational-surrogacy> [https://perma.cc/SH7H-EZMX] (last visited Oct. 13, 2024).

22. Robert W. Rebar, *What Are the Risks of the Assisted Reproductive Technologies (ART) and How Can They be Minimized?* 12 REPROD. MED. BIOLOGY 151, 151 (2013).

23. *Id.* at 152.

24. Lisa Roscoe, *Surrogacy — Wish Fulfillment or Exploitation?*, MATERNITY ACTION (Feb. 4, 2020), <https://maternityaction.org.uk/2020/02/surrogacy-wish-fulfilment-or-exploitation/> [https://perma.cc/W6EF-G2NV].

25. YALE MED., *supra* note 21.

traditional surrogacy.²⁶ In gestational surrogacy, embryos made of the sperm and egg of the intended parents are implanted into the surrogate's uterus through IVF for the surrogate to carry and deliver.²⁷ The fetus does not share any DNA with or relation to the surrogate. In traditional surrogacy, the surrogate is related to the fetus.²⁸ Here, the surrogate's own eggs are used to create the pregnancy that they then carry and deliver.²⁹ The surrogacy processes may be purely altruistic, where the surrogate mother is not paid for her services, or commercial, where the surrogate mother is compensated for her services.³⁰

To begin the surrogacy process, intended parents will generally work with a surrogacy agency to find a viable surrogate.³¹ Surrogate agencies generally have a rigorous screening process and strict standards around age, health, weight, pregnancy history, criminal history, financial stability, and medication use.³² Once a surrogate is identified, the contracting process begins.³³ Both the surrogate and the intended parents are represented by attorneys, and all negotiations are handled between their respective attorneys.³⁴

Surrogacy contracts generally address issues surrounding parental rights, custody issues, location of delivery, future contact between parties, insurance for both parties, control over medical decisions during the pregnancy, payment of medical bills and liability for medical complications, availability of medical history and personal medical information of the surrogate, intended parents presence during doctor's visits, financial considerations, and legal fees.³⁵ Intended parents and surrogate insurance policies are often evaluated at this point to ensure there is no lapse in coverage and that anticipated and unanticipated medical expenses will be covered.³⁶ Intended parents may also obtain the services of an escrow agent to facilitate payments to protect the relationship between the surrogate and intended parents if any issues arise.³⁷ Once the complexities of this phase of the process are decided, an embryo

26. *Gestational Surrogacy*, CLEVELAND CLINIC, <https://my.clevelandclinic.org/health/articles/23186-gestational-surrogacy> [<https://perma.cc/YB4P-HESK>] (last visited Oct. 13, 2024).

27. *Id.*

28. *Id.*

29. *Id.*

30. Brian Clowes & Marisa Cantu, *The Ethics of Surrogacy*, HUM. LIFE INT'L., <https://www.hli.org/resources/surrogacy-ethical-issues/> [<https://perma.cc/4EM8-D8TT>] (last updated June 5, 2023).

31. *See Parent Roadmap*, COLLECTIVE SURROGACY, <https://www.collectivesurrogacy.com/surrogacy-roadmap> [<https://perma.cc/F6WH-5YSW>] (last visited Nov. 21, 2024).

32. *Am I Eligible?*, COLLECTIVE SURROGACY, <https://www.collectivesurrogacy.com/am-i-eligible> [<https://perma.cc/5QHP-QN9R>] (last visited Nov. 21, 2024).

33. *Id.*

34. *Legal Aspects of Domestic Gestational Carrier Agreements*, RESOLVE, <https://resolve.org/learn/family-building-options/surrogacy/legal-aspects/> [<https://perma.cc/CA4Z-97W6>] (last visited Nov. 21, 2024).

35. *Id.*

36. *Id.*

37. *Id.*

transfer will be scheduled with the surrogate.³⁸ To reduce the resulting number of multiple pregnancies and maximize the number of resulting live births, IVF clinics are limited to transferring only one embryo per procedure.³⁹ Once a pregnancy is confirmed, parental oversight and involvement will vary, and it will generally follow guidelines set forth in the surrogacy contract.⁴⁰ Once a surrogate has completed the first trimester of pregnancy, or has reached the statutorily designated point in the pregnancy, intended parents will obtain a birth order.⁴¹ A birth order allows intended parents to establish the parentage of their child before they are even born.⁴² To file a pre-birth order, intended parents and surrogates must sign statements of parentage for the unborn baby and doctors must complete an affidavit stating they completed the embryo transfer.⁴³ If intended parents do not obtain a birth order, then one or both intended parents will be required to adopt the child.⁴⁴ Not all states allow intended parents to file a pre-birth order, and instead, may require the filing of a post-birth order.⁴⁵ Post-birth orders are generally filed three to five days after the birth of the child.⁴⁶ The birth of the child is dictated by a delivery plan, which is generally outlined in the surrogacy contract, or as a separate plan developed by the intended parents, surrogates, and the healthcare facility, and determines who will be allowed in the birthing chamber, who will cut the umbilical cord, and who will hold the baby first, amongst other things.⁴⁷ Once the child is born, the remaining phases of the surrogacy process are dictated heavily by state law.⁴⁸ Intended parents may have to file a birth certificate or post birth order establishing their parentage, request citizenship and obtain a passport for any child born abroad, or potentially complete an adoption.⁴⁹

38. *Id.*

39. *How Surrogacy Works: A Step-by-Step Guide*, SENSIBLE, <https://www.sensible-surrogacy.com/surrogacy-guide/how-does-surrogacy-work/#embryo-transfer> [https://perma.cc/T4K5-WJC9] (last visited Nov. 21, 2024); *Guidance on the Limits to The Number of Embryos to Transfer: A Committee Opinion (2021)*, ASRM, <https://www.asrm.org/practice-guidance/practice-committee-documents/guidance-on-the-limits-to-the-number-of-embryos-to-transfer-a--committee-opinion-2021/> [https://perma.cc/Y3BN-REBN] (last visited Mar. 8, 2025).

40. SENSIBLE, *supra* note 39; ASRM, *supra* note 39.

41. *How You Can Protect Your Parental Rights in Surrogacy*, AM. SURROGACY, <https://www.americansurrogacy.com/parents/pre-birth-orders> [https://perma.cc/T5GB-S8LE] (last visited Nov. 21, 2024).

42. *Id.*

43. RESOLVE, *supra* note 34.

44. *Id.*

45. AM. SURROGACY, *supra* note 41.

46. *Id.*

47. William Houghton, *How Does Surrogacy Work*, SENSIBLE, <https://www.sensible-surrogacy.com/surrogacy-guide/how-does-surrogacy-work/#embryo-transfer> [https://perma.cc/T4K5-WJC9] (last visited Nov. 21, 2024).

48. See discussion *supra* Part III.A; see discussion *infra* Part IV.B.

49. Houghton, *supra* note 47.

B. Cost of Domestic and International Surrogacy

In 2022, the global commercial surrogacy industry was valued at approximately \$14 billion and is projected to rise to \$129 billion by 2032.⁵⁰ Even with this increased market capitalization, the surrogacy process remains largely unaffordable for Americans. A complete surrogacy process may cost as much as \$200,000, reflecting \$20,000 to \$80,000 for medical expenses, \$3,000 to \$15,000 for legal support, \$6,000 to \$54,000 for surrogacy recruiting programs, and \$20,000 to \$55,000 for carrier compensation.⁵¹ The median household income of all households in the United States in 2024 was \$83,730, which does not come close to covering the full cost of the surrogacy process and makes this largely unaffordable without additional assistance.⁵² Many intended parents must rely on medical insurance coverage and tax reimbursement to cover the remaining financial obligations imposed, and if that is not enough, may only be able to afford to hire an international surrogate from a lower-cost country, which creates an additional set of risks.⁵³

The increased costs of domestic surrogacy have led to an increase in international surrogacy births, so much so, that it is believed that approximately 20,000 children are born through the international surrogacy market annually.⁵⁴ Ukraine, Georgia, Mexico, the Philippines, and Colombia are several of the most popular international markets for surrogacy.⁵⁵ In Ukraine, a full surrogacy process costs between \$40,000 to \$65,000.⁵⁶ Gestational surrogacy is limited to married heterosexual couples, and the embryos must be produced using the sperm of the intended father and the eggs of the intended mother.⁵⁷ In Georgia,

50. Lauren Danielowski, *Reproduction as Work: Addressing a Gap in Current Economic Rights Discourses*, 25 HEALTH & HUM. RTS. J. 2, 29 (2023); Karen Gilchrist, *The Commercial Surrogacy Industry Is Booming as Demand for Babies Rises*, CNBC (Mar. 7, 2023, 1:37 AM), <https://www.cnbc.com/2023/03/07/womb-for-rent-more-women-are-working-in-commercial-surrogacy-industry.html> [<https://perma.cc/SDF7-ZLUJ>].

51. Pedro Brandao & Nicolás Garrido, *Commercial Surrogacy: An Overview*, 44 REV. BRAS. GYNECOL. OBSTET. 1141, 1142 (2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9800153/> [<https://perma.cc/H82E-F6YS>].

52. MELISSA KOLLAR & ZACH SCHERER, INCOME IN THE UNITED STATES: 2024 45 (U.S. CENSUS BUREAU, Sep. 2025), <https://www2.census.gov/library/publications/2025/demo/p60-286.pdf> [<https://perma.cc/AS49-KVKF>] (noting that the median household income amount reflects an aggregate composed of family households comprised of married-couple households, female householders with no spouse present households, male householders with no spouse present households, and female and male nonfamily households).

53. See discussion *infra* Parts IV.C, V.B.

54. *International Surrogacy—Call for Action by the International Social Service Network*, INT’L SOCIAL SERV. U.S., <https://www.iss-usa.org/international-surrogacy-call-for-action-by-the-international-social-service-network/> [<https://perma.cc/9MHP-2CWN>] (last visited Nov. 21, 2024).

55. *Best Countries for Surrogacy: All that Intended Parents Need to Know*, INT’L FERTILITY GROUP BLOG, <https://ifg-ivf.com/blog/best-countries-for-surrogacy-all-that-intended-parents-need-to-know.html> [<https://perma.cc/VPJ2-R36P>] (last visited Nov. 21, 2024).

56. *Id.*

57. *Id.*

a full surrogacy process may cost between \$30,000 to \$60,000, and a standard process encompasses surrogate selection, medical procedures, legal assistance, and ongoing support in one location, making it easier, more streamlined, and affordable for intended parents.⁵⁸ In Mexico, surrogacy costs range between \$40,000 to \$60,000, is available to everyone, and does not restrict homosexual couples or single intended parents.⁵⁹ As domestic costs increase, the international surrogacy market is becoming an increasingly cost-effective option.

C. Moral and Ethical Dilemmas

There is a whirlwind of controversy surrounding the moral and ethical implications of surrogacy. Many oppositionists to surrogacy believe that surrogacy commodifies women's bodies, exploits women, poses unnecessary health risks, infringes upon bodily autonomy, and is a form of "reproductive prostitution."⁶⁰ There is often a socioeconomic inequality between surrogate mothers and intended parents, who are often wealthier, have advanced education, and have higher status careers.⁶¹ Many of the women in surrogacy arrangements are vulnerable and not well-educated, and because of this, may not have proper informed consent.⁶²

In countries like China, where surrogacy is strictly prohibited, surrogates can be bound to contractual obligations that infringe upon their rights and put them at risk for physical injury.⁶³ Since the enactment of heightened restrictions in China, there have been increased instances of illegal black market surrogacy operations that have perpetuated child trafficking operations and exploited women for profit.⁶⁴ India was also once a booming surrogacy market, but in 2016, legislators passed sweeping legislation that made commercial surrogacy

58. *Id.*

59. *See How Much does Gestational Carrier Cost in Mexico*, CAREM SC, <https://carem.mx/en/how-much-does-gestational-carrier-cost-in-mexico/> [https://perma.cc/7RNZ-6PU5] (last visited Mar. 4, 2026); *see also Surrogacy Program Cost in Mexico*, NEWLIFE MEXICO, <https://www.newlifemexico.net/surrogacy-program-cost-mexico/> [https://perma.cc/SXS4-M8LF] (last visited Mar. 4, 2026).

60. *Understanding Surrogacy Controversy: What's The Big Deal?*, AM. SURROGACY BLOG (Sep. 10, 2018), <https://www.americansurrogacy.com/blog/understanding-surrogacy-controversy-whats-the-big-deal/> [https://perma.cc/3DB3-GGUU]; Sneha Singh, *Who Do You Belong To? Bodily Autonomy Violations and Health Risks During Surrogacy*, FEM LENS BLOG (June 8, 2022), <https://femlens.com/blog-post/who-do-you-belong-to-bodily-autonomy-violations-and-health-risks-during-surrogacy/> [https://perma.cc/CX3E-EMDP]; Clowes & Cantu, *supra* note 30.

61. Roscoe, *supra* note 24.

62. Singh, *supra* note 60.

63. Yue Zhao, *Protection of Rights and Legal Remedies for Surrogate Mothers in China*, HUMAN. & SOC. SCI. COMM'N (2023), <https://www.nature.com/articles/s41599-023-02370-x> [https://perma.cc/YZ9E-2W8K].

64. Zhang Long, *Qingdao Authorities to Probe Claims of Illegal Surrogacy Operation*, SHINE (Aug. 29, 2024, 10:45 PM), <https://www.shine.cn/news/nation/2408293138/> [https://perma.cc/J5FF-YG8W].

illegal, requiring surrogates to be close relatives to the intended parents and banning foreigners and non-resident Indians from seeking surrogate mothers in India.⁶⁵ This legislation was enacted largely to prevent and address the exploitation of surrogate mothers.⁶⁶ So, while regulating surrogacy has many positive effects, it does not completely prevent the exploitation of surrogates, and in some cases, perpetuates this exploitation.

Proponents of surrogacy claim that surrogacy has the opposite effect: that it serves as a vehicle for impoverished women to lift themselves out of poverty.⁶⁷ In a study published by the National Institute of Health (“NIH”) evaluating the social paradoxes of commercial surrogacy in developing countries, it was found that women in India often decided with their husbands whether to become a surrogate, and the primary intention was to improve the socioeconomic condition of the family.⁶⁸ Surrogacy allowed women to work in better conditions than would otherwise be unavailable to them.⁶⁹ So, for those parents whose only remaining option is to utilize an international surrogate, their journey towards building a family will likely be impeded by a plethora of moral, ethical, and legal obstacles and risks.

IV. ANALYSIS OF CURRENT SURROGACY REGULATIONS

The growing infertility industry has become one of the most heavily regulated industries, with regulations spanning across federal and state levels that regulate every facet of the process.⁷⁰ Even with this increased prominence, surrogacy is still not explicitly regulated under these frameworks and is often excluded from any form of comprehensive regulation.⁷¹

A. Federal Regulation of Assisted Reproductive Technology and the Exclusion of Surrogacy

Clinics and physicians providing ART services are bound by federal

65. Vaibhav Tiwari, *Surrogacy Regulation Bill Passed In Lok Sabha: 10 Points*, NDTV (Dec. 19, 2018, 7:34 PM), <https://www.ndtv.com/india-news/surrogacy-regulation-bill-passed-in-lok-sabha-10-points-1965215> [<https://perma.cc/76UN-8JN2>].

66. Bronwyn Parry & Raki Ghoshal, *Regulation of Surrogacy in India: Whenceforth Now?* BMJ GLOB. HEALTH (Oct. 8, 2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC6195148/> [<https://perma.cc/5FYJ-6LPR>].

67. *Id.*

68. Virginie Rozée et al., *The social paradoxes of commercial surrogacy in developing countries: India before the new law of 2018*, BMC WOMEN'S HEALTH (Oct. 15, 2020), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7559454/> [<https://perma.cc/XFW7-JH8B>].

69. *Id.*

70. *Oversight of Assisted Reproductive Technology*, ASRM, <https://www.asrm.org/advocacy-and-policy/media-and-public-affairs/oversite-of-art/> [<https://perma.cc/C94M-5A83>] (last visited Nov. 21, 2024).

71. *Id.*

guidelines to maintain federal licensing.⁷² The Fertility Clinic Success Rate and Certification Act mandates that clinics performing ART provide data for all procedures performed to the CDC.⁷³ The Food and Drug Administration (“FDA”) regulates drugs and devices used in IVF and other ART processes.⁷⁴ If a patient undergoing ART treatment uses donor gametes, then the tissues used are subject to heightened FDA screening.⁷⁵ The Clinical Laboratory Improvement Act sets federal standards for facilities or sites that test human specimens, including the facilities used in ART processes, and the College of American Pathologists, the American Board of Obstetrics and Gynecology, and the American Board of Urology set ethical guidelines and membership requirements for physicians providing ART treatment and services.⁷⁶ Still, even with such heightened scrutiny and strict guidelines, there is one common thread amongst these regulations: surrogacy is noticeably absent.

There have been multiple attempts to pass federal surrogacy legislation, several of which have recently been introduced to the United States House of Representatives (“the House”) and died in committee. The “Preventing Forced Abortions Act of 2024” was introduced to the House on July 10, 2024, and if it becomes law, will limit the enforceability of any clauses in a surrogacy contract that requires a surrogate mother to have an abortion at the request of any intended parent, agent, or party of the surrogacy contract from being enforced in federal court.⁷⁷ On July 20, 2021, the Support Through Loss Act was introduced to the Senate Health, Education, Labor, and Pensions committee, and if it becomes law, will allow Americans to receive paid leave following a pregnancy loss, failed surrogacy arrangement, or a “diagnosis or event that impacts pregnancy or fertility.”⁷⁸

On June 27, 2023 the Equal Access to Reproductive Care Act was introduced to the House of Representatives, and if it becomes law, will amend §213(d) of the Internal Revenue Code (“IRC”) to include “traditional reproductive surrogacy” and “gestational reproductive surrogacy” in the definition of “Assisted Reproduction.”⁷⁹ It will also expand the “coverage of surrogacy” definition to include intended parents by incorporating “. . . intends

72. *Policy Documents: The Fertility Clinic Success Rate and Certification Act*, CDC, <https://www.cdc.gov/art/nass/policy.html> [<https://perma.cc/RQ8N-8ZP9>] (last visited Nov. 21, 2024); see *Clinical Laboratory Improvement Amendments*, CDC, <https://www.cdc.gov/clia/php/about/index.html> [<https://perma.cc/B3RY-NLCC>] (last visited Nov. 21, 2024); see also ASRM, *supra* note 70.

73. See Fertility Clinic Success Rate and Certification Act of 1992, H.R. 4773, 102nd Cong. (1992); see also *Policy Documents: The Fertility Clinic Success Rate and Certification Act*, *supra* note 72.

74. ASRM, *supra* note 70.

75. *Id.*

76. See 42 U.S.C. § 201 *et seq.*; *Clinical Laboratory Improvement Amendments*, *supra* note 72; ASRM, *supra* note 70.

77. Preventing Forced Abortions Act of 2024, H.R. 8985, 118th Cong. (2024).

78. Support Through Loss Act, S.2390, 117th Cong. (2021).

79. Equal Access to Reproductive Care Act, H.R. 4391, 118th Cong. (2023).

to take legal custody or responsibility for any children born as a result of such assisted reproduction.”⁸⁰ These pieces of legislation have not advanced past committee review since initially being introduced.

Additionally, The Model Uniform Parentage Act (“UPA”) was modified in 2017 and has been enacted in California, Washington, and Vermont.⁸¹ Although the UPA has not been enacted uniformly across the United States, it serves as a guide to ensure consistent results across states and limit forum shopping for favorable state laws.⁸² The UPA rules have evolved to provide safeguards of protection for gestational and genetic surrogacy arrangements, guidelines for surrogacy agreements and practice, and protections for genetic surrogates to withdraw consent.⁸³

B. Inconsistent State Regulation

Because surrogacy is not regulated at the federal level, the states have borne the burden of regulating surrogacy, and that regulation is inconsistent at best.⁸⁴ The legality of surrogacy, surrogate contract enforceability, compensation, and the process of establishing parentage with the court are key issues that vary significantly at the state level.⁸⁵

California, Connecticut, Washington, D.C., Delaware, Maine, New Hampshire, Nevada, Rhode Island, Vermont, and New Jersey are the most surrogate friendly states.⁸⁶ Generally, in these states, surrogacy is legal, pre-birth orders are granted throughout the state, and both parents will be named on the birth certificate.⁸⁷ California surrogacy rules have largely been established by precedent.⁸⁸

Calvert v. Johnson and *Buzzanca v. Buzzanca*, two cases argued in the state of California where surrogates challenged the parental rights of the intended parents to a surrogate-born child have held that the determination of parentage

80. Equal Access to Reproductive Care Act, H.R. 4391, 118th Cong. (2023).

81. Susan L. Crockin et al., *Legal Principles and Essential Surrogacy Cases Every Practitioner Should Know*, 113 FERTILITY AND STERILITY 908, 909 (2020); UNIFORM PARENTAGE ACT (UNIF. L. COMM’N 2017); CAL. FAM. CODE §§ 7600–7606 (2020); WASH. REV. CODE § 26.26A.001 et seq. (2019); VT. STAT. ANN. tit. 15C, § 101 et seq. (2018).

82. Jhonell Campbell, *Gestational Surrogacy Contract Terms Under the 2017 Uniform Parentage Act*, 9 CHILD & FAM. L.J. 3, 4–5 (2021).

83. UNIFORM PARENTAGE ACT (UNIF. L. COMM’N 2017).

84. *What does SCOTUS’s “Chevron Deference” Ruling Mean for the Future of Federal Reproductive Rights?*, CTR. FOR REPROD. RTS., <https://reproductiverights.org/scotus-chevron-deference-reproductive-rights/> [<https://perma.cc/UX7W-MX6H>] (last visited Sep. 9, 2024).

85. *Id.*

86. *US Surrogacy law Map by State*, SURROGATE FIRST, <https://surrogatefirst.com/for-intended-parents/us-surrogacy-law-map/> [<https://perma.cc/NKT6-J2W4>] (last visited Nov. 21, 2024).

87. *Id.*

88. *What you Need to Know About Surrogacy Laws in California*, AM. SURROGACY, <https://www.americansurrogacy.com/surrogacy/california-surrogacy-laws> [<https://perma.cc/HQT3-25PH>] (last visited Nov. 21, 2024); see *infra* notes 89–91 and accompanying text.

in gestational surrogacy is guided by intent of the parties.⁸⁹ Additionally, in January 2013, California Family Code § 7960 went into effect, permitting and legalizing surrogacy.⁹⁰ This codifies the requirements parties must follow when entering a surrogacy arrangement, sets forth disclosure requirements and mandatory provisions that must be included in surrogacy agreements, and provides guidelines for establishing parentage.⁹¹

Thirty-two states are viewed as surrogate friendly, where surrogacy is legal, but pre-birth orders vary in their availability and additional post-birth legal procedures may be required.⁹² In 2021, New York enacted the New York State Child-Parent Security Act, which legalizes gestational surrogacy and establishes legal criteria for gestational surrogacy agreements to protect both the surrogates and intended parents.⁹³ In Maryland, gestational surrogacy is permitted, but surrogacy contracts that involve the payment of a fee to the birth mother are illegal and unenforceable, and the decision to grant adoption is based on the best interest of the child.⁹⁴

Five states are generally not favorable to surrogacy and have incredibly complex processes.⁹⁵ In these states, surrogacy is legal, but pre-birth orders are generally unavailable and pose a slew of legal issues, and surrogate contracts are void and unenforceable.⁹⁶ In Arizona, gestational surrogacy is expressly prohibited by the Arizona Revised Statute §25-218, which also makes surrogacy contracts unenforceable.⁹⁷ In Indiana, gestational surrogacy is prohibited, making surrogate contracts void, unenforceable, and against public policy.⁹⁸ Gestational surrogacy still exists in Indiana, and many jurisdictions within the state will grant pre-birth orders.⁹⁹ This inconsistency adds a layer of complexity and confusion for intended parents and surrogate mothers, which ultimately may

89. AM. SURROGACY, *supra* note 88.

90. CAL. FAM. CODE § 7960 (2013).

91. *Id.*

92. SURROGATE FIRST, *supra* note 86 (highlighting that Alabama, Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Maryland, Minnesota, Missouri, Mississippi, Montana, North Carolina, North Dakota, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Wisconsin, and West Virginia are considered surrogacy friendly states).

93. *The New York State Child-Parent Security Act: Gestational Surrogacy*, N.Y. STATE DEP'T OF HEALTH, <https://www.health.ny.gov/community/pregnancy/surrogacy/> [<https://perma.cc/S2WL-7N3D>] (last visited Oct. 12, 2024).

94. *Gestational Surrogacy Regulations in Maryland*, GO STORK, https://www.gostork.com/us_state/maryland/ [<https://perma.cc/FNW4-98SW>] (last visited Jan. 6, 2026).

95. SURROGATE FIRST, *supra* note 86 (highlighting that Idaho, Indiana, Tennessee, Virginia, Arizona, and Wyoming are states that have policies that are not favorable for surrogacy).

96. *Id.*

97. *Gestational Surrogacy Regulations in Arizona*, GO STORK, https://www.gostork.com/us_state/arizona/ [<https://perma.cc/Q4MH-HLME>] (last visited Oct. 10, 2024); ARIZ. REV. STAT. § 25-218 (2024).

98. *Gestational Surrogacy Regulations in Indiana*, GO STORK, https://www.gostork.com/us_state/indiana/ [<https://perma.cc/69DV-WUX5>] (last visited Oct. 10, 2024); *see also* IND. CODE § 31-20-1-1 (2024).

99. GO STORK, *supra* note 98.

lead to abuse or further issues throughout the surrogacy process.

Louisiana is the least surrogate-friendly state; commercial surrogacy is outright prohibited, all parties to an unsanctioned surrogacy arrangement may be subject to civil and criminal penalties, and surrogacy is limited to only heterosexual married couples.¹⁰⁰ Surrogacy Bill HB 1002, enacted on August 1, 2016, “restricts gestational surrogacy to heterosexual married couples using their own gametes and places onerous requirements on surrogacy arrangements . . . [such as a] no compensation requirement.”¹⁰¹ Under Louisiana law, contracts to compensate a traditional surrogate are contrary to public policy, and thus, are void and unenforceable.¹⁰² Married heterosexual couples using their own egg and sperm may only be declared legal parents in a pre-birth order if they have “[both] been residents of Louisiana for at least [six] months, surrogacy is medically necessary, and [the gestational carrier] is not paid compensation . . . [additionally] court approval prior to embryo transfer is required.”¹⁰³ Because of this restrictive policy, intended parents are unable to obtain an adoption order if they bear no genetic relation to the surrogate-born child, and unmarried couples, homosexual couples, or couples who require the use of donor eggs and sperm are completely restricted from using surrogacy as a form of ART.¹⁰⁴

Similarly to Louisiana, Michigan was once one of the most unfavorable states for surrogacy, but with the recent enactment of the Assisted Reproduction and Surrogacy Parentage Act, Michigan has become a model for how impactful proper regulation may be to intended parents. Under new regulation, gestational surrogacy is permitted and the “intended parents [are recognized] as the resulting child’s sole legal parents.”¹⁰⁵ Prior to the enactment of this Act, a couple was once forced to adopt their twins born by surrogate after a judge denied them parental rights simply because the twins had been carried by a surrogate.¹⁰⁶ Michigan law did not view the intended parents as the legal parents, and required the twin’s birth certificates to list the names of the surrogate parents instead of the intended parents, even though the couple and the couple’s fertility doctor stated in an affidavit that the intended parents were the biological parents of the twins born via surrogacy.¹⁰⁷ The couple had to go through the costly adoption process that entailed visits from social workers, intrusive questions

100. *Gestational Surrogacy in Louisiana*, CREATIVE FAM. CONNECTIONS, <https://www.creativefamilyconnections.com/us-surrogacy-law-map/louisiana/> [https://perma.cc/W5PZ-UZLQ] (last visited Nov. 21, 2024).

101. *Id.*

102. LA. REV. STAT. § 9:2713 (2023), *amended by*, LA. REV. STAT. § 9:2720 (2025).

103. LA. REV. STAT. § 9:2720 *et seq.*; CREATIVE FAM. CONNECTIONS, *supra* note 100.

104. CREATIVE FAM. CONNECTIONS, *supra* note 100.

105. MICH. COMP. LAWS § 722.1701 *et seq.* (2025); *Gestational Surrogacy in Michigan*, CREATIVE FAM. CONNECTIONS, <https://creativefamilyconnections.com/us-surrogacy-law-map/michigan/> [https://perma.cc/Z753-RV2K] (last visited Jan. 6, 2026).

106. See Maria Cramer, *Couple Forced to Adopt Their Own Children After a Surrogate Pregnancy*, N.Y. TIMES (Jan. 31, 2021), <https://www.nytimes.com/2021/01/31/us/michigan-surrogacy-law.html> [https://perma.cc/8WM2-DKNK].

107. *Id.*

about their upbringing and approach to parenting, fingerprinting, and criminal background checks; essentially, these parents had to prove that they were fit to adopt their own child.¹⁰⁸ Since the passage of the Assisted Reproduction and Surrogacy Parentage Act, parents will no longer have to go through this long, demoralizing, and expensive process. Michigan serves as a model for change that many non-surrogate friendly states may emulate.

C. Exclusionary Health Insurance Policies

While states are making leaps and bounds in their regulations of various forms of ART, there is a jarring gap in the coverage of surrogacy; no state expressly requires surrogacy procedures to be covered by private insurance providers or employers, and any insurance providers that do provide surrogacy coverage, do so voluntarily.¹⁰⁹ Surrogacy is the black sheep of the ART industry, and is consistently excluded in legislation and actions that regulate other forms of ART and pregnancy-related activities.

1. Private Health Insurance

Private insurance companies generally do not cover the cost of surrogacy, embryo transfers, or any corresponding fertility treatments.¹¹⁰ These plans may offer a benefit allowing coverage for freezing and retrieving eggs, but that benefit does not extend to cover the cost of donated eggs, and artificial insemination may only be covered if the surrogate is using a combination of her own eggs with the genetic father's sperm.¹¹¹ Private insurance companies may even include a clause in their insurance policy that excludes medical coverage for surrogate pregnancies, but if this is not included, they are required to cover the costs as they normally would if it were a traditional pregnancy, excluding companion fertility treatments.¹¹² ART and surrogacy coverage is now a premium benefit that is used to attract and retain top employees. Starbucks, Walmart, Adobe, American Express, Bain and Company, Bank of America, Google, and The Walt Disney Company are amongst a growing list of companies that have realized the value of including fertility coverage into their portfolio of employee benefits.¹¹³ Starbucks offers \$25,000 for IVF, \$10,000 for

108. *Id.*

109. *Medical Insurance for the Surrogate*, SENSIBLE, <https://www.sensible-surrogacy.com/find-insurance-for-surrogate-mother-in-the-us/> [<https://perma.cc/UEC7-89AC>] (last visited Nov. 21, 2024).

110. *Id.*

111. *Id.*

112. *Id.*

113. Kassi Strong, *15 Companies That Offer Fertility Benefits, and What You Need to Know About Each*, RESCRIPTED (Dec. 4, 2022), <https://rescripted.com/posts/15-companies-that-offer-fertility-benefits> [<https://perma.cc/BT3R-653B>].

IVF-related medications, and \$10,000 for surrogacy and adoption.¹¹⁴ Walmart has partnered with Kindbody, a clinic system that provides IVF, surrogacy, and adoption assistance, and offers employees \$20,000 for IVF, surrogacy, and adoption, and \$10,000 for IVF-related medications.¹¹⁵ Adobe heavily subsidizes the cost of surrogacy and offers a \$60,000 lifetime coverage for fertility services.¹¹⁶

Several states have enacted laws that require private insurers to provide IVF and fertility preservation coverage.¹¹⁷ In California, large group insurers with more than 100 employees are required to provide coverage for the diagnosis and treatment of infertility and fertility services, including IVF.¹¹⁸ Arkansas has enacted laws that require all individual and group insurance policies that provide maternity benefits to cover IVF.¹¹⁹

Louisiana and Montana have passed laws that require private insurance providers to provide fertility preservation coverage and some infertility coverage.¹²⁰ Louisiana requires private health coverage plans include coverage for standard fertility preservation services for covered individuals who have been diagnosed with cancer and whose treatments may directly or indirectly cause iatrogenic infertility.¹²¹ Texas has passed laws that requires group insurers to offer coverage for IVF, and employers may choose whether or not to include infertility coverage as part of their employee health benefit package.¹²² Oklahoma and Kentucky have passed laws that require private insurance plans to provide coverage for standard fertility preservation services.¹²³ Oklahoma recently passed legislation that went into effect on January 1, 2025, that requires any health benefit plan to provide coverage for standard fertility preservation services to covered individuals diagnosed with cancer when a medically necessary treatment may directly or indirectly cause iatrogenic infertility.¹²⁴

None of these state laws apply to medical plans protected under the Employee Retirement Income Security Act of 1974 (“ERISA”) or self-insured

114. *Id.*

115. *Id.*

116. *Id.*

117. *Insurance Coverage by State*, RESOLVE, <https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/> <https://perma.cc/D4VN-95ZR> (last updated Sep. 30, 2024) (highlighting California, Utah, Colorado, Illinois, Maryland, Delaware, New Jersey, New York, Connecticut, Massachusetts, Rhode Island, New Hampshire, and Maine’s policies).

118. *Id.*

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

plans.¹²⁵ ERISA was established to protect individuals enrolled in private health plans by setting minimum standards of protection.¹²⁶ ERISA does not cover plans managed by government entities, religious organizations, or plans maintained solely to comply with laws pertaining to workers compensation, unemployment, or disability.¹²⁷ A recent example is California's recent passage of Senate Bill 729, which requires fully insured, large group health plans to provide coverage for infertility and fertility diagnosis and treatment.¹²⁸ Under ERISA, religious employers, self-funded ERISA plans, and small group plans are exempt from this coverage mandate.¹²⁹

2. Public Health Insurance

Medicare and Medicaid are two public health insurance programs available to Americans and are managed by the Centers for Medicare and Medicaid Services.¹³⁰ Medicare was created in 1965 by Title XVIII of the Social Security Act and provides federal health insurance to the elderly and disabled.¹³¹ Individuals who have paid into the Social Security system for a total of ten years are aged sixty-five and older, are disabled and eligible for Social Security benefits, or have end-stage renal disease, which is permanent kidney failure requiring dialysis or transplant, may qualify for Medicare.¹³² Medicaid was created in 1965 under Title XIX of the Social Security Act, was designed to provide publicly funded healthcare for low-income children and adults, and is co-administered by the states and federal government.¹³³ Medicaid coverage has been expanded to cover low-income pregnant women, the disabled, dependent children and their mothers, and beneficiaries who are not eligible for any cash assistance program, so long as they meet the federally required minimum

125. See Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.*; see also *ERISA*, U.S. DEPT. OF LAB., <https://www.dol.gov/general/topic/health-plans/erisa> [<https://perma.cc/25ER-F922>] (last visited Mar. 6, 2025). Even if a state enacts legislation that requires all employers to cover IVF procedures, ERISA may block states from requiring certain plans to meet this requirement, as “self-insured ERISA plans are not required to provide coverage for state-mandated benefits, such as coverage of mammograms or Pap smears,” and in this case, IVF or surrogacy coverage. *ERISA PLANS*, KFF 61–62, <https://www.kff.org/wp-content/uploads/sites/3/2015/06/c111.pdf> [<https://perma.cc/YN9A-TDWD>] (last visited Mar. 2, 2026).

126. *Id.*

127. *Id.*

128. Jesse Hansen, *IVF Treatment Coverage Mandates: A State-by-State Breakdown*, ONEDIGITAL (Oct. 10, 2024), <https://www.onedigital.com/blog/ivf-coverage-by-state/> [<https://perma.cc/8DWJ-DX2Z>].

129. *Id.*

130. COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, OVERVIEW OF PUBLIC HEALTH INSURANCE PROGRAMS 153–58 (Nat'l Acad. of Sci., 2022), <https://www.ncbi.nlm.nih.gov/books/NBK221009/> [<https://perma.cc/R68L-PVK9>] [hereinafter Nat'l Acad. of Sci.].

131. *Id.* at 153; see also 42 U.S.C. § 1395 *et seq.*

132. *Id.*

133. *Id.*; 42 U.S.C. § 1396 *et seq.*

standards.¹³⁴ The federally required minimum standards allow Medicaid enrollment for individuals that have children under the age of six, are pregnant women whose family income is below 133% of the federal poverty level, and children ages 6–18 with family incomes below 100% of the federal poverty level.¹³⁵ States set income standards for adults without children, and parents of children are categorically eligible if they meet income and asset tests.¹³⁶ Indiana sets a monthly income limit of \$4,055 for a family of five and a monthly income limit of \$6493.45 for pregnant individuals.¹³⁷ The Affordable Care Act (“ACA”) is the seminal piece of healthcare legislation that has expanded access to affordable healthcare to all Americans.¹³⁸ The ACA made sweeping reforms to the healthcare and health insurance industry, and established regulatory requirements to the individual and family health insurance market, expanded Medicaid to cover low-income adults, established an individual mandate and employer mandate and penalty, and established premium subsidies and cost-sharing reductions available in the health insurance exchange and Marketplace for individuals with self-funded coverage.¹³⁹

While these federally subsidized programs have drastically broadened access to healthcare, they provide an antiquated approach to covering ART technology and outright fail to include surrogacy in their protections. No Medicaid program covers artificial insemination or in-vitro fertilization, and most Medicaid recipients pay out of pocket for fertility treatments.¹⁴⁰ Surrogates’ income generally precludes them from qualifying for many forms of public assistance, such as Medicaid.¹⁴¹ Medicare may cover certain doctor’s visits, outpatient care, medical supplies, and some medically necessary fertility treatments, but will not cover IVF or surrogacy.¹⁴²

The ACA requires health insurers in the Marketplace to include maternity

134. Nat’l Acad. of Sci., *supra* note 130.

135. *Id.*

136. *Id.*

137. *Eligibility Guide*, IND. MEDICAID FOR MEMBERS, https://www.in.gov/medicaid/members/apply-for-medicaid/eligibility-guide/#Pregnant_Individuals [https://perma.cc/C9E4-ND5N] (last visited Nov. 21, 2024).

138. Elizabeth Davis, *The Difference Between Medicaid and Obamacare*, VERYWELL HEALTH, <https://www.verywellhealth.com/whats-the-difference-between-medicaid-obamacare-1738843> [https://perma.cc/3FUA-5C4M] (last updated Sep. 15, 2024).

139. *Id.*

140. Gabriela Weigel et al., *Coverage and Use of Fertility Services in the U.S.*, KFF (Sep. 15, 2020), <https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/> [https://perma.cc/S2YJ-29RM].

141. *The Surrogacy Source: Can I be on Public Assistance & Become A Gestational Surrogate?*, FERTILITY SOURCE COS. (Feb. 17, 2016), <https://www.fertilitysourcecompanies.com/blog/the-surrogacy-source-can-i-be-on-public-assistance-and-become-a-gestational-surrogate> [https://perma.cc/7TVM-H5Z7].

142. *Does Medicare Cover Fertility Treatments?*, MEDICARE.ORG <https://www.medicare.org/articles/does-medicare-cover-fertility-treatments/> [https://perma.cc/WQA3-Z68D] (last visited Nov. 22, 2024).

care, which generally includes surrogacy.¹⁴³ Many of the policies that include surrogacy are costly and can cost upwards of \$600 per month, and must be purchased during an open enrollment period in November and December.¹⁴⁴ If individuals plan to enroll outside of the open enrollment period, they must purchase policies on the open market, which can cost anywhere from \$1,000 to \$1,500 per month.¹⁴⁵ In response to the growing expense of IVF, the Trump administration issued a directive titled, “Expanding Access to In Vitro Fertilization,” in February 2025, expressly stating the administration’s intent to decrease the financial burden of IVF and to increase the number of benefits available to intended parents.¹⁴⁶ Surrogacy was noticeably absent from this directive.

3. TRICARE

TRICARE is the uniformed services health care program for active-duty service members, active-duty family members, National Guard and Reserve members and their families, retirees and retiree family members, and certain former spouses.¹⁴⁷ Benefits extend to sponsors and their family members and vary depending on an individual’s beneficiary category.¹⁴⁸ TRICARE coverage for surrogacy is considered a limited benefit, and TRICARE pays second for services and supplies related to maternity care, including antepartum care, child birth, postpartum care, and complications of pregnancy for a surrogate mother who is a TRICARE beneficiary or has a contractual agreement with intended parents.¹⁴⁹ Under this policy, surrogate mothers seek reimbursement from the adoptive parents, and any amount designated for medical expenses under the surrogacy contract must be exhausted before TRICARE will cover the benefits of the surrogate mother.¹⁵⁰ Without a surrogate contract, TRICARE does not cover maternity services provided to a TRICARE beneficiary acting as a surrogate.¹⁵¹ TRICARE does not address whether TRICARE is preserved in states where surrogacy is illegal or where surrogacy contracts are either illegal,

143. William Houghton, *Buying Health Insurance for Your Surrogate*, SENSIBLE, <https://www.sensible-surrogacy.com/find-insurance-for-surrogate-mother-in-the-us/> [https://perma.cc/67NV-XE37] (last visited Nov. 22, 2024).

144. *Id.*

145. *Id.*

146. *Expanding Access to In Vitro Fertilization*, THE WHITE HOUSE (Feb. 18, 2025), <https://www.whitehouse.gov/presidential-actions/2025/02/expanding-access-to-in-vitro-fertilization/> [https://perma.cc/TY3P-US9H].

147. *TRICARE 101*, TRICARE, <https://www.tricare.mil/Plans/New> [https://perma.cc/J8ND-5UKD] (last visited Nov. 22, 2024).

148. *Eligibility*, TRICARE, <https://www.tricare.mil/Plans/Eligibility> [https://perma.cc/GJ9K-32EX] (last visited Nov. 22, 2024).

149. *Surrogacy*, TRICARE, <https://tricare.mil/CoveredServices/IsItCovered/Surrogacy> [https://perma.cc/JR5N-SKB3] (last visited Nov. 22, 2024).

150. *Id.*

151. *Id.*

unenforceable, or viewed as unfavorable to public policy.

In March 2024, the Department of Defense (“DoD”) amended its ART services to allow severely ill and injured active-duty service members to use donor gametes and embryos procured at their own expense.¹⁵² The DoD and the Department of Veterans Affairs (“VA”) provide some coverage for ARTs, including IVF, egg freezing, fertility medications, and IUI, but with the restrictions that the service member have a serious illness or injury sustained during active duty, and that that injury creates a need for ART to procreate.¹⁵³ In October 2024, several female service members challenged the service connection requirement of this amendment, claiming the requirement that veterans must show that their need for IVF must be connected to their military service violated the Fifth Amendment of the Constitution, the Affordable Care Act, and the Administrative Procedure Act.¹⁵⁴ Amber Bohlman, one of the plaintiffs, is a Marine Corps veteran who cannot demonstrate that her infertility is service connected, and was denied coverage of her ART because she failed to satisfy the service connection requirement.¹⁵⁵ Lindsay Church, another plaintiff, is a nonbinary Navy veteran who has a service-connected disability but has been told that the disability is not a direct cause of her infertility, and therefore, does not satisfy the service connection requirement.¹⁵⁶ An unnamed plaintiff, who is a female active-duty military service member, has gone through several rounds of failed IUI with her wife, and the only remaining medically-indicated procedure is IVF.¹⁵⁷ This member is precluded from receiving coverage for IVF because she does not have a category II or III illness that satisfies the service connection requirement.¹⁵⁸ The District Court dismissed this suit without prejudice for lack of subject matter jurisdiction and failure to state a claim, and the Plaintiff’s filed an appeal with the Second Circuit Court of Appeals in January 2025 that is still pending review.¹⁵⁹

Although there are limitations to the IVF treatment coverage, it is still possible for individuals to obtain coverage for IVF treatment; the same cannot be said for surrogacy, as the inclusion of surrogacy as an available form of ART is noticeably absent.

In a general policy statement on April 4, 2024, the VA explicitly stated that, “third-party donation and surrogacy are not covered benefits—the benefit is

152. Joseph Clark, *DOD Amends Assisted Reproductive Services Policy for Severely Ill and Injured Active Duty Service Members*, TRICARE NEWSROOM (Mar. 11, 2024), <https://newsroom.tricare.mil/News/TRICARE-News/Article/3703473/dod-amends-assisted-reproductive-services-policy-for-severely-ill-and-injured-a> [https://perma.cc/YV9F-838M].

153. *Id.*

154. *Nat’l Org. for Women-New York City v. U.S. Dep’t of Def.*, 755 F. Supp. 3d 350, 354 (S.D.N.Y. 2024).

155. *Id.* at 358.

156. *Id.*

157. *Id.* at 357–58.

158. *Id.* at 358.

159. *Id.* at 367.

designed to allow the member and spouse to become biological parents through reproductive technologies where Active Duty injury or illness has made it impossible to conceive naturally.”¹⁶⁰ The policy further elaborated that “gestational surrogacy . . . will remain outside the scope of VA IVF services.”¹⁶¹ The DoD’s amended policy allows for a third-party gestational carrier in limited instances, but the VA does not extend that coverage; Congress’ authorization for VA to provide fertility counseling and treatment, including ART, is limited to providing these services to covered veterans and their spouses.¹⁶² Therefore, the VA may not provide IVF services to a person who is neither the covered veteran nor the spouse of a covered veteran.¹⁶³ While the DoD’s policy is less exclusionary, VA’s authorization for whom it can cover supersedes DoD policy.¹⁶⁴ In April 2025, the Expanding Access to Fertility Care for Servicemembers and Dependents Act was introduced to the House to expand TRICARE coverage to include ART, regardless of whether previous requirements are met or applicable.¹⁶⁵ If enacted, this will eliminate the requirement for coverage only to be extended if infertility results from serious illness or injury resulting from service-connected disability, amongst other restrictive requirements.¹⁶⁶ As transformative as this bill would be to expanding ART coverage to service members who once were excluded from coverage, the coverage is limited to “. . . assisted reproduction, including intravaginal insemination, intracervical insemination, and intrauterine insemination . . . [i]n-vitro fertilization . . . the preservation of embryos, eggs, or sperm through cryopreservation . . . [and] [s]uch other forms of assisted reproductive services as determined appropriate by the Secretary.”¹⁶⁷ Again, surrogacy is noticeably absent in policy that, if passed, would federally regulate ART.

D. Exclusionary Tax Policies

Under the IRC Section 213(a), taxpayers are allowed to deduct expenses paid for medical care of the taxpayer to the extent the expenses exceed 7.5% of the tax payers adjusted gross income.¹⁶⁸ Section 213(d)(1)(A) provides that

160. Instructions for Determining Eligibility for In Vitro Fertilization and IVF Benefit, 89 Fed. Reg. 23518, 23519 (Apr. 4, 2024) (to be codified at 38 CFR pt. 17).

161. *Id.* at 23521.

162. *Id.*

163. *Id.*

164. Amanda Miller, *VA’s New IVF Policy Doesn’t Cover Surrogates or Unmarried Partners, Unlike Tricare*, MILITARY.COM (Apr. 23, 2024, 5:34 PM), <https://www.military.com/daily-news/2024/04/23/vas-new-ivf-policy-doesnt-cover-surrogates-or-unmarried-partners-unlike-tricare.html> [<https://perma.cc/ZH3V-ECUT>].

165. Expanding Access to Fertility Care for Servicemembers and Dependents Act, H.R. Res. 3025, 119th Cong. (2025).

166. *Id.* at 2.

167. *Id.* at 3.

168. I.R.S. Priv. Ltr. Rul. 109450-20 (Jan. 12, 2021), <https://www.irs.gov/pub/irs-wd/202114001.pdf> [<https://perma.cc/J5MX-SSYS>].

permissible medical care deductions include amounts paid for the “diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”¹⁶⁹ Surrogacy related expenses are viewed differently than individual pregnancy and maternity expenses because services to a surrogate are not provided directly to the tax payer, which is required by the IRC.¹⁷⁰ The IRC does not explicitly expand its coverage to include ARTs, but instead, has done so through various Private Letter Rulings (“PLR”). The IRS defines a PLR as “a written statement issued to a taxpayer that interprets and applies tax laws to the taxpayer’s represented set of facts.”¹⁷¹ A PLR is issued in response to a written request submitted by a taxpayer and may not be relied on as a precedent by other taxpayers or by IRS personnel.”¹⁷²

There are several notable IRS PLR’s that have addressed the tax status of surrogates: PLR 202114001, PLR 2004-0187, and PLR 2002-0291.¹⁷³ PLR 202114001 responded to an inquiry by a male same sex couple, Taxpayers “A” and “B,” who wished to have a child using sperm donated by Taxpayer A, an egg donated by Taxpayer B’s sister, and a gestational surrogate to carry the child to term.¹⁷⁴ The couple sought a ruling under IRC § 213 as to the viability of deducting medical expenses attributed to both individuals, egg retrieval, sperm donation, IVF, surrogate childbirth expenses, surrogate medical insurance related to the pregnancy, legal and agency fees for the surrogacy, and any other medical expenses relating to the surrogacy.¹⁷⁵ The IRS concluded that the costs and fees related to egg donation, IVF procedures and gestational surrogacy do not qualify as deductible medical expenses, and only the medical expenses directly attributable to the tax payers, such as the sperm donation and freezing, were deductible within the limitations of IRC § 213.¹⁷⁶

PLR 2004-0187, and relatedly PLR 2002-0291, responded to an inquiry by an individual seeking a ruling that the “cost of using a surrogate mother to bear [their] child would be allowed as an exception to the tax on early distributions

169. *Id.*

170. Anu Gogna & Kathleen Rosenow, *Since You Asked: Can an Employer Provide Surrogacy Benefits on a Tax-Favored Basis?*, WTW (Mar. 28, 2023), <https://www.wtwco.com/en-us/insights/2023/03/since-you-asked-can-an-employer-provide-surrogacy-benefits-on-a-tax-favored-basis> [<https://perma.cc/JDH9-WB96>].

171. *Tax Exempt Bonds Private Letter Rulings: Some Basic Concepts*, IRS, <https://www.irs.gov/tax-exempt-bonds/teb-private-letter-ruling-some-basic-concepts> [<https://perma.cc/7TH5-LJP7>] (last visited Nov. 22, 2024).

172. *Id.*

173. I.R.S. Priv. Ltr. Rul. 109450-20 (Jan. 12, 2021), <https://www.irs.gov/pub/irs-wd/202114001.pdf> [<https://perma.cc/J5MX-SSYS>]; I.R.S. Priv. Ltr. Rul. 2004-0187 (Sep. 13, 2004), <https://www.irs.gov/pub/irs-wd/04-0187.pdf> [<https://perma.cc/CXA9-G6WK>]; I.R.S. Priv. Ltr. Rul. 2002-0291 (Aug. 12, 2002), <https://www.irs.gov/pub/irs-wd/02-0291.pdf> [<https://perma.cc/Y3GC-96UF>].

174. I.R.S. Priv. Ltr. Rul. 109450-20 (Jan. 12, 2021), <https://www.irs.gov/pub/irs-wd/202114001.pdf> [<https://perma.cc/J5MX-SSYS>].

175. *Id.*

176. *Id.*

from an individual retirement plan under § 401(k) of the [IRC].”¹⁷⁷ The individual sought to borrow money from their 401(k) plan to cover surrogacy-related expenses, as loan amounts from distributions in some events are not treated as taxable distributions to the plan and are not subject to an early distribution penalty.¹⁷⁸ In both instances, the IRS determined that a surrogate mother is not considered the taxpayer, the taxpayers spouse, or a non-relative dependent, as listed in § 512(a), and neither is an unborn child, so medical expenses paid for a surrogate mother and her unborn child generally do not qualify for 213(a) deduction.¹⁷⁹

Reimbursable ART expenses include any medical fees directly involving the insured and their dependents or spouse, clinic fees for standard procedures involved in surrogacy, hormone therapy, sperm donation, IVF, and egg donation and retrieval; They do not cover the cost of surrogacy itself.¹⁸⁰ *Morrissey v. United States* challenged the applicability of IRC § 213 allotted expenses. Here, Morrissey and his male partner sought to have a child through IVF, using Morrissey’s sperm to fertilize donated eggs and create embryos that were then implanted into a surrogate mother.¹⁸¹ Morrissey claimed to be “effectively infertile” because he is in a homosexual relationship, and it is physiologically impossible for two men to conceive a child through sexual relations.¹⁸² In this process, Morrissey paid nearly \$57,000 out of pocket for IVF-related expenses, \$1,500 for procedures performed directly to him, such as sperm collection, \$55,000 to identify, retain, and compensate the egg donor and surrogate for their services, which included payment for their services, medical care and coverage, travel, and other related expenses.¹⁸³ In response to his amended return claiming \$36,538 in medical expenses and a refund of \$9,539, the IRS concluded that Mr. Morrissey only spent \$1,500 for his blood work and sperm collection, and thus does not meet the 7.5% threshold for allowable deductions.¹⁸⁴ Accordingly, Mr. Morrissey could not deduct the expenses unless he was also able to deduct expenses relating to the identification, retention, and care of the egg donor and gestational carrier, which the IRS concluded were not qualified deductible expenses.¹⁸⁵ The IRS denied Mr. Morrissey’s refund sought, disallowed his IVF-

177. I.R.S. Priv. Ltr. Rul. 2004-0187, 1 (Sep. 13, 2004), <https://www.irs.gov/pub/irs-wd/04-0187.pdf> [<https://perma.cc/CXA9-G6WK>]; I.R.S. Priv. Ltr. Rul. 2002-0291 (Aug. 12, 2002), <https://www.irs.gov/pub/irs-wd/02-0291.pdf> [<https://perma.cc/Y3GC-96UF>].

178. I.R.S. Priv. Ltr. Rul. 2004-0187, 1 (Sep. 13, 2004), <https://www.irs.gov/pub/irs-wd/04-0187.pdf> [<https://perma.cc/CXA9-G6WK>]; I.R.S. Priv. Ltr. Rul. 2002-0291 (Aug. 12, 2002), <https://www.irs.gov/pub/irs-wd/02-0291.pdf> [<https://perma.cc/Y3GC-96UF>].

179. I.R.S. Priv. Ltr. Rul. 2004-0187, 2 (Sep. 13, 2004), <https://www.irs.gov/pub/irs-wd/04-0187.pdf> [<https://perma.cc/CXA9-G6WK>]; I.R.S. Priv. Ltr. Rul. 2002-0291 (Aug. 12, 2002), <https://www.irs.gov/pub/irs-wd/02-0291.pdf> [<https://perma.cc/Y3GC-96UF>].

180. Houghton, *supra* note 143.

181. *Morrissey v. U.S.*, 871 F.3d 1260, 1263 (11th Cir. 2017).

182. *Id.*

183. *Id.*

184. *Id.*

185. *Id.* at 1264

related deductions, and concluded that the expenses were not directly provided to the taxpayer [Mr. Morrissey], his spouse, or his dependent, and thus were disallowed.¹⁸⁶ On appeal, the District Court sided with the IRS, holding that the IRC does not permit Mr. Morrissey to “deduct the expenses attributable to the identification, retention, compensation, and care of the women who served as the egg donor and gestational surrogate in his IVF process.”¹⁸⁷

Magdalin v. Commissioner is another seminal tax case, where a father with normal reproductive capabilities sought deduction of surrogate and IVF related medical expenses.¹⁸⁸ The court held that expenditures incurred by a taxpayer to undergo in vitro fertilization processes are not eligible for reimbursement under the IRC § 213, and the First Circuit Affirmed.¹⁸⁹ All of these cases have one common thread: intended parents were using surrogates to birth their children, who would ultimately become their future dependents. Our antiquated tax code does not consider the complexities of surrogacy, and failure to update the internal revenue code to reflect the complexities of a multi-billion-dollar industry constitutes a failure to regulate.

E. Urgency Behind the Need to Regulate

To fully understand how to make sweeping regulatory changes to surrogacy law, it is imperative to first understand the gravity of a need for regulation. As infertility rates rise, and ART becomes more advanced and accessible, it is inadequate that legislation still does not consider surrogacy a viable ART worthy of regulation.¹⁹⁰ Surrogacy is often the last resort for intended parents desperate to make their dreams of having a family a reality. Failing to regulate perpetuates the problems that plague surrogacy, and excluding surrogacy from other forms of ART diminishes how powerful of a resolution surrogacy may be to infertility. Surrogacy is an economic issue, a human rights issue, and an employee benefits issue that necessitates regulation. This section will discuss the intricacies behind the urgent need for regulation, the implications of failing to regulate, and potential state and federal legislative solutions.

1. Economic Implications

Regulation needs to be passed to decrease the cost of surrogacy. The cost of surrogacy is nearly triple the average household income in the United States.¹⁹¹ As the cost of living continues to rise, the cost of surrogacy will only increase,

186. *Id.* at 1263–64.

187. *Id.* at 1272.

188. *Magdalin v. C.I.R.*, 96 T.C.M. (CCH) 491 (Tax 2008), *aff'd*, No. 09-1153, 2009 WL 5557509 (1st Cir. Dec. 17, 2009).

189. *Id.* at 3.

190. See discussion *supra* Parts IV.A, IV.B.

191. See *supra* notes 51–59 and accompanying text.

thus making it unaffordable for most of the United States population.¹⁹² State regulation has allowed other forms of ARTs to remain affordable and accessible, so regulating surrogacy would likely have the same effect.¹⁹³ Studies have shown that costs may be a treatment barrier for ARTs.¹⁹⁴ In states with no mandated fertility services coverage, or mandates that did not include assisted reproductive technologies, couples were up to 46% more likely to discontinue care than counterparts who lived in states with comprehensive mandates that required assisted reproductive technology coverage.¹⁹⁵ Additionally, studies have shown that in states that have enacted mandates requiring employers of a certain population to include fertility-related services, there were instances of higher ART utilization, fewer embryos per transfer, and lower rates of multiple gestations, which in turn, lowered the cost of these ART procedures.¹⁹⁶

The global commercial surrogacy industry is projected to rise to \$129 billion by 2032.¹⁹⁷ There are significant economic interests at stake with a market that size, and failure to federally regulate would be negligent of our legislature. Congress regulates all major economic activities in the United States, yet they fail to regulate one that impacts so many Americans and has such an impact on the economy. With the rising cost of domestic surrogacy, coupled with the vast amount of limitations, intended parents will likely start taking their money to international countries for surrogacy services; this is a real and urgent threat to our economy.

2. Human Rights Implications

Second, surrogacy is a human rights issue. As of 2017, surrogacy was completely banned in fifty countries, legal in forty countries, not regulated in thirty countries, and partially tolerated in twenty-one countries.¹⁹⁸ In countries where surrogacy is outright banned, surrogacy does not cease to exist; it shifts to exist outside of the public eye, and without the scrutiny of public view, thus

192. See *supra* notes 51–59 and accompanying text.

193. Jacqueline C. Lee et al., *Association of State Insurance Coverage Mandates with Assisted Reproductive Technology Care Discontinuation*, 228(3) AM. J. OF OBSTETRICS AND GYNECOLOGY 1, 6 (Nov. 9, 2022), <https://pubmed.ncbi.nlm.nih.gov/36368429/> [<https://perma.cc/3NM7-E4JK>] (noting findings that individuals living in states without mandated ART coverage were more likely to discontinue treatment after unsuccessful ART care cycles compared to individuals living in states with mandated ART insurance coverage).

194. *Id.*

195. *Id.*

196. *Id.*

197. See Danielowski, *supra* note 50 (noting that the international surrogacy market is a “rapidly expanding and changing reproductive tourism economy, which is transnational economy.” *Id.*); see also Gilchrist, *supra* note 50.

198. Yuri Hibino, *Ongoing Commercialization of Gestational Surrogacy Due to Globalization of the Reproductive Market before and after the Pandemic*, 14 ASIAN BIOETHICS REV. 349, 350 (Aug. 18, 2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9386202> [<https://perma.cc/Z9UT-PHKJ>].

creating a breeding ground for exploitation.¹⁹⁹ Surrogacy has the power to empower women to uplift themselves from poverty, and if regulated properly, gives them the tools to protect themselves from exploitation. Individuals that utilize IVF and other forms of ART have many legal safeguards at their disposal to remedy any exploitation or unjust treatment; if surrogacy was legal, and regulated, these protections would be extended, but without regulation, women are at risk of exploitation and persecution with little to no remedy.²⁰⁰ If the United States does not take action to consistently regulate the domestic surrogacy market across the United States, or take action to make domestic surrogacy more affordable and accessible, American intended parents will be driven to more affordable and accessible international markets, which in turn, will perpetuate human rights violations.

3. Employer and Employee Implications

Third, surrogacy is an employee benefits issue. For employers to remain competitive, they need to offer benefits to their employees that support them through all phases of life. With the advancement and availability of ART, companies are starting to include fertility benefits in their portfolio of coverage.²⁰¹ Many major companies now offer robust IVF, surrogate, and adoption benefits to their employees.²⁰² As the market for top talent gets more competitive, employees can be more selective of where they work, and for individuals looking to start a family, fertility benefits are a competitive and attractive benefit that may become a deciding factor in where they choose to work.

V. PROPOSED CHANGES TO LAW

To protect the rights of intended parents, surrogates, and all remaining parties involved in the surrogacy process, it is imperative that sweeping reform is passed at the federal and state levels that make surrogacy more affordable and accessible. Making surrogacy more accessible and affordable goes hand in hand with one another—if we make surrogacy more accessible, it will become more affordable, and vice versa. Today, surrogacy is largely available only to those that can afford the staggering costs, live in states where surrogacy is legal or subsidized, or those that have the means to travel and work with out of state surrogates that live in “surrogate friendly” states. To remedy this, we must regulate surrogacy consistently with other forms of ART, expand current ART regulations to include surrogacy in their scope of regulations, provide protections for all parties involved in the surrogacy process, and amend and

199. *Id.* at 353.

200. *See* Danielowski, *supra* note 50; *see also* Gilchrist, *supra* note 50.

201. *See supra* notes 106–12 and accompanying text.

202. *See supra* notes 106–12 and accompanying text.

expand legislation that promotes the accessibility of surrogacy.

A. Legislative Action to Increase Affordability

To make surrogacy become a viable option, is imperative that any regulation that impacts the affordability of ART at the federal and state level should be amended and extended to include surrogacy.

First, Congress should start by passing the Equal Access to Reproductive Care Act (“EARCA”)²⁰³ If EARCA becomes law, expenses arising from surrogacy will now be treated as medical expenses of the taxpayer.²⁰⁴ This would allow families to deduct the cost of egg retrieval, sperm donation, IVF, surrogate childbirth expenses, surrogate medical insurance related to the pregnancy, legal and agency fees for the surrogacy, and any other medical expenses relating to the surrogacy from their taxes, which would save families thousands of dollars.²⁰⁵

Second, in addition to expanding the deductibility of expenses associated with surrogacy, adoption tax credits should be expanded to cover the cost of surrogacy-related adoptions.²⁰⁶ Currently, an individual is eligible to claim an adoption credit of up to \$16,810 in qualified expenses if a qualified child is adopted.²⁰⁷ A qualified child includes a child that is under the age of 18, and is physically or mentally incapable of self-care.²⁰⁸ In many “non-surrogacy friendly” states, intended parents are required to adopt their biological children that are born through surrogacy, and under current tax code, are required to bear the burden of this expense.²⁰⁹

Third, it is imperative that flexible spending account (“FSA”) and health savings account (“HSA”) rules be modified to allow deduction of expenses for third-party surrogates. The IRS has limited qualified medical expenses to only approved expenses incurred by the individual, their spouse, and any dependents.²¹⁰ Under this current structure, surrogates are noticeably excluded because they are a third party, and benefits traditionally extend only to a covered individual and their spouse, thus preventing intended parents from deducting any expenses that they would otherwise be able to deduct if they were carrying

203. Equal Access to Reproductive Care Act, H.R. 4391, 118th Cong. (1st Sess. 2023).

204. *Id.*

205. I.R.S. Priv. Ltr. Rul. 109450-20 (Jan. 12, 2021), <https://www.irs.gov/pub/irs-wd/202114001.pdf> [<https://perma.cc/BPK2-JEHM>] (illustrating how these procedures are not currently included and how enacting EARCA would make them included).

206. *See Adoption Credit*, IRS, <https://www.irs.gov/credits-deductions/individuals/adoption-credit> [<https://perma.cc/N44L-AL4C>] (last visited Feb. 2, 2025).

207. *Id.*

208. *Id.*

209. *See* discussion *supra* Part V.B.

210. *See Publication 969 (2024), Health Savings Accounts and Other Tax Favored Health Plans*, IRS, https://www.irs.gov/publications/p969#en_US_2024_publink1000204083 [<https://perma.cc/G9S7-K8PK>] (last visited Feb. 2, 2025) (discussing qualified medical expenses for HSA and FSA plans).

their child themselves.²¹¹

Fourth, “mandate to offer” and “mandate to cover” laws requiring companies of certain sizes to offer ART and fertility benefits to employees, should be codified under federal law, and extended to include surrogacy.²¹² The One Big Beautiful Bill, enacted into public law in July 2025, codified provisions of the expired Tax Cuts and Jobs Act and Achieving A Better Life Experience Act that allowed designated beneficiaries of disabled individuals contribute to tax-favored savings accounts that can be used for disability-related expenses.²¹³ Because reproduction is recognized as a major life activity, infertility is treated as a disability under the Americans with Disabilities Act (“ADA”); accordingly, there may be a potential avenue to extend ABLE savings account eligibility to individuals struggling with infertility, allowing those funds to be used for ART and surrogacy expenses.²¹⁴

Fifth, IRC § 213(a) must be expanded to include unreimbursed surrogacy-related expenses in the definition of “deductible medical expenses.” This expansion allows intended parents to deduct expenses related to the identification, compensation, and medical care of a surrogate.²¹⁵ IRC § 401(k) must also be amended to allow for surrogacy related expenses to be included in the definition of a qualified medical expenses that may be deductible if it exceeds 7.5% of an intended parent’s income.²¹⁶ With surrogacy costs rapidly increasing, these tax incentives are necessary to limit the mounting financial burdens that intended parents face.

B. Legislative Action to Increase Accessibility

In addition to codifying and modifying current legislation that would make surrogacy more affordable, it is imperative that sweeping changes also be made to increase accessibility for all parties involved in the surrogacy process.

First, the Model Uniform Parentage Act (“MUPA”), which serves as a standardized baseline of regulations to which states may implement in a blanket policy, or modify to develop their own policies, should be enacted in all fifty states.²¹⁷ This would provide consistent protection for gestational and genetic

211. *Surrogate Mother: HSA Eligibility*, HSA STORE, <https://hsastore.com/hsa-eligibility-list/s/surrogate-mother?> [<https://perma.cc/GQ8H-TTTP>] (last visited Feb. 2, 2025).

212. *See supra* notes 125–129 and accompanying text.

213. *See* Pub. L. No. 119-21, Title XI, Subtitle A, Part 3, 139 Stat. 72 (2025); *see also* CONG. RSCH. SERV., R47846, REFERENCE TABLE: EXPIRING PROVISIONS IN THE “TAX CUTS AND JOBS ACT” (TCJA, P.L. 115-97) (2024).

214. *How does the Americans with Disabilities Act (ADA) Apply to Employees Who Have Infertility*, JAN: CONSULTANT’S CORNER, <https://askjan.org/publications/consultants-corner/vol12iss09.cfm> [<https://perma.cc/AGM9-QL4F>] (last visited Feb. 2, 2025); *Infertility Discrimination*, RESOLVE, <https://resolve.org/advocacy/our-issues/infertility-discrimination/> [<https://perma.cc/JY54-ECG8>] (last visited June 1, 2026).

215. *See discussion supra* Part IV.D.

216. *See discussion supra* Part IV.D.

217. Crockin, Edmonds & Amy Altman, *supra* note 81.

surrogacy arrangements and provide guidelines for surrogacy agreements, surrogacy practice, and protections for genetic surrogates to withdraw consent; regardless of where a surrogate or intended parent lives, they know that regulations will remain consistent if they relocate or return to another state.²¹⁸

Second, Congress should enact the Preventing Forced Abortions Act of 2024.²¹⁹ This Act sets forth guidelines that prohibit federal courts from enforcing surrogacy contracts that (1) require surrogates to have an abortion, and (2) allow intended parents to withhold compensation for surrogates that refuse to have an abortion.²²⁰ If passed in the House, surrogates will regain their right to bodily autonomy and have safeguards in place to protect them from being forced to have an unwanted abortion, even if they were initially amenable.²²¹ This would provide surrogates with more bodily autonomy and control, and potentially open the door for individuals to become surrogates that were previously hesitant to become surrogates because of the lack of bodily autonomy.

Third, the Expanding Access to Fertility Care for Servicemembers and Dependents Act should be amended to expressly include surrogacy in the definitions of covered ART services and codified by Congress.²²² The “connected to military service” requirement under TRICARE and lack of express language including surrogacy in the approved definitions must be eliminated, because the current language providing inclusion of “other forms of assisted reproductive services as determined appropriate by the Secretary” opens the door to potential inconsistency caused by wavering political influence, and may lead to further inconsistent regulation.²²³ Requiring individuals who have served our country, and continue to serve our country, to prove that their inability to carry a child to term must be connected and derived from their military service is dehumanizing, demoralizing, and must be eliminated.

VI. CONCLUSION

The only way to make surrogacy affordable and accessible to many Americans is to make sweeping regulations that codify federal protections for surrogacy and extend current regulations of ART to include surrogacy. Without these sweeping changes, there will be a lack of consistent protections for surrogates, intended families, and children, and in turn, surrogacy will never become an affordable and accessible option for intended parents trying to conceive, and many individuals unable to conceive naturally will never be able to have a family that is genetically related to them; many people that turn to

218. *Id.*

219. *See supra* note 77 and accompanying text.

220. *See* Press Release, Andy Ogles, Congressman, Ogles Introduces Bill to Stop Forced Abortions (July 10, 2024), <https://ogles.house.gov/media/press-releases/ogles-introduces-bill-stop-forced-abortions> [<https://perma.cc/UB6N-XGWB>]; *see also supra* note 77 and accompanying text.

221. *See supra* note 77 and accompanying text.

222. *See supra* notes 165–167 and accompanying text.

223. *See supra* notes 165–167 and accompanying text.

surrogacy have gone through extreme devastation and this is their last hope.

Without federal regulations in place to secure cohesive protections, it is the responsibility of other governing bodies to adjust policies and laws to that regulate surrogacy. It is imperative that all fifty states enact the Model Uniform Parentage Act, that Congress enact the Preventing Forced Abortions Act, and that the Expanding Access to Fertility Care for Servicemembers and Dependents Act be amended and codified. This is not just a state issue, this is a federal issue that impacts reproductive rights, human rights, and the economy. The lack of regulation impacts interstate commerce and encroaches upon constitutionally protected rights, so it is imperative that surrogacy is no longer excluded from ART Regulations, and instead, treated as another powerfully impactful ART.

RE-ENTRY HOUSING AND MENTAL HEALTH: HOW PREVIOUSLY INCARCERATED INDIVIDUALS COULD QUALIFY FOR PROTECTIONS UNDER THE FAIR HOUSING ACT'S DEFINITION OF HANDICAP

PATRICIA CAVANAUGH*

"It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped."

— Hubert H. Humphrey¹

I. INTRODUCTION

At a community mental health center, a homeless client explains to his mental health therapist the struggle to find housing. The client shares, "I'm a felon, and no place will accept me because of my past." The therapist asks, "[h]ow does it feel to experience rejection because of your past?" He responds, "[i]t makes me feel like I am nothing. I feel like I don't deserve a place to live, like my life doesn't even matter . . . no matter how hard I try to turn things around, people still only see me as a criminal."²

Returning to the community from jail or prison is a complex transition for individuals and communities; this transition is called reentry.³ Without housing, there can be no successful community reentry.⁴ The challenges recently released individuals face as they try to piece together their lives outside prison walls are complicated by their struggle to secure housing. Formerly incarcerated individuals are nearly ten times more likely to experience homelessness than the

* J.D. Candidate, 2026, I.U. Robert H. McKinney School of Law; M.A. in Mental Health Counseling & Art Therapy, University of Indianapolis, 2020; B.S. in Pre-Art Therapy, University of Indianapolis 2018. The author gratefully acknowledges Professor Julie Gilgoff and Brittany Kelly for their invaluable mentorship during the Note writing and editing process. In addition, the author offers her deepest gratitude to the therapy clients whose experiences inspired her path to law school. Their stories remain at the heart of this Note.

1. Hubert S. Humphrey, Vice Pres. United States, Address at the Hubert H. Humphrey Dep't of Health & Hum. Servs. Building Dedication (Nov. 4, 1977). Hubert Humphrey was a former Vice President of the United States, and he is generally known for his advocacy of civil rights.

2. This depicted session is based upon the writer's professional experiences as a licensed mental health therapist.

3. *Reentry/Transition*, NAT'L INST. OF CORRS., <https://nicic.gov/resources/resources-topics-and-roles/topics/reentrytransition> [<https://perma.cc/R83V-P8GM>] (last visited Feb. 3, 2025) ("[r]eentry refers to the transition of offenders from prisons or jails back into the community"); *Overview of Reentry*, NAT'L INST. OF JUST. (June 7, 2013), <https://nij.ojp.gov/topics/articles/overview-reentry> [<https://perma.cc/Y2F7-7UQ4>] ("[o]ffender reentry, the transition from life in jail or prison to life in the community").

4. Kimberly Burrowes, *Can Housing Interventions Reduce Incarceration and Recidivism?*, HOUSING MATTERS (Feb. 27, 2019), <https://housingmatters.urban.org/articles/can-housing-interventions-reduce-incarceration-and-recidivism> [<https://perma.cc/93QK-NAQM>].

general public.⁵ Without stable housing, previously incarcerated individuals are less likely to be successful in reentry or to connect to needed services and support systems. A successful transition from jails and prisons into secure housing can reduce the risk of rearrest, relapse, or other negative behavioral outcomes that might land an individual back in a correctional institution.⁶ Housing is a protective factor for previously incarcerated individuals and is an important aspect of public health and safety.

Reentry housing takes many forms, including group homes, halfway houses, sober living homes, or transitional living facilities.⁷ In recent years, many housing advocates expected the overall quantity of reentry housing to rise because of government plans to reduce prison overcrowding, implementation of alternative measures to decrease rates of recidivism, and sentencing time reductions for non-violent crimes.⁸ However, political pushback on these matters has halted such attempts for reforming re-entry transitions services.⁹ Amid a rising national housing affordability crisis, individuals face tougher obstacles to a successful reentry.¹⁰ In addition, local jurisdictions and community members often object to reentry housing being built in their neighborhoods, raising public safety concerns.¹¹

The Fair Housing Act (“FHA”), enacted as Title VIII of the Civil Rights Act of 1968, originally prohibited housing discrimination based on race, color,

5. Lucius Couloute, *Nowhere to Go: Homelessness among formerly incarcerated people*, PRISON POL’Y INITIATIVE (Aug. 2018), <https://www.prisonpolicy.org/reports/housing.html> [https://perma.cc/7VM5-S2W5].

6. THE REENTRY COORDINATION COUNCIL, COORDINATION TO REDUCE BARRIERS TO REENTRY: LESSONS LEARNED FROM COVID-19 AND BEYOND, 8 (2022), <https://www.justice.gov/opa/press-release/file/1497911/dl> [https://perma.cc/B3RK-2ZS4].

7. BUREAU OF JUST. ASSISTANCE, REENTRY HOUSING OPTIONS: THE POLICYMAKERS’ GUIDE 1–3 (2010), <https://www.cmcainternational.org/wp-content/uploads/2019/10/reentry-housing-options-policymakers.pdf> [https://perma.cc/CV2N-ZZXL].

8. See, e.g., The First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194 (2018).

9. See, e.g., *Trump Promises to Militarize Police, Reincarcerate Thousands, and Expand Death Penalty*, AM. C.L. UNION (July 19, 2024), <https://www.aclu.org/news/criminal-law-reform/trump-promises-to-militarize-police-reincarcerate-thousands-and-expand-death-penalty> [https://perma.cc/CM54-8WDY].

10. Justin Dorazio, *Strengthening Access to Housing for People With Criminal Records Is Key to Successful Reentry*, CTR. FOR AM. PROGRESS (Apr. 17, 2023), <https://www.americanprogress.org/article/strengthening-access-to-housing-for-people-with-criminal-records-is-key-to-successful-reentry/> [https://perma.cc/H4HB-EJJD].

11. See, e.g., Shakkira Harris, *‘It’s gonna save lives’: Neighbors weigh in on proposed recovery home for women on Indy’s north side*, WRTV INDIANAPOLIS (Apr. 8, 2022, 2:24 PM), <https://www.wrtv.com/news/local-news/indianapolis/north-side/its-gonna-save-lives-neighbors-weigh-in-on-proposed-recovery-home-for-women-on-indys-north-side> [https://perma.cc/9BHX-D66U]; James Jarvis, *Plan to support group homes for people in recovery meets resistance*, ARLNOW (Oct. 10, 2024, 1:15 PM), <https://www.arlnow.com/2024/10/10/plan-to-support-group-homes-for-people-in-recovery-meets-pushback-from-some-residents/> [https://perma.cc/FW7W-S3RM].

religion, sex, or national origin.¹² In 1988, the FHA was amended to extend its protections to include familial status and disability.¹³ The FHA defines disability or “handicap”¹⁴ as: “(1) a physical or mental impairment which substantially limits one or more of [a] person’s major life activities, (2) a record of having such an impairment, or (3) being regarded as having such an impairment.”¹⁵ Under this statutory definition of disability, an individual is required to satisfy only a single criterion or meaning of disability. The “regarded as,” or third prong, was intended to be interpreted broadly. Congress’ intent was to address conscious and unconscious perceptions by society of an individual’s physical or mental impairment, whether real or perceived.¹⁶ The focus of this third prong extends beyond the severity of an actual disability or impairment.¹⁷ Rather, the “regarded as” prong protects individuals from housing discrimination related to biases or prejudices about their disability or assumed disability.¹⁸

While the FHA prohibits housing discrimination, previously incarcerated individuals are not afforded protection under the Act. Since having a criminal record is not a federally protected characteristic, local governments or ordinances may use an individual’s criminal history as a basis to deny or reject housing opportunities for those individuals.¹⁹ While the FHA broadly extends to a range of considered “handicaps,” not every debilitating mental or physical condition elicits the protections from housing discrimination. Some types of mental health conditions can be considered handicaps under the FHA.²⁰ Individuals in recovery for drug or alcohol addiction have also been considered protected on the basis of handicap.²¹ Since handicap includes individuals recovering from substance or alcohol use, sober living homes are afforded

12. 42 U.S.C. §§ 3601–3619; see John Hamer, *Handicap Discrimination, Zoning, and the Federal Fair Housing Act*, 13 ME. B.J. 166, 166 (1998).

13. 42 U.S.C. §§ 3601– 3619; see Hamer, *supra* note 12.

14. For persons with disabilities, terminology is not insignificant. For years, persons with disabilities were referred to by dehumanizing terms such as “the handicapped” or “the retarded.” The Americans with Disabilities Act (“ADA”) uses the term “disability,” as does Section 504 of the Rehabilitation Act, while the FHA uses the term “handicap.” Despite the variations, the definitions mirror one another. The term “handicap” is used, within this paper, to be consistent with the FHA. However, it is necessary to note that the term “handicap” is disfavored among disability rights advocates, and the term “disability” is preferred. Person-first language (“people with. . .”) is considered the best practice to avoid stigmatizing language, and it is important to ask people or groups of individuals on their preference.

15. 42 U.S.C. § 3602(h).

16. Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

17. 24 C.F.R. § 100.201(d)(2) (2026); Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

18. Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

19. See 42 U.S.C. § 3604(f)(1)–(3).

20. 24 C.F.R. § 100.201(a)(2) (2026).

21. *Id.*

protection under the FHA.²² If a group home markets itself as a recovery home for substance use, then it will have a better chance of withstanding pushback from communities and meet the requirements of an FHA claim. In contrast, a group home solely focused on reentry may struggle to succeed without the strong support and advocacy of its community. However, many questions remain unanswered regarding the FHA's applicability on residential reentry homes or group homes for previously incarcerated individuals without a substance use disorder or qualifying mental health condition.²³

This Note argues that reentry housing, specifically group homes for the formerly incarcerated, should qualify for the FHA's protection under the "regarded as" prong of handicap. Previously incarcerated individuals should be afforded protection from housing discrimination based on actual or purported mental health conditions that contributed to their involvement with the justice system, emerged while incarcerated, or developed post-release. Part I of this Note includes an introduction. Part II provides a general overview of the FHA and an overview of the meaning of handicap or disability discrimination, including a discussion of legislative intent. Part III analyzes the existing FHA protections and their application to the reentry population, discusses the requirements plaintiffs must meet to prove FHA violations, and examines the housing claims available for reentry group homes. It also elaborates on the proposal that previously incarcerated individuals in need of housing should be afforded protection under the FHA's definition of "handicap." Specifically, the "regarded as" prong of the FHA's handicap definition may allow for such protection. Part IV provides the Note's conclusion.

II. BACKGROUND

A. General Protections Under the Fair Housing Act

The enactment of the FHA in 1968 prohibited housing discrimination based on race, color, religion, or national origin.²⁴ The FHA Amendments of 1988 extended the definition of "protected class" to include the "handicapped," or rather, individuals with disabilities.²⁵ The Amendments also added "familial status" as a protected group to prevent discrimination against people based on their family situation.²⁶ Thus, as amended in 1988, the FHA prohibits discriminatory conduct relating to race or color, religion, sex, national origin,

22. Matthew M. Gorman, Anthony Marinaccio & Christopher Cardinale, *Fair Housing for Sober Living: How the Fair Housing Act Addresses Recovery Homes for Drug and Alcohol Addiction*, 42 URB. LAW. 607, 608–09 (2010).

23. *Id.* at 614.

24. Fair Housing Act of 1968, Pub. L. No. 90-284, tit. VIII, 82 Stat. 73 (1968).

25. 42 U.S.C. §§ 3604(c)–(f); 3605; 3606; 3617; 3631 ("FHA Amendments of 1988").

26. 42 U.S.C. §§ 3604(a)–(e); 3605; 3606; 3617; 3631.

familial status, or disability.²⁷ The Department of Housing and Urban Development (“HUD”) is responsible for administering the FHA.²⁸

The FHA prohibits housing providers, landlords, sellers, property owners, and other participants in the housing market from engaging in discriminatory housing practices against any members of a protected class. First, these actors may not refuse to sell or rent a dwelling, or refuse to negotiate for its sale or rental, on discriminatory grounds.²⁹ Second, they may not discriminate against any person in the terms, conditions, or privileges associated with the sale or rental of a dwelling.³⁰ Third, they may not advertise or publish any notice or statement relating to the sale or rental of a dwelling that expresses a preference, limitation, or discrimination based on a protected class.³¹ Fourth, they may not engage in conduct that makes a dwelling unavailable to a member of a protected class.³² Fifth, they may not induce or attempt to induce, for financial gain, any person to sell or rent a dwelling in a manner that would restrict access for members of a protected class.³³ Finally, the FHA prohibits denying a dwelling to any buyer or renter because that individual, or any person associated with them, is a member of a protected class.³⁴

B. Understanding Handicap

In the 1985 Supreme Court case *City of Cleburne v. Cleburne Living Center*, the Court held that group home residents were not a suspect class, despite the City’s “irrational prejudice” against those with mental disabilities.³⁵ The Cleburne Living Center, a group home for residents with mental disabilities, filed suit against the City of Cleburne.³⁶ The group home alleged that a zoning ordinance violated the Equal Protection Clause because it discriminated against residents with mental disabilities.³⁷ In its ruling, the Supreme Court refused to apply strict scrutiny to discrimination against those residents with disabilities.³⁸ After this decision, housing advocates sought legislative remedies for people with handicaps or disabilities.³⁹ To remedy this shortcoming, the FHA was amended to expressly include people with disabilities in the scope of protections

27. 42 U.S.C. § 3604. Some states have adopted additional housing protections, such as source of income discrimination or recognition of sexual orientation as a protected status.

28. 42 U.S.C. § 3608.

29. 42 U.S.C. § 3604(a).

30. 42 U.S.C. § 3604(b).

31. 42 U.S.C. § 3604(c).

32. 42 U.S.C. § 3604(d).

33. 42 U.S.C. § 3604(e).

34. 42 U.S.C. § 3604(f)(1).

35. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442, 450 (1985).

36. *Id.* at 435–37.

37. *Id.* at 437.

38. *Id.* at 446–47.

39. F. Willis Caruso, *Fair Housing Modifications and Accommodations in the '90s*, 29 J. MARSHALL L. REV. 331, 333 (1996).

afforded.⁴⁰

The 1988 FHA Amendments adopted the broad definition of “handicapped” from the Rehabilitation Act of 1973 and the Americans with Disabilities Act.⁴¹ From the House Report, the intent of Congress is clear on the goal of the 1988 FHA Amendments:

[It] is a clear pronouncement of a national commitment to end the unnecessary exclusion of persons with handicaps from the American mainstream. It repudiates the use of stereotypes and ignorance, and mandates that persons with handicaps be considered as individuals. Generalized perceptions about disabilities and unfounded speculations about threats to safety are specifically rejected as grounds to justify exclusion.⁴²

The FHA’s definition of “handicap” has three statutory prongs:

- (1) a physical or mental impairment which substantially limits one or more of such person’s major life activities,
 - (2) a record of having such an impairment, or
 - (3) being regarded as having such an impairment,
- but such term does not include current, illegal use of or addiction to a controlled substance.⁴³

The first prong defines a disability as a physical or mental impairment that substantially limits one or more of an individual’s major life activities.⁴⁴ This prong adopts the general understanding that a disability creates a substantial limitation to an individual’s daily functioning. The term “major life activity” includes “functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.”⁴⁵ The question of whether a substantial limitation of a major life activity exists is a matter of fact for courts to determine, often considering medical diagnoses.

While the FHA broadly extends to a range of considered handicaps, not every mental or psychological condition is covered under FHA protections.⁴⁶ Rather, jurisdictions vary, often on a case-by-case or fact-specific basis, on

40. 42 U.S.C. § 3604; *see supra* note 14 (noting that “handicap” is an outdated term and that current best practice favors the use of “disability” and person-first language, such as “people with disabilities”).

41. *See* 29 U.S.C. § 705(20); *see also* 42 U.S.C. § 12102(1).

42. Fair Housing Amendments Act Committee Report, H.R. REP. NO. 711, 100th Cong., 2d Sess. 3355 (1988).

43. 42 U.S.C. § 3602(h).

44. 42 U.S.C. § 3602(h)(1).

45. 24 C.F.R. § 100.201(b) (2026).

46. Brian J. Connolly & Dwight H. Merriam, *Planning and Zoning for Group Homes: Local Government Obligations and Liability Under the Fair Housing Amendments Act*, 47 URB. LAW. 225, 233 (2015).

whether a certain condition should be considered a handicap. The term “physical or mental impairment” includes a wide range of physiological conditions and mental or psychological disorders.⁴⁷ It is important to note that the FHA does not protect people who currently engage in the use of alcohol or illegal drug use, even if that alcohol use or drug use would otherwise meet the qualifications of substantially limiting a major life activity. Within the handicap definition, this exclusion is written as, “. . . such term does not include current, illegal use of or addiction to a controlled substance.”⁴⁸ However, individuals that are in recovery for drug or alcohol addiction have been considered handicapped under the FHA.⁴⁹ The legislature’s attempt to distinguish between these two groups fails to recognize the recovery process; recovery from substance use is a continuous journey, with risks of relapse being a part of the process. Individuals actively struggling with substance use or dependence greatly benefit from housing stability to support their recovery. Under this regulatory language, the FHA neglects to offer housing protection for a group of individuals who need it most. Possibly, this provision is driven by motivations that ultimately favor landlords over the individuals it purports to help.

The second prong protects individuals with disabilities who have a record of, or a history of, a physical or mental impairment. An individual having a record of such impairment “means [that individual] has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.”⁵⁰ This prong recognizes that an individual may fit the statutory description if they have a history of a disability or impairment. Often, courts will consider medical diagnoses or an individual’s history of medical treatment as pertinent facts.

If an individual’s “handicap” does not meet the conditions of the first two prongs within the definition, the third prong of handicap may still apply. The third prong is the focus of this Note. The rationale for the third prong was articulated by the Supreme Court in *Sch. Bd. of Nassau Cnty., Fla. v. Arline*.⁵¹ The Court concluded that, by including this test in the Rehabilitation Act of 1973, “Congress acknowledged that society’s accumulated myths and fears about disability and diseases are as handicapping as are the physical limitations that flow from actual impairment.”⁵² This third prong provides protection for

47. 24 C.F.R. § 100.201(a) (2026).

48. 42 U.S.C. § 3602(h).

49. *See*, *Valley Hous. LP v. City of Derby*, 802 F. Supp. 2d 359, 384 (D. Conn. 2011); *Oxford House v. Township of Cherry Hill*, 799 F. Supp. 450, 459 (D.N.J. 1992); *Oxford House, Inc. v. Browning*, 266 F. Supp. 3d 896, 910–11 (M.D. La. 2017).

50. 24 C.F.R. § 100.201(c) (2026).

51. *Sch. Bd. of Nassau Cnty., Fla. v. Arline*, 480 U.S. 273, 284 (1987); Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

52. *Arline*, 480 U.S. at 284; Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

people that may otherwise be treated adversely as a result of stigmatizing perceptions held by others. An individual who is denied housing or benefits “because of myths, fears, and stereotypes associated with disabilities would be covered under this third test whether or not the person’s physical or mental condition would be considered a disability under the first or second test in the definition.”⁵³

The third prong of handicap, being “regarded as” having an impairment, encompasses three interpretations: (1) an individual’s physical or mental impairment is treated by another person as a substantial limit to one or more major life activities; (2) an individual’s physical or mental impairment substantially limits one or more major life activities because of the attitudes of others; or (3) an individual does not have any impairments but is treated by another person as having an impairment.⁵⁴

Under the first interpretation, if a housing entity “excludes or takes action to treat a person worse than it otherwise would because of some physical or mental condition the person has,” the individual is regarded as having a substantially limiting impairment.⁵⁵ In such circumstances, it is immaterial whether the condition in fact limits a major life activity. Rather, the dispositive inquiry is whether the individual was treated as if they had such a limitation. If so, that treatment alone is sufficient to satisfy the third prong.

The second interpretation, where an impairment is substantially limiting due to the attitudes of others, captures the role of stigma, bias, and social perception. In this context, “regarded as” having an impairment includes circumstances in which a person “[h]as a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward such impairment.”⁵⁶ It recognizes that a condition may become disabling not solely because of its inherent characteristics, but because of how others respond to it. In this sense, the “regarded as” prong explicitly accounts for the socially constructed dimensions of disability.

Finally, the third interpretation applies where an individual has no impairment but is nevertheless treated as though they do.⁵⁷ Under this regulatory language, if a housing entity “excludes or takes action to treat a person worse than it otherwise would because of some physical or mental condition the person has or is believed to have, then the covered entity has treated the person as having a substantially limiting impairment.”⁵⁸ Here, liability attaches when a

53. Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

54. 24 C.F.R. § 100.201(d) (2026).

55. *ADA Policy Brief Series #15: Supreme Court’s Decisions Discussing “Regarded As” Prong of the ADA Definition of Disability*, NAT’L COUNCIL ON DISABILITY 11 (May 21, 2003), <https://www.ncd.gov/report/ada-policy-brief-series-15-supreme-courts-decisions-discussing-regarded-as-prong-of-the-ada-definition-of-disability/> [<https://perma.cc/JC59-P43E>].

56. 24 C.F.R. § 100.201(d)(2) (2026).

57. *Id.*

58. NAT’L COUNCIL ON DISABILITY, *supra* note 55.

housing provider acts on the belief, accurate or not, that the individual has a physical or mental condition and, on that basis, subjects them to adverse treatment. The existence of an actual impairment is therefore irrelevant; what matters is the perception and the resulting discriminatory conduct. In such circumstances, the individual is “regarded as” having a disability.

C. Group Homes for People with Disabilities

Previously incarcerated individuals should be afforded the same FHA protections as residents of sober living homes. Sober living homes are often a primary housing option for individuals reentering society, particularly those recovering from substance use disorders. Rates of substance abuse and dependence are significantly higher among the reentry population,⁵⁹ and such housing may be among the few viable options available to individuals with criminal records. Because individuals in recovery from drug or alcohol addiction are considered “handicapped” under the FHA,⁶⁰ sober living homes, and their residents, are protected from discriminatory housing practices.

The 1988 FHA Amendments’ prohibitions against handicap or disability discrimination intended, amongst its other objectives, to prevent restrictions on communal housing opportunities like group homes for people with disabilities. The House Judiciary Committee report explicitly states that the 1988 Amendments Act was intended to apply to “state or local land use and health and safety laws, regulations, practices or decisions which discriminate against individuals with handicaps.”⁶¹ Congress was aware of instances where local governments had applied laws and regulations in a discriminatory manner against “congregate living arrangements for persons with handicaps.”⁶² Beyond governmental discrimination based on “an irrational prejudice” against people with disabilities, Congress expressed concern about possible neutral laws or rules that would have a discriminatory impact on housing opportunities for those with disabilities.⁶³ The House Judiciary Committee expressed the breadth of this concern: “The Act is intended to prohibit the application of special requirements through land-use regulations, restrictive covenants, and conditional or special use permits that have the effect of limiting the ability of such individuals to live in the residence of their choice in the community.”⁶⁴

Despite these intentions to prevent restrictions on communal housing options for people with disabilities, the FHA’s protections extend only to housing units or facilities that are considered a “dwelling.” A dwelling is defined

59. See *infra* section III(B) (A Lack of Understanding of Mental Health Conditions as It Relates to the Formerly Incarcerated).

60. See, e.g., *Oxford House v. Township of Cherry Hill*, 799 F. Supp. 450, 459 (D.N.J. 1992); *Corp. of Episcopal Church in Utah v. W. Valley City*, 119 F. Supp. 2d 1215, 1219 (D. Utah 2000).

61. H.R. REP. NO. 100-711, at 24 (1988).

62. H.R. REP. NO. 100-711, at 23 (1988).

63. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 450 (1985).

64. H.R. REP. NO. 100-711, at 24 (1988).

as, “any building, structure, or portion thereof which is occupied as, or designed or intended for occupancy as, a residence by one or more families, and any vacant land which is offered for sale or lease for the construction or location thereon of any such building, structure, or portion thereof.”⁶⁵ The FHA does not elaborate further on this definition. Thus, courts have leaned on their own interpretation, resulting in various definitions of what may classify as a dwelling, in many instances excluding group homes.

Many courts have not considered transitional or short-term living facilities as a dwelling under the FHA.⁶⁶ Other courts have been willing to extend the protections of the FHA to a broader definition of short-term rehabilitation facilities or nursing homes.⁶⁷ The broader interpretation of a dwelling has allowed various group homes to bring claims against local jurisdictions under the FHA. The term “group home” is not a legal term but generally refers to housing occupied by groups of unrelated individuals. There are many kinds of group homes: youth group homes, homes for people with intellectual or developmental disabilities, substance-abuse recovery homes, sober living homes, halfway homes, re-entry homes, or low-income homes. Some group homes are sponsored by organizations that offer various services for individuals living in the home, such as counseling, supportive services, case management, transportation, food, healthcare, or medical treatment.⁶⁸

The Third Circuit developed a two-step analysis for what is considered a dwelling for purposes of applying FHA protections: (1) whether the facility is intended or designed for occupants intending to remain in the facility for a significant period of time, and (2) whether those occupants would view the facility as a place to return to during that period.⁶⁹ Although this analysis

65. U.S.C. § 3602(b).

66. *Patel v. Holley House Motels*, 483 F.Supp. 374, 381 (S.D. Ala. 1979) (holding that a motel was not a dwelling); *Schneider v. County of Will* 190 F.Supp.2d 1082, 1087 (N.D. Ill. 2002) (holding that a proposed bed and breakfast is not a dwelling); *Johnson v. Dixon*, 786 F.Supp. 1, 4 (D.D.C. 1991) (holding that homeless and emergency shelters are not characterized as a dwelling).

67. *Hovsons, Inc. v. Twp. of Brick*, 89 F.3d 1096, 1102 (3d Cir. 1996) (proposed nursing home was a dwelling); *Connecticut Hosp. v. City of New London*, 129 F. Supp. 2d 123, 134–36 (D. Conn. 2001) (holding that temporary outpatient treatment housing for people recovering from alcohol and substance use is a dwelling); *Schwarz v. City of Treasure Island*, 544 F.3d 1201, 1216 (11th Cir. 2008) (holding halfway houses are dwellings); *United States v. Hughes Mem’l Home*, 396 F.Supp. 544, 549 (W.D. Va. 1975) (holding a children’s home with a four-year average stay was a dwelling); *Baxter v. City of Belleville*, 720 F.Supp. 720, 731 (S.D. Ill. 1989) (holding hospice for terminally ill HIV patients was a dwelling); *United States v. Commonwealth of Puerto Rico*, 764 F.Supp. 220, 223–25 (D.P.R. 1991) (applying FHA to case challenging the closure of a nursing home).

68. *Exploring Different Types of Group Homes: A Guide to Starting Your Own Group Home*, GROUP HOMEHUB (Feb. 24, 2024), <https://grouphomehub.com/exploring-different-types-of-group-homes-a-guide-to-starting-your-own/> [https://perma.cc/GQ9M-3DYV] (The Author draws on professional experience as a mental health practitioner working with individuals in group home settings).

69. *Lakeside Resort Enters., LP v. Bd. of Sup’rs of Palmyra Twp.*, 455 F.3d 154, 158–60 (3d Cir. 2006).

requires a court's discretion, it provides more guidance than the FHA's definition of a dwelling. The first step requires a court's discretion to determine what constitutes a significant period of time. Since no blanket rule or guideline exists on this analysis, courts vary on defining what constitutes a significant period of time.⁷⁰ For example, migrant farm workers living in cabins for five months constituted a dwelling under the FHA.⁷¹ In contrast, individuals living in group homes for alcohol and drug treatment for six weeks also constituted a dwelling.⁷² The second step requires a court's discretion to decide whether occupants view or perceive their group home or facility as a place to return to. A place to return to may be defined as an occupant's feeling of being at home.⁷³ Courts may also analyze how and in which way the occupants use the facility as their home.⁷⁴ Often, courts consider tasks like cooking and cleaning as evidence that the occupant treated the facility as their home.⁷⁵

The FHA's definition of a dwelling has led to inconsistencies in applying protections to group homes, particularly affecting temporary or transitional facilities like sober living homes and reentry group homes. Since jurisdictions differ in their interpretations of whether a group home qualifies as a dwelling, these types of group homes face challenges when seeking the FHA's protections. By analyzing the duration of stay and whether occupants perceive the facility as home, the Third Circuit's two-step analysis provides a more comprehensive framework for determining whether a facility qualifies as a dwelling. This analysis is particularly relevant for reentry group homes, where residents often stay for a significant period to achieve stability. Additionally, individuals in reentry homes perceive these facilities not just as a place to stay, but as a vital space for recovery and reintegration after incarceration. Given this understanding, reentry group homes, much like sober living homes, should be classified as dwellings under the FHA, as both serve as essential housing for communal recovery.

70. *United States v. Columbus Country Club*, 915 F.2d 877, 884–85 (3d Cir. 1990) (seasonal or summer homes were considered dwellings); *Connecticut Hosp. v. City of New London*, 129 F.Supp.2d 123, 132, 135 (D. Conn. 2001) (residents living in group homes for alcohol and drug treatment, in which average length of stay is six weeks, are dwellings); *Villegas v. Sandy Farms, Inc.*, 929 F.Supp. 1324, 1328 (D. Or. 1996) (cabins occupied by migrant farm workers during the five-month harvest season are dwellings).

71. *Villegas*, 929 F.Supp. at 1328.

72. *Connecticut Hosp.*, 129 F.Supp.2d at 132, 135.

73. *Lakeside Resort Enters.*, 455 F.3d at 159.

74. *Gorman, Marinaccio & Cardinale*, *supra* note 22, at 610.

75. *Lakeside Resort Enters.*, 455 F.3d at 159–60 (“residents would eat meals together, return to their rooms in the evening, receive mail at the facility and make it their ‘residence’ while they were there . . . residents hung picture on their walls and had visitors”).

III. ANALYSIS

A. Existing FHA Protections Do Not Apply to the Reentry Community

Despite the many protections the FHA affords, its application does not account for the housing needs of the reentry population. The FHA's direct threat provision is frequently invoked to improperly justify the exclusion of previously incarcerated individuals from housing. First, the direct threat provision provides no protections for individuals with a handicap or disability if they pose a direct threat to the safety of others or their property.⁷⁶ Second, the law does not reflect an understanding of mental health conditions that are caused by a person's contact with the justice system. Thus, existing FHA protections enforced by local jurisdictions ought to apply to group homes for the reentry population. The following Section analyzes these existing barriers.

1. Direct Threat Provision Wrongfully Justifies Housing Discrimination

The FHA has an exception to its general protection against housing discrimination for people with disabilities: the direct threat provision. The FHA affords no protections to individuals with a handicap or disability who present a direct threat to the persons or property of others.⁷⁷ This direct threat provision was included in the 1988 Amendments Act "to allay the fears of those who believe that the nondiscrimination provisions of this Act would force landlords and owners to rent or sell to persons whose tenancies could pose such a risk."⁷⁸ Therefore, "a dwelling need not be made available to an individual whose tenancy can be shown to constitute a direct threat and a significant risk of harm to the health or safety of others."⁷⁹

Courts generally decide whether an individual with a mental condition poses a direct threat on a fact-specific, case-by-case basis. "Generalized assumptions, subjective fears, and speculation are insufficient to prove the requisite direct threat."⁸⁰ Courts are required to examine objective evidence for proof of dangerous behavior. For example, homeowners brought a claim against state officials to prevent two group homes for individuals with mental illness from being built in their residential areas.⁸¹ Based on the profile of the prospective residents that were to live in the group homes, the homeowners claimed that these individuals posed a "heightened risk of dangerousness to the community."⁸² The plaintiffs based the risk of danger argument on the prospective residents' history of involuntary commitments, past failures in

76. 42 U.S.C. § 3604(f)(9).

77. *Id.*

78. H.R. REP. NO. 100-711, at 28 (1988).

79. *Id.* at 30.

80. H.R. REP. NO. 100-711, at 29 (1988).

81. *Township of West Orange v. Whitman*, 8 F.Supp.2d 408, 411-13 (D.N.J. 1998).

82. *Id.* at 428.

community settings, and psychiatric diagnoses.⁸³ However, the court found that plaintiffs could not meet the burden of proving individualized dangerousness, which must be met to deny these people housing.⁸⁴ Thus, the residents could not be excluded from the protections of the FHA.⁸⁵

A belief of direct threat does not satisfy the requirement for objective evidence.⁸⁶ Evaluating the behavior of a tenant through the scope of a resident's subjective fears would be "contrary to the clear legislative intent that there be proof by objective facts of a direct threat."⁸⁷ The risk assessment of dangerousness should be based on an objective analysis by health care professionals of the prospective tenant's or homeowner's behavior.⁸⁸

There is no single type of behavior that constitutes a direct threat; rather, it encompasses a range of conduct. The following examples illustrate situations in which a landlord or housing provider successfully argued that a tenant should be evicted based on concerns about their behavior. Conduct involving physical harm or clear threats to the safety of other tenants will typically qualify as a direct threat. For example, a tenant who strikes and injures another resident would likely meet this standard.⁸⁹ However, a tenant may also be deemed a direct threat based on a significant risk of harm, even in the absence of actual injury. In one instance, a tenant who engaged in altercations with other residents, chased children with a knife, listened to loud and vulgar music, and made inappropriate sexual comments was found to pose a direct threat to his neighbors.⁹⁰ In another, a tenant's behavior was deemed a direct threat where he appeared nude in front of other residents, repeatedly failed to secure a building entrance, verbally attacked others, and displayed misogynistic signs in his apartment window.⁹¹

Congress intended for the direct threat provision to be interpreted in light of the Supreme Court's decision, *Sch. Bd. of Nassau Cnty., Fla. v. Arline*, which was decided one year before the passage of the 1988 FHA Amendments.⁹² In that case, the Court held that a teacher with a disability—tuberculosis—could not be fired because of her contagious condition if she were "otherwise qualified" for the position.⁹³ Even if the teacher did pose a threat to the health and safety of others, she would be "otherwise qualified" if that threat could be eliminated by a reasonable accommodation.⁹⁴ Due to the statutory protections

83. *Id.*

84. *Id.*

85. *Id.*

86. *Wirtz Realty Corp. v. Freund*, 721 N.E.2d 589, 598–99 (Ill. App. 3d 1999).

87. *Id.* at 597.

88. *Id.* at 598–99.

89. *See Roe v. Hous. Auth. of Boulder*, 909 F.Supp. 814, 817 (D. Colo. 1995).

90. *Foster v. Tinnea*, 705 So.2d 782, 785–87 (La. Ct. App. 1997).

91. *Arnold Murray Constr., L.L.C. v. Hicks*, 621 N.W. 2d 171, 173, 176 (S.D. 2001).

92. *Arline*, 480 U.S. at 273.

93. *Id.* at 284.

94. *Id.* at 287–89.

to people with disabilities under the FHA, courts require that landlords provide reasonable accommodations. In interpreting *Sch. Bd. of Nassau Cnty., Fla. v. Arline*,⁹⁵ courts have emphasized that individuals may not be denied housing based on disability alone, even if they pose a direct threat to the health and safety of others. However, if a landlord can show that no reasonable accommodation for a tenant would eliminate or sufficiently mitigate a direct threat to the health or safety of others, then an accommodation need not be granted.

It is not entirely clear what kind of showing courts require before they conclude that a reasonable accommodation would not minimize or eliminate the risk posed by the tenant's behavior. Yet, the caselaw suggests that very little evidence or inquiry is required by the courts.⁹⁶ In *Foster v. Tinnea*, the court held that a tenant who suffered from brain damage was not entitled to a reasonable accommodation because his rude comments to other tenants constituted a direct threat.⁹⁷ The court concluded that the landlord was entitled to refuse the tenant's lease renewal because no reasonable accommodation could eliminate or minimize the risk which the tenant posed to other residents.⁹⁸ In *Arnold Murray Construction, L.L.C. v. Hicks*, the court held that a tenant who suffered from a brain injury was not entitled to a reasonable accommodation because his emotional outbursts, verbal threats, and other behavior posed a direct threat to his neighbors.⁹⁹ The court concluded that no reasonable accommodation would eliminate or diminish the risk that the tenant posed to other tenants, and thus, an eviction was allowed.¹⁰⁰ In both cases, the court looked at the danger or behavior of the tenants but did not discuss possible accommodations for the mental health concerns. Rather, if the landlord can demonstrate that no reasonable accommodation would eliminate or acceptably minimize the "threat" posed by the tenant, then the landlord is not required to implement such an accommodation.¹⁰¹

The direct threat provision poses a significant problem for the reentry population. Even though an individual's mental health condition qualifies as a disability, that same individual can be denied housing because of a landlord's perception that the tenant's behavior poses a risk to others. The landlord may be influenced by the knowledge of the individual's previous incarceration when assessing the risk, which points to the importance of the law to protect this vulnerable population. In practice, an applicant can be deemed "an undesirable applicant because of [their] extensive criminal record."¹⁰²

95. *Id.* at 273.

96. *See, e.g., Foster v. Tinnea*, 705 So.2d 782, 786 (La. Ct. App. 1997); *Arnold Murray Constr., L.L.C. v. Hicks*, 621 N.W. 2d 171, 176 (S.D. 2001).

97. 705 So.2d at 784–87.

98. *Id.* at 786.

99. 621 N.W. 2d at 173–76.

100. *Id.* at 176.

101. *Id.*

102. *Talley v. Lane*, 13 F.3d 1031, 1035 (7th Cir. 1994) (holding that the housing authority's determination based on the applicant's legal history is a discretionary decision).

The direct threat provision was not intended to deny housing for individuals with a disability based on assumptions, fears, or speculation, but rather, it was intended for the following purpose:

Generalized assumptions, subjective fears, and speculation are insufficient to prove the requisite direct threat [. . .] If a landlord determines, by objective evidence that is sufficiently recent to be credible, and not from unsubstantiated inferences, that the applicant will pose a direct threat to the health or safety of others, the landlord may reject the applicant as a tenant. In assessing information, the landlord may not infer that a history of a physical or mental illness or disability, or treatment for such illnesses or disabilities, constitutes proof that an applicant will be unable to fulfill his or her tenancy obligations.¹⁰³

The concern of landlords or housing owners was accommodated by the direct threat exception to the FHA. It provided for the possibility that “a dwelling need not be made available to an individual whose tenancy can be shown to constitute a direct threat and a significant risk of harm to the health or safety of others.”¹⁰⁴ However, “if a reasonable accommodation could eliminate the risk, entities covered under this Act are required to engage in such accommodation pursuant to . . . the Act.”¹⁰⁵ The problem is that the application of the direct threat provision has reached beyond “objective evidence . . .” to answer the question on whether “. . . [an] applicant will pose a direct threat to the health or safety of others.”¹⁰⁶ Rather, the direct threat provision has provided housing owners and landlords the means to discriminate against individuals with a criminal record without considering the individual’s protected disability under the FHA.

Housing providers and landlords routinely conduct criminal background checks as part of their tenant screening processes and deny housing because of the existence of a criminal conviction, even if the individual would otherwise be qualified. It is estimated that more than 100,000,000 people, nearly one out of every three adults, have some sort of criminal record, including a history of arrest, conviction, and incarceration;¹⁰⁷ However, the exact number of applicants rejected due to their criminal record remains unclear.¹⁰⁸ Quantifying the impact of criminal record exclusions is challenging, as there is no way to determine how

103. H.R. REP. NO. 100-711, at 29–30 (1988).

104. *Id.* at 29.

105. *Id.* at 28.

106. *Id.* at 30.

107. SURVEY OF STATE CRIMINAL HISTORY INFORMATION SYSTEMS, 2012, U.S. DEP’T OF JUST. 2 (2024), <https://www.ojp.gov/pdffiles1/bjs/grants/244563.pdf> [<https://perma.cc/H8SN-GH32>].

108. *No Second Chance, People with Criminal Records Denied Access to Public Housing*, HUM. RTS. WATCH (Nov. 18, 2004), <https://www.hrw.org/report/2004/11/18/no-second-chance/people-criminal-records-denied-access-public-housing> [<https://perma.cc/59CM-9J9N>].

many applicants are denied. Additionally, it is impossible to estimate how many individuals refrain from applying due to ineligibility before the application process even begins. In a response to a Freedom of Information Act request, HUD reported that 46,657 applicants for project-based housing were denied housing in 2002 because of “one strike” criteria.¹⁰⁹ “One strike” refers to federal housing law and policy that excludes people with certain types of criminal records from eligibility for federal public housing programs.¹¹⁰ Yet, this data represents only a fraction of rejected applicants.

Legal actions may reveal a representation of how frequently applicants or prospective tenants are rejected because of their criminal record. New York City’s Commission on Human Rights filed a lawsuit against PRC Management, LLC for their blanket policy of denying housing to prospective tenants with criminal histories without considering the nature, severity, or date of their arrest or criminal conduct.¹¹¹ PRC Management, LLC controlled 100 buildings, including 5,000 units citywide.¹¹² In 2018, a settlement was reached based on the Commission’s investigation.¹¹³ The “Commission required PRC Management, LLC, to pay fines and damages, create and distribute new screening and application policies, train staff on new policies and law, and invite applicants previously denied housing because of their criminal history to reapply[;]” thus, a positive result for thousands of New Yorkers.¹¹⁴ Savannah Chatham County Fair Housing Council, Inc. brought legal action against CHG Westgate and American Management Company Inc. for instituting a blanket “ninety nine-year rule” which barred tenants if a person in the family has a record or a felony or misdemeanor within the past ninety nine years.¹¹⁵ The Defendants owned ninety four units in ten buildings, along with two buildings that received Section 8 financing.¹¹⁶ In 2018, a settlement was reached.¹¹⁷ Although these examples do not include estimates of applicant rejections or denials, the settlements highlight the widespread nature of rejections and denials of prospective tenants based on blanket bans of criminal records.

109. *Id.*

110. *Id.*

111. *NYC Commission on Human Rights Settles Landmark Housing Discrimination Case with Bronx Management Company*, NYC COMM’N ON HUM. RTS. (Dec. 6, 2018) <https://www.nyc.gov/assets/cchr/downloads/pdf/press-releases/PRESS%20RELEASE%20-%20Criminal%20History%20Disparate%20Impact%20Press%20Release%20120618.pdf> [https://perma.cc/PS5K-893K]

112. *Id.*

113. *Id.*

114. *Id.*

115. *Sams v. Ga West Gate, LLC*, No. CV415-282, 2017 WL 436281, at *1–2 (S.D. Ga. Jan. 30, 2017).

116. Jan Skutch, *Fair-housing suit settled with Garden City defendants*, SAVANNAH MORNING NEWS (Jan 15, 2018, 5:30 PM), <https://www.savannahnow.com/story/news/crime/2018/01/15/fair-housing-suit-settled-garden-city-defendants/13842279007/> [https://perma.cc/7QUW-P2U8] (noting that Westgate was HUD Section 8–financed affordable housing, a federal rental subsidy program subject to HUD regulations).

117. *Id.*

Research finds that an individual's criminal history, including those individuals with mental health conditions or substance use concerns, is not predictive of housing stability for this population and largely unrelated to predicting housing problems.¹¹⁸ Therefore, excluding people with criminal records will not necessarily make housing safer. To combat the idea that violent offenses are the reason these exclusions are needed, a recent study analyzed fifteen offenses or types of prior convictions and the effects on housing outcomes.¹¹⁹ Negative housing outcomes analyzed in this study included losing housing due to lease violations, leaving without notice, or non-payment of rent.¹²⁰ Importantly, the study found that an individual's criminal background, including assault, fraud, property offenses, major drug-related offenses or violent offenses, did not significantly increase the likelihood of negative housing outcomes.¹²¹ Most categories had no significant impact on housing outcomes, including minor public order offenses, prostitution, alcohol-related offenses (e.g., public consumption/open bottle), DUI/DWI, and a number of other categories.¹²² The study only found mild increase in risk on negative housing outcomes with the following four categories: major drug-related offenses, property offenses (e.g., theft, burglary), assault, and fraud.¹²³ This study undermines the common belief that offense type significantly affects an individual's housing success.¹²⁴ Thus, the study challenges common misconceptions about using criminal background checks as a predictor for negative housing outcomes.

It is more accurate that negative outcomes increase for individuals who are unable to find or are denied housing. Successful transitions from jails and prisons into secure housing can reduce the risk of rearrest, relapse, or any negative behavioral outcomes.¹²⁵ A study found that the risk of recidivism increased by 35% for individuals without an address at the start of probation and

118. Daniel K. Malone, *Assessing Criminal History as a Predictor of Future Housing Success for Homeless Adults with Behavioral Health Disorders*, 60 PSYCHIATRIC SERVS. 224, 227–28 (2009).

119. Cael Warren, *Success in Housing: How Much Does Criminal Background Matter?*, WILDER RSCH. 12–13 (2019), https://www.wilder.org/sites/default/files/imports/AEON_Housing_Success_CriminalBackground_Report_1-19.pdf [<https://perma.cc/BZP4-4NH3>].

120. *Id.* at 10; Notably, the study's definition of negative housing outcomes, such as nonpayment of rent, lease violations, or vacating a unit without notice, captures conduct that is often shaped by broader social and economic conditions rather than individual dangerousness. These outcomes frequently reflect underlying social determinants of health, including housing instability, poverty, barriers to employment, limited access to mental health or substance use treatment, and lack of community support. As a result, such outcomes are not reliable indicators of a tenant's propensity to pose a safety risk to others but rather may signal systemic challenges and barriers.

121. *Id.* at 19.

122. *Id.* at 17.

123. *Id.* at 19.

124. *Id.* at 19.

125. REENTRY COORDINATION COUNCIL, *supra* note 6.

44% for individuals who experienced homelessness during probation.¹²⁶ These findings expand on prior research that finds homelessness, after incarceration, is a recidivism risk factor.¹²⁷

The existing legal channels available for individuals with criminal records to challenge instances of housing discrimination are limited. A housing provider's policies or practices regarding the review of an individual's criminal history before making a housing decision may violate the FHA. In situations where criminal records are considered in housing decisions, the housing provider typically claims the safety of the property and other residents as the primary concern.¹²⁸ In 2016, HUD issued guidance to Public Housing Authorities (PHAs) on the FHA and criminal records.¹²⁹ In its 2016 guidance, HUD highlighted two policies or practices, in particular, that are likely illegal under the FHA: (1) exclusions based on prior arrests that did not result in convictions; and (2) blanket bans based on prior convictions.¹³⁰

First, exclusions based on prior arrests that did not result in convictions likely violate the FHA. Not only will these exclusions almost certainly have a disparate impact on protected classes, but they also will never be justified because an arrest indicates nothing more than a suspicion of having committed a crime; therefore, the mere fact of an arrest, without conviction, should not be relevant for housing decisions like denying a prospective tenant's application.

Further, blanket bans based on prior convictions likely violate the FHA. If a housing provider automatically denies anyone or all applicants with a conviction history, this likely is a violation of the statute. Housing providers often impose a blank ban on people with convictions without considering a variety of factors like the type of conviction, the length of time that has elapsed since the criminal conduct, and other mitigating factors. Other similarly problematic policies enforced by housing providers may include bans involving broad categories of convictions or the use of unreasonably long lookback periods for criminal records screenings. Like exclusions based solely on arrests, these bans almost certainly have a disparate impact on protected classes.

126. Leah A. Jacobs & Aaron Gottlieb, *The Effect of Housing Circumstance on Recidivism: Evidence from a Sample of People on Probation in San Francisco*, 47 CRIM. JUST. & BEHAV. 1097, 1111 (2020).

127. See Valerie A. Clark, *Predicting Two Types of Recidivism Among Newly Released Prisoners: First Addresses as "Launch Pads" For Recidivism or Reentry Success*, 62 CRIME & DELINQ. 1364 (2016); see also Benjamin Steiner, Mathew D. Makarios, & Lawrence F. Travis, *Examining the Effects of Residential Situations and Residential Mobility on Offender Recidivism*, 61 CRIME & DELINQUENCY 375 (2015).

128. U.S. DEP'T OF HOUS. & URB. DEV., OFFICE OF GENERAL COUNSEL GUIDANCE ON APPLICATION OF FAIR HOUSING ACT STANDARDS TO THE USE OF CRIMINAL RECORDS BY PROVIDERS OF HOUSING AND REAL ESTATE-RELATED TRANSACTIONS 4 (2016), https://www.hud.gov/sites/documents/hud_ogcguidappfhastandcr.pdf [<https://perma.cc/JK5K-XU9F>].

129. PHAs are local agencies that determine public housing eligibility based on general guidelines published by the federal Department of Housing and Urban Development (HUD); see U.S. DEP'T OF HOUS. & URB. DEV., *supra* note 128.

130. U.S. DEP'T OF HOUS. & URB. DEV., *supra* note 128 at 5–6.

Although convictions generally serve as sufficient evidence of criminal conduct, blanket bans fail to accurately assess former convicts on an individualized basis rather than on assumptions or generalizations about who may pose a safety risk.

Beyond these recognized policies or practices considered by the HUD to be a violation under the FHA, a previously incarcerated individual can request a reasonable accommodation if they have a recognized disability that resulted in their criminal charges or conviction. In cases where criminal conduct is connected to an individual's disability, a housing provider may need to provide a reasonable accommodation in the form of modifying its policies or practices around criminal records; however, this is not a guarantee. When requesting a reasonable accommodation, individuals should explain how their disability contributed to the criminal conduct. For example, in *Simmons v. T.M. Assocs. Mgmt., Inc.*, the plaintiff's complaint alleged a failure to make a reasonable accommodation when the apartment complex did not reconsider his application because of his criminal record.¹³¹ The court concluded that the apartment complex could not deny the plaintiff's proposed reasonable accommodation for his mental health disability even though he had a conviction for indecent exposure.¹³² The court determined there was no "ironclad rule" that a criminal conviction bars an individual protection afforded by disability anti-discrimination statutes.¹³³ Since there are so few existing housing claims under the FHA for individuals with legal or criminal records, it leaves previously incarcerated individuals without helpful precedent in many jurisdictions. Using the "regarded as" prong of the FHA's definition of handicap, however, may open the door for plaintiffs that have been denied housing because of their criminal conviction to bring a claim of disability discrimination on a larger scale.

HUD expanded on this guidance by issuing another memo in 2022, with guidelines encouraging Public Housing Authorities to make their 2023 housing policies as inclusive as possible for people with criminal records or legal histories.¹³⁴ It remains to be seen how PHAs will incorporate this, especially under the new conservative Presidency. Although PHAs are only one form of low-income housing, there are still limitations to HUD's guidance, which does not address housing for the formerly incarcerated in the private market.

131. *Simmons v. T.M. Assocs. Mgmt., Inc.*, 287 F. Supp. 3d 600, 601–02 (W.D. Va. 2018).

132. *Id.* at 602–04.

133. *Id.* at 604.

134. See U.S. DEP'T OF HOUS. & URB. DEV., IMPLEMENTATION OF THE OFFICE OF GENERAL COUNSEL'S GUIDANCE ON APPLICATION OF FAIR HOUSING ACT STANDARDS TO THE USE OF CRIMINAL RECORDS BY PROVIDERS OF HOUSING AND REAL ESTATE-RELATED TRANSACTIONS (2022), <https://www.hud.gov/sites/dfiles/FHEO/documents/Implementation%20of%20OGC%20Guidance%20on%20Application%20of%20FHA%20Standards%20to%20the%20Use%20of%20Criminal%20Records%20-%20June%2010%202022.pdf> [https://perma.cc/Y5XX-X5SG].

2. A Lack of Understanding of Mental Health Conditions as It Relates to the Formerly Incarcerated

The law does not adequately reflect the realities of mental health conditions among individuals who have had contact with the justice system. Although the FHA recognizes certain mental health conditions as protected disabilities, that protection is often illusory for previously incarcerated individuals. In practice, even when an individual's mental health condition qualifies as a disability, housing providers may still deny housing based on the individual's criminal history. As a result, individuals with criminal records are frequently excluded from housing opportunities notwithstanding their protected status under the FHA. This disconnect reveals a critical gap in both the FHA and the surrounding case law, which fail to account for the intersection of mental health-related disabilities and criminal history. The result is a significant barrier to housing for the reentry population—one that undermines the FHA's broader anti-discrimination goals. This Section addresses that gap by first examining the prevalence of mental health conditions among justice-involved individuals, then reviewing the extensive body of research on how incarceration exacerbates or produces such conditions, and finally analyzing the structural and social barriers, particularly during reentry, that shape mental health outcomes and housing instability.

To paint a picture of this disparity, it is necessary to provide figures on the prevalence of mental health conditions within this population. People with mental illness and/or substance use disorder suffer disproportionate rates of incarceration, with an estimated two million people with mental illness and substance use disorder being booked into jails every year.¹³⁵ It is estimated that 64% of people in local jails suffer from mental illness.¹³⁶ The rate of serious mental illness is four to six times higher in jail than in the general population.¹³⁷ The prevalence of incarcerated individuals with substance use disorders is seven times higher compared to those in the general population.¹³⁸ It can be assumed that these mentioned estimates are much higher because it is well documented

135. SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., EXECUTIVE ORDER SAFE POLICING FOR SAFE COMMUNITIES: ADDRESSING MENTAL HEALTH, HOMELESSNESS, AND ADDICTION REPORT 1, <https://www.samhsa.gov/sites/default/files/safe-policing-safe-communities-report.pdf> [https://perma.cc/WL6R-VXUQ].

136. Press Release, The White House, Office of the Press Sec'y, FACT SHEET: Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration (June 30, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle> [https://perma.cc/WU5G-6FP2].

137. Ram Subramanian, et al., *Incarceration's Front Door: The Misuse of Jails in America*, VERA INST. OF JUST., https://www.vera.org/downloads/publications/incarcerations-front-door-report_02.pdf [https://perma.cc/S3LY-KVVZ] (last updated July 29, 2015).

138. THE COUNCIL OF STATE GOV'T JUST. CENTER, *The Justice and Mental Health Collaboration Program (JMHC) FAQs*, <https://csgjusticecenter.org/projects/justice-and-mental-health-collaboration-program-jmhcp/faqs/> [https://perma.cc/KW3J-B527] (last visited Mar. 9, 2025).

that mental health conditions are significantly under reported due to a variety of factors like stigma and biases.¹³⁹

Once incarcerated, people face additional challenges beyond their criminal sentencing and punishment that leads to developing mental health symptoms or worsening mental health conditions. Many jailed individuals do not receive necessary mental health treatment to alleviate these concerns.¹⁴⁰ More importantly, the circumstances of the carceral environment are inherently damaging, and mental health interventions are simply unable to mitigate the lived experience of incarceration. Consequently, many individuals develop mental health conditions while incarcerated.

Abundant literature explains how the circumstances of incarceration further worsen mental health conditions or lead individuals to develop mental health conditions. Many of the defining features of incarceration are linked to negative mental health outcomes: compounding impacts of little autonomy;¹⁴¹ poor nutrition;¹⁴² overcrowding;¹⁴³ limited medical care;¹⁴⁴ decreased social connectedness;¹⁴⁵ and strict prison rules.¹⁴⁶ Other factors contribute to worsening mental health amongst incarcerated individuals. For example, solitary confinement, which is used in forty-four states and in federal government facilities,¹⁴⁷ can result in a wide range of mental health symptoms.¹⁴⁸ Individuals held in solitary confinement exhibit a range of negative physiological and psychological reactions: anger; perceptual distortions and hallucinations; increased anxiety and nervousness; fears of

139. See Yoichiro Takayanagi, et al., *Accuracy of Reports of Lifetime Mental and Physical Disorders: Results from the Baltimore Epidemiological Catchment Area Study*, 71 JAMA PSYCHIATRY 273–80 (2014); Joyce Mason, et al., *Health Reporting from Different Data Sources: Does it Matter for Mental Health?*, 26 J. MENTAL HEALTH POL’Y & ECON. 33–57 (2023); Francesca Mongelli, Penelope Georgakopoulou & Michele T. Pato, *Challenges and Opportunities to Meet the Mental Health Needs of Underserved and Disenfranchised Populations in the United States*, 18 FOCUS 16–24 (2020).

140. See Fuller Torrey et al., *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, TREATMENT ADVOCACY CTR & NAT’L SHERIFFS ASS’N, at 8 (2014); SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 135, at 1.

141. Vanjani Rahul, *On Incarceration And Health — Reframing The Discussion*, 376 THE NEW ENGLAND J. OF MED. 2411–13 (2017).

142. Jerome Sarris, et al., *Nutritional Medicine as Mainstream in Psychiatry*, 2 THE LANCET PSYCHIATRY 271, 271–74 (2015); NAT’L RSCH. COUNCIL AND INST. OF MED., HEALTH AND INCARCERATION: A WORKSHOP SUMMARY, at 8 (2013).

143. NAT’L RSCH. COUNCIL AND INST. OF MED., HEALTH AND INCARCERATION: A WORKSHOP SUMMARY, at 8 (2013).

144. *Id.* at 7–14.

145. See Priya Wickramaratne et al., *Social Connectedness as a Determinant of Mental Health: A Scoping Review*, 17 PLOS ONE (2022).

146. Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARVARD C.R.-C.L. L. REV. (2006).

147. AM. C. L. UNION, *Briefing Paper: The Dangerous Overuse of Solitary Confinement in the United States*, at 2 (2014), https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf [<https://perma.cc/39W2-EPLD>]

148. *Id.* at 4.

persecution; lack of impulse control; severe and chronic depression; appetite loss and weight loss; withdrawal; blunting of affect and apathy; talking to oneself; sleeping problems and nightmares; confusing or distortions in thought processes; self-mutilation; and lower levels of brain function, including a decline in EEG activity after only seven days in solitary confinement.¹⁴⁹

Beyond the effects of solitary confinement, incarcerated individuals experience other environmental factors that contribute to high rates of mental health conditions. A major contributing factor is violence in prisons and jails.¹⁵⁰ Incarcerated individuals experience and witness violence within their living environment, leading to development of acute or chronic trauma diagnoses, like post-traumatic stress disorder. One study analyzed violent episodes in jails during a six-month period and found that 35% of men and 24% of women experience physical violence. Similarly, 10% of men and 24% of women are sexually harassed or assaulted in prison.¹⁵¹ Research also suggests that persistent fear of the possibility of violence can account for mental health symptoms, including hypervigilance, which is key in anxiety-related diagnoses, including anxiety disorders and post-traumatic stress disorder.¹⁵² Thus, violence within the carceral setting is considered a contributing factor to mental health conditions, even if an inmate does not experience direct physical or sexual violence.

Once an individual is released from jail or prison, it is implausible to imagine that mental health conditions are immediately alleviated. Of course, individuals are eager for release from incarceration; however, the problems that people encounter post-release indicate that this eagerness is often short lived because of the difficulties encountered. During the time after release from jail or prison, it is critical for this population to receive support and resources. The

149. See Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME AND JUST. 441–528 (2006); Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. OF PSYCHIATRY 1450, 1452–53 (1983); Craig Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement*, 49 CRIME & DELINQ. 124, 130–33 (2003); Richard Korn, *The Effects of Confinement in the High Security Unit at Lexington*, 15 SOC. JUST. 8 (1988); Holly A. Miller, *Reexamining Psychological Distress in the Current Conditions of Segregation*, 1 J. OF CORRECTIONAL HEALTHCARE 39, 48 (1994); Stanley L. Brodsky & Forest R. Scogin, *Inmates in Protective Custody: First Data on Emotional Effects*, 1 FORENSIC REP. 267 (1988); Holly A. Miller & Glenn R. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, 7 CRIM. BEHAV. & MENTAL HEALTH 85, 91 (1997); Paul Gendreau et al., *Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement*, 79 J. OF ABNORMAL PSYCHOL. 54, 57–58 (1972).

150. Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health*, PRISON POL’Y INITIATIVE (May 13, 2021), <https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/> [https://perma.cc/LUP5-PRRX].

151. Nancy Wolff, Jing Shi & Jane A. Siegel, *Patterns of Victimization Among Male and Female Inmates: Evidence of an Enduring Legacy*, 24 VIOLENCE AND VICTIMS 469–84 (2009).

152. Paul Boxer, Keesha Middlemass & Tahlia Delorenzo, *Exposure to Violent Crime during Incarceration: Effects on Psychological Adjustment following Release*, 36 CRIM. JUST. & BEHAV. 793, 802 (2009).

risk of death by suicide or opioid overdose dramatically increases in the first days and weeks after an individual is released from jail or prison, illustrating the seriousness of potential risks.¹⁵³

Nationally, about 80% of individuals released from prison have a chronic medical, substance use, or psychiatric condition.¹⁵⁴ Due to the lack of access to mental health services and supports in the community, individuals are at a higher risk of repeated incarceration.¹⁵⁵ Research has shown that people with severe mental illness coupled with a criminal record are more likely to be discriminated against in mental health care settings.¹⁵⁶ Also, many patients with incarceration histories have described hospitals as mirroring a carceral-like environment, negatively impacting their care.¹⁵⁷ As defined in mental health diagnoses, avoidance or anxiety around certain places, persons, or experiences are clinical symptoms of trauma.¹⁵⁸ For example, a diagnosis of post-traumatic stress disorder includes “persistent avoidance of stimuli associated” with the traumatic event or experience.¹⁵⁹

The threat or actual experience of violence while incarcerated affects an individual’s mental health post-release. Researchers examined the effects of exposure to violent crime while incarcerated on longer term psychological adjustment following release.¹⁶⁰ The study found a connection between violent experiences while incarcerated to an increasing severity of antisocial behavior and emotional distress post-release.¹⁶¹ This research is indicative of trauma symptoms and diagnoses among the reentry population.

Mental health professionals have identified recurring mental health conditions or diagnoses could appear while working with the reentry population. Generally, formerly incarcerated individuals may experience distress, anxiety, depression, and a decline in self-esteem.¹⁶² Some diagnoses like substance abuse

153. Ingrid Binswanger et al., *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009*, 159 ANN INTERN MED. 592–600 (2013); Ingrid Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 357 N ENGL J. MED. 157–65 (2007).

154. Shira Shavit et al., *Transitions Clinic Network: Challenges And Lessons In Primary Care For People Released From Prison*, 36 HEALTH AFFAIRS 1006–15 (2017).

155. Glena Wrenn et al., *The Fierce Urgency of Now: Improving Outcomes for Justice-Involved People With Serious Mental Illness and Substance Misuse*, 69 PSYCHIATRIC SERV., at 829–30 (2018).

156. Nishar Brumfield et al., *“It’s a revolving door”: understanding the social determinants of mental health as experienced by formerly incarcerated people*, 11 HEALTH JUST., at 2 (2023).

157. *Id.* at 2.

158. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 5TH ED., TEXT REVISION (DSM-5-TR), at 302 (2022).

159. *Id.* at 302.

160. Boxer et al., *supra* note 152, at 794.

161. *Id.* at 802 (noting that antisocial behavior is indicated by general antisocial tendencies, recent aggressive behavior, and aggressive personality, and emotional distress is indicated by depressive symptoms, anxious symptoms, and recent episodes of emotional distress).

162. Jason Schnittker et al., *Out and down: Incarceration and psychiatric disorders*, 53 J. HEALTH AND SOC. BEHAV. 448, 449–50 (2012).

or personality disorders are popularly associated with this population. Other diagnoses prevalent in this population include mood disorders, like major depressive disorder, bipolar disorder, or persistent depressive disorder. In one study, major depressive disorder was found to be more prevalent than substance use disorder amongst former inmates.¹⁶³ Interestingly, this study found that across six different types of disabilities, the consequences of mood disorders are more strongly associated with disability compared to substance use disorders or impulse control disorders.¹⁶⁴

Formerly incarcerated individuals must also navigate a variety of social and economic factors post-release.¹⁶⁵ One study conducted through interviews of formerly incarcerated adults found that screenings for criminal records were not only stigmatizing, but also an “enduring mark that serves to justify the ongoing denial of rights and resources for those that have been to prison.”¹⁶⁶ Formerly incarcerated people are systematically prohibited from employment opportunities and quality housing because of these background checks and criminal history screenings. In response to this stress or strain, individuals are likely to experience negative emotions, like depression, resentment, anxiety, and anger.¹⁶⁷ Material hardship, along with the accompanying negative emotions, are linked to an increase in criminal behavior.¹⁶⁸ Individuals have reported that discrimination from employment and housing due to a criminal record cannot be ameliorated or cured with therapy and medications.¹⁶⁹ Said differently, therapy and medication cannot remedy such significant basic needs, like housing or employment; both of these are considered social determinants of health.¹⁷⁰ According to the definition adopted by the Center for Disease Control and Prevention, social determinants of health (“SDOH”) are the “conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”¹⁷¹ By this definition, research considers incarceration, justice system involvement, and conditions of confinement as SDOH.¹⁷²

Although not a recognized psychiatric disorder, the National Incarceration

163. *Id.* at 455.

164. *Id.* at 459.

165. Leah A. Jacobs & Aaron Gottlieb, *The Effect of Housing Circumstance on Recidivism: Evidence from a Sample of People on Probation in San Francisco*, 47 CRIM. JUST. & BEHAV. 1097–1115, at 1099 (2020).

166. Danya Keene et al., *Stigma, Housing and Identity After Prison*, 66 SOCIOLOGICAL REV. 799–815 (2018).

167. Leah A. Jacobs & Aaron Gottlieb, *supra* note 162, at 1099.

168. *Id.* at 1099.

169. Shivani Nishar et al., *“It’s a revolving door”: understanding the social determinants of mental health as experienced by formerly incarcerated people*, 11 HEALTH JUST., at 2 (2023).

170. *Id.*

171. *Social Determinants of Health (SDOH)*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jan. 17, 2024), <https://www.cdc.gov/socialdeterminants/index.htm> [<https://perma.cc/6PXF-CVHV>].

172. Nishar Brumfield et al., *supra* note 156, at 2.

Association has advocated for recognition of the mental health effects of reentry, calling it post-incarceration syndrome (PICS).¹⁷³ It defines PICS as:

[A] psychiatric disorder that affects individuals who have been incarcerated and then are released back into society. It is characterized by a range of psychological, emotional, and social difficulties that can arise as a result of being imprisoned. These difficulties can include depression, anxiety, post-traumatic stress disorder (PTSD), difficulty adjusting to life outside of prison, and difficulty forming and maintaining relationships.¹⁷⁴

This is a modern attempt to describe the psychological challenges that individuals who have been incarcerated may face upon reentry into the community. According to this definition, one of the causes of PICS is stigma, which may contribute to poor mental health states, isolation, and shame.¹⁷⁵ PICS attempts to create a diagnostic understanding of this complex transition and the known mental health implication for this population, perhaps constituting its own mental health diagnosis that could qualify an individual for FHA protections.

3. Restrictions and Obstacles for Group Homes

Group homes can bring to light conflicting interests.¹⁷⁶ On one hand, sober living homes and recovery homes foster collective recovery, as many group homes for those with disabilities require a greater number of unrelated people to live together to provide a supportive environment or to be economically feasible.¹⁷⁷ On the other hand, as many community residents and local jurisdictions argue, group homes create a lack of safety in their community.

“Single-family” zoning provides unique challenges, and often prevent a group home from receiving zoning permits in a neighborhood where only nuclear families or small groups of unrelated persons are permitted.¹⁷⁸ Many zoning ordinances define “family” to include people living together, resembling a family unit. In *City of Edmonds v. Oxford House, Inc.*, the zoning provision for single-family units excluded a group home for eight or more adults recovering from alcohol and drug use.¹⁷⁹ The provision defined “family” as “related by genetics, adoption, or marriage, or a group of five or fewer

173. *Post Incarceration Syndrome (PICS)*, NAT’L INCARCERATION ASS’N, <https://joinnia.com/post-incarceration-syndrome/> [<https://perma.cc/2FXE-MRXM>] (last visited Mar. 9, 2025).

174. *Id.*

175. *Id.*

176. Gorman, Marinaccio & Cardinale, *supra* note 22, at 612.

177. John Hamer, *Handicap Discrimination, Zoning, and the Federal Fair Housing Act*, 13 ME. B. J. 166, 168 (1998).

178. *Id.* at 168.

179. 514 U.S. 725, 728 (1995).

[unrelated] persons.”¹⁸⁰ The Court addressed the question of whether an ordinance setting maximum occupancy limits and regulating who may live in a single-family home qualifies as an exemption under § 3607(b)(1) of the FHA.¹⁸¹ The FHA permits any reasonable statute or ordinance that sets the maximum number of occupants.¹⁸² The Supreme Court held that the City’s zoning provision did not clearly set a maximum occupancy because it did not cap the number of people who may live in a dwelling, but rather, defined who may compose a “family” in a single family residential area.¹⁸³ Therefore, the Court held that the exemption in the FHA did not apply to the City’s provision and a question of discrimination remained for the lower courts.¹⁸⁴ However, the dissent argued that the “the majority’s discussion . . . is completely irrelevant to the question presented in *this* case.”¹⁸⁵ The dissent found that the “five occupant limit” readily qualifies as a “restrictio[n] regarding the maximum number of occupants permitted to occupy the dwelling.”¹⁸⁶ While the majority found that the definition of family is not a maximum occupancy restriction, it left open the issue on whether a restriction based on the number of unrelated individuals was valid under the FHA.¹⁸⁷

Conditional use permits are another land use designation that pose an obstacle for group homes trying to operate in a particular neighborhood. Municipalities can conditionally permit uses in a district, contingent on the requested use and various criteria. Subjecting group homes to conditional use approval may violate the FHA when a municipality treats group homes differently from similarly situated single-family residences.¹⁸⁸ There are varying judicial outcomes in deciding whether variance or permit restrictions constitute

180. *Id.*

181. *Id.*

182. *Id.* at 736–38.

183. *Id.* at 738.

184. *Id.*

185. *Id.* at 746.

186. *Id.* at 738–39.

187. See *Courage to Change Ranches Holding Co. v. El Paso Cnty., Colorado*, 73 F.4th 1175, 1193–94 (10th Cir. 2023) (holding that the County’s five-person occupancy limit for disabled people in a single-family residential are facially discriminatory); *Dr. Gertrude A. Barber Ctr., Inc. v. Peters Twp.*, 273 F. Supp. 2d 643, 656–57 (W.D. Pa. 2003) (holding that a home for four people with disabilities established a disparate treatment claim against the Townships for its three-person occupancy cap for nonrelated people); compare with *Keys Youth Servs., Inc. v. City of Olathe, KS*, 248 F.3d 1267, 1275–76 (10th Cir. 2001) (holding that the City’s occupancy cap of eight unrelated disabled persons living together as a family was reasonable in light of legitimate public safety concerns regarding a group home for ten adolescent males); *Oxford House-C v. City of St. Louis*, 77 F.3d 249, 252–53 (8th Cir. 1996) (holding that an eight person limitation was valid because it was relationally related to a legitimate government interest of controlling traffic congestion and noise in residential areas).

188. John Hamer, *Handicap Discrimination, Zoning, and the Federal Fair Housing Act*, 13 ME. B. J. 166, 168–69 (1998).

a violation under the FHA.¹⁸⁹ Required spacing and distance requirements between a group home and other facilities is also an obstacle for their operation. Some courts have ruled that requiring minimum separation distances between group homes constitutes disparate treatment discrimination, as group homes are treated differently from similarly situated single-family residences.¹⁹⁰ Subjecting group homes to requirements beyond those applicable to other single-family residences may constitute disparate treatment discrimination, according to some courts.¹⁹¹ The relevant test that is applied in these cases balances the enforcement agency's safety rules or interest of public safety against the cost or burden on the group home and its residents.

In other instances of FHA violations as they pertain to group home settings, a Maryland court invalidated three county regulations—the neighbor notification rule, the review board hearing requirement, and the “exceptional person” rule.¹⁹² The group homes that challenged these provisions provided community based housing and support services to elderly people.¹⁹³ The County required group home providers to send notification letters to each neighboring property owner of a proposed group home site and neighborhood civic organizations.¹⁹⁴ In these notification letters, the group home was required to include a variety of

189. *Bryant Woods Inn, Inc. v. Howard Cnty., Md.*, 124 F.3d 597, 605–06 (4th Cir. 1997) (holding that a County did not violate the FHA by its refusal of a zoning variance for a group home seeking to expand from eight to fifteen residents); *Brandt v. Vill. of Chebanse, Ill.*, 82 F.3d 172, 175 (7th Cir. 1996) (holding that the village's denial of a variance to permit the demolition of a single family dwelling to create a four-unit dwelling for people with handicaps was not a violation under the FHA); *Compare with, Judy B. v. Borough of Tioga*, 889 F.Supp. 792, 802–04 (M.D. Pa. 1995) (holding that the denial of zoning variance for a group home for people recovering from drug addictions and mental illnesses violated the FHA).

190. *Larkin v. State of Mich. Dep't of Soc. Servs.*, 89 F.3d 285, 292 (6th Cir. 1996) (holding 1,500-foot spacing requirement violated the FHA); *Nevada Fair Hous. Ctr., Inc. v. Clark Cnty.*, 565 F. Supp. 2d 1178, 1187 (D. Nev. 2008) (finding that the 1,500-foot spacing requirement between group homes were facially discriminatory in violation of the FHA); *United States v. City of Chicago Heights*, 161 F. Supp. 2d 819, 846 (N.D. Ill. 2001) (holding that City violated the FHA by denying a residential facility for mentally ill people because of its 1,000-foot spacing requirement).

191. John Hamer, *Handicap Discrimination, Zoning, and the Federal Fair Housing Act*, 13 ME. B.J. 166, 170-171 (1998); *See Bangerter v. Orem City Corp.*, 46 F.3d 1491, 1504 (10th Cir. 1995) (holding that a requirement for twenty-four supervision on a group home for people with mental disabilities could only be justified if there was additional evidence and warranted remand); *Marbrunak, Inc. v. City of Stow, Ohio*, 974 F.2d 43, 48 (6th Cir. 1992) (holding that the City's fire and safety requirements on a residence for women with mental disabilities violates the FHA); *Oxford House, Inc. v. Browning*, 266 F. Supp. 3d 896, 914–916 (M.D. La. 2017) (ruling in favor of group's home FHA challenge because Fire Marshall's safety requirements on plaintiff were not required of single-family residences); *New Horizons Rehabilitation, Inc. v. State*, 400 F. Supp. 3d 751, 770 (S.D. Ind. 2019) (holding that a commercial fire suppression system requirement on a group home is unreasonable); *Cf., Summers v. City of Fitchburg*, 940 F.3d 133, 142 (1st Cir. 2019) (upholding town's enforcement of state law requiring sprinklers at plaintiff's group homes).

192. *Potomac Grp. Home Corp. v. Montgomery Cnty., Md.*, 823 F. Supp. 1285, 1302 (D. Md. 1993).

193. *Id.* at 1288.

194. *Id.*

information, including the type of group home planned, an identification of the type of “exceptional person” who will live there, and contact information for the County to address complaints or questions about the proposed group home.¹⁹⁵ The Code required that only an “exceptional person” may live in a group home.¹⁹⁶ The “exceptional person” rule required a resident of a group home to be both physically and mentally capable of exiting the home in an emergency without assistance.¹⁹⁷ In addition, the County required the group home to be subjected to an evaluation by a program review board.¹⁹⁸ Ultimately, the court concluded that these three provisions violated the FHA because it created discriminatory impediments which would prevent disabled persons, like the elderly group home residents, from living where they choose.¹⁹⁹ In addition, the County’s rationales for the challenged provisions were found to be inadequate.²⁰⁰

In Ohio, a court struck down a one-year moratorium on the establishment of new adult care facilities because there was evidence of intentional discrimination.²⁰¹ The City justified the one-year moratorium by claiming it was to “to provide ‘a calming down period’” and it was passed for the “preservation of public health [and] safety.”²⁰² The City referenced that the moratorium was passed to “control a problem of overconcentration of mentally handicapped residents.”²⁰³ The court found that the City’s actions were indefensible, and the one year moratorium discriminated against group homes for adults with mental disabilities, in violation of the FHA.²⁰⁴

In the state of Indiana, there are different definitions of what a family is or how many unrelated individuals may live together in a dwelling. For example, in Evansville, Indiana, family is defined as “an individual or married couple and the children thereof with not more than two other persons related directly to the individual or married couple by blood or marriage; or a group of not more than five unrelated persons, living together as a single housekeeping unit in a dwelling unit.”²⁰⁵ In South Bend, Indiana, family is defined more narrowly as:

One or more persons related by blood, legal adoption, or marriage, living and cooking together as a single housekeeping unit; or, a number of persons, but not exceeding two, who are not related by blood, legal adoption, or marriage, living and cooking together as a single

195. *Id.*

196. *Id.* at 1291.

197. *Id.*

198. *Id.* at 1289.

199. *Id.* at 1301.

200. *Id.*

201. *Epicenter of Steubenville, Inc. v. City of Steubenville*, 924 F. Supp. 845, 853–54 (S.D. Ohio 1996).

202. *Id.* at 850.

203. *Id.*

204. *Id.* at 850–51.

205. EVANSVILLE, IND. MUN. CODE § 15.15.010 (2024).

housekeeping unit, shall be deemed to constitute a family.²⁰⁶

These examples of zoning variations within the same state indicate the discrepancy amongst jurisdictions.

In Indiana, variances, conditional use permits, and safety requirements also present problems for group homes. Since 2023, the American Civil Liberties Union of Indiana (ACLU-IN) has filed six complaints against Indiana Department of Homeland Security.²⁰⁷ All the plaintiffs of these cases consist of organizations that provide treatment and sober living homes to men with substance abuse disorders. The Indiana Department of Homeland Security inspected these group homes and imposed Class 1 structure requirements, such as the installation of fire suppression systems. The ACLU-IN argues that these group homes should be classified as Class 2 structures, like traditional or nuclear family homes, rather than Class 1. The ACLU-IN contends that the additional burdens and requirements placed on these group homes are not applied to comparable single-family homes, claiming that the Indiana Department of Homeland Security has intentionally discriminated against these group homes, particularly against men in substance abuse recovery. This, the ACLU-IN asserts, violates the Rehabilitation Act, the FHA, and the Americans with Disabilities Act (“ADA”).

Ken Falk, ACLU-IN legal director, emphasized the importance of group homes, especially as it relates to the reentry population. He explained,

Many of these people come out of a prison setting. Many of them come out of a short term, three-day stay to basically detox . . . If there’s not a place for them to go, a place for them to learn how to be healthy again, then they risk the endless cycle of going back into their addiction. That’s why the homes are so important.²⁰⁸

Recent developments in this litigation underscore the strength of these claims. As of March 11, 2026, the U.S. District Court for the Southern District of Indiana ruled in favor of four group home operators and their residents, holding that the State unlawfully discriminated against them in violation of the

206. SOUTH BEND, IND. MUN. CODE § 21-02.02 (2024).

207. *See* Next Step Recovery Home, Inc. v. State of Ind. et al., No. 1:24-cv-00353 (S.D. Ind. Feb. 26, 2024); Inspiration Ministries, Inc. v. State of Indiana et al., Docket No. 1:23-cv-02027 (S.D. Ind. Nov 09, 2023); Firebrand Ministries, Inc. v. State of Indiana et al., Docket No. 1:24-cv-00630 (S.D. Ind. Apr 10, 2024); Place Of Grace, Inc. v. State of Indiana et al., Docket No. 1:24-cv-01272 (S.D. Ind. Jul 29, 2024); Behind the Wire Ministries, Inc. v. State Of Indiana et al., Docket No. 1:24-cv-00143 (S.D. Ind. Jan 23, 2024); Harmony Home of Huntington, Inc. v. State of Indiana et al., Docket No. 1:24-cv-01228 (S.D. Ind. Jul 22, 2024).

208. Abigail Ruhman, *Court: Indiana Dept. of Homeland Security Likely Discriminated Against People with Disabilities*, IPB NEWS (Nov. 10, 2024, 8:00 AM), <https://www.lpm.org/news/2024-11-10/court-indiana-dept-of-homeland-security-likely-discriminated-against-people-with-disabilities> [<https://perma.cc/85XE-6PLZ>].

ADA, the FHA, and the Rehabilitation Act.²⁰⁹ This decision reinforces the argument that regulatory frameworks, even when framed as neutral safety measures, can function as discriminatory barriers to housing for individuals with disabilities, including those in substance use recovery.

There are innumerable forms that land use discrimination takes against group homes for the disabled. Each form of discrimination poses problems for formerly incarcerated individuals that are looking for housing options, placing yet another impediment for successful integration back into the community.

B. Requirements to Prove FHA Violations and Housing Claims

Standing extends not only to individual plaintiffs, but also to entities that seek to provide housing to individuals who fall within the FHA's definition of "handicap," when their efforts are impeded by discrimination directed at prospective residents. In such cases, the plaintiff bears the initial burden of establishing a *prima facie* case of housing discrimination, including demonstrating the existence of a qualifying handicap under the FHA.²¹⁰

Three legal theories are available to a plaintiff in an FHA claim involving group homes and local zoning regulations.²¹¹ The plaintiff may allege that (1) the local government engaged in intentional discrimination, or disparate treatment, against persons with disabilities, (2) the zoning regulation in question had a disparate impact, or discriminatory effect on persons with disabilities, or (3) the local government failed to make a reasonable accommodation for a person or group based on a disability.

1. Intentional Discrimination

Plaintiffs who wish to prove a claim of intentional discrimination need to show that the local government ordinance or action is either facially discriminatory or motivated by discriminatory intent.²¹² For example, if the ordinance or action by a local government clearly states that group homes for people with disabilities are only permitted in industrial or commercial zoning districts then it would be analyzed as intentional discrimination. This type of ordinance would ban group homes in residential areas, serving as evidence of intentional discrimination aimed at keeping people with disabilities separate from traditional neighborhoods. Once a plaintiff establishes a *prima facie* case

209. *Federal Court Finds Indiana Unlawfully Discriminated Against Recovery Homes*, ACLU IN (Mar. 11, 2026), <https://www.aclu-in.org/press-releases/federal-court-finds-indiana-unlawfully-discriminated-against-recovery-homes/> [<https://perma.cc/WP8G-5QZ8>] (Four of the six ACLU-IN cases, *see supra* note 207: Place of Grace, Harmony Home of Huntington, Inspiration Ministries, and Next Step Recovery Home).

210. Connolly & Merriam, *supra* note 46, at 242–43.

211. Connolly & Merriam, *supra* note 46, at 244; *see e.g.*, *Gamble v. City of Escondido*, 104 F.3d 300, 304–05 (9th Cir. 1997).

212. Connolly & Merriam, *supra* note 46, at 244.

of facial discrimination by demonstrating that the protected group has been subject to explicit discriminatory treatment, the government has the opportunity to demonstrate that the challenged provision or action is permissible because of a legitimate reason.²¹³ Most of the federal appellate courts have found that a facially discriminatory ordinance is legitimate if the restriction in question responds to legitimate safety concerns, so long as the safety concerns are not based on stereotypes.²¹⁴ Once the defendant has successfully articulated a legitimate reason for its facially discriminatory zoning policy, the plaintiff can show that the local government intentionally discriminated against the protected, disabled class of residents, or that the reason offered by the government for the discrimination is a mere pretext for discrimination.²¹⁵

If the ordinance or action by a local government is outwardly neutral, then it can still be challenged as discriminatory intent. A plaintiff may succeed on a discriminatory intent claim if they are able to provide evidence that the local government acted upon discriminatory comments made to the public.²¹⁶

2. Disparate Impact

Disparate impact, also referred to as discriminatory effect, applies to a law that is facially neutral, but in practice has a disproportionate impact on a protected group.²¹⁷ The use of disparate impact in claims has been a source of controversy amongst the courts. In 2015, The Supreme Court resolved in *Texas Department of Housing and Community Affairs v. The Inclusive Communities Project, Inc.* that disparate impact analysis is permissible in FHA claims.²¹⁸ These claims are difficult for plaintiffs to establish because courts require plaintiffs to demonstrate a causal connection between the rule or policy and the discriminatory effect.²¹⁹

In analyzing disparate impact, the federal courts of appeals developed a variety of tests to determine whether a zoning action has a disparate impact on a protected group. One disparate impact test comes from the Seventh Circuit Court of Appeals' decision in *Metropolitan Housing Development Corp. v.*

213. See, e.g., *Larkin v. Mich. Dep't of Soc. Servs.*, 89 F.3d 285, 290 (6th Cir. 1996); *Bangerter v. Orem City Corp.*, 46 F.3d 1491, 1498 (10th Cir. 1995).

214. *Cnty. House, Inc. v. City of Boise*, 490 F.3d 1041, 1050 (9th Cir. 2007); *Larkin v. Mich. Dep't of Social Servs.*, 89 F.3d 285, 290 (6th Cir. 1996); *Bangerter v. Orem City Corp.*, 46 F.3d 1491, 1503–04 (10th Cir. 1995).

215. *Connolly & Merriam*, *supra* note 46, at 245.

216. *Connolly & Merriam*, *supra* note 46, at 252; See, e.g., *Stewart B. McKinney Found., Inc. v. Town Plan & Zoning Comm'n of Town of Fairfield*, 790 F. Supp. 1197, 1212 (D. Conn. 1992).

217. *Connolly & Merriam*, *supra* note 46, at 252.

218. *Texas Dep't of Hous. & Cmty. Affs. v. Inclusive Communities Project, Inc.*, 576 U.S. 519, 545–46 (2015).

219. *Connolly & Merriam*, *supra* note 46, at 255; *Texas Dep't of Hous. & Cmty. Affs. v. Inclusive Communities Project, Inc.*, 576 U.S. 519, 539–41 (2015).

Village of Arlington Heights.²²⁰ This test relies on four factors to determine whether a regulation has a disparate impact.²²¹ The first factor is the strength of the plaintiff's showing of discriminatory effect; the second factor looks to whether there is any evidence of discriminatory intent, even if such evidence is not sufficient to show discriminatory intent; the third factor considers the defendant's asserted interest in the challenged action; and the fourth factor is whether the plaintiff seeks to compel the defendant governmental entity to affirmatively provide housing for the protected group in question, or whether the plaintiff is simply seeking to remove barriers to housing for the protected group.²²² Other federal appellate courts have adopted versions of this test.²²³ Two other circuit courts employ an alternative approach to disparate impact in housing, applying a burden-shifting framework.²²⁴ Under this approach, after a plaintiff establishes a prima face case, then the burden shifts to the defendant to justify that its policy or practice had a legitimate, non-discriminatory objective.²²⁵

3. *Failing to Make a Reasonable Accommodation*

The FHA requires local zoning authorities or local governments to make reasonable accommodations for people with disabilities. Under the statute, authorities are required "to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling."²²⁶ The reasonable accommodation prong of the FHA has generated a significant amount of conflicting litigation.²²⁷ Under the statute, there are three issues inherent in reasonable accommodation analysis: (1) the reasonableness of the accommodation requested, (2) the necessity of the accommodation to afford persons with disabilities the opportunity to use the dwelling, and (3) whether the person with a disability has been given the opportunity to enjoy the dwelling on

220. 558 F.2d 1283, 1290 (7th Cir. 1977).

221. *Id.* at 1290–93.

222. *Id.*

223. *Reinhart v. Lincoln Cnty.*, 482 F.3d 1225, 1231 (10th Cir. 2007); *Arthur v. City of Toledo, Ohio*, 782 F.2d 56, 575 (6th Cir. 1986); *Smith v. Town of Clarkton, N. C.*, 682 F.2d 1055, 1065 (4th Cir. 1982).

224. *Resident Advisory Bd. v. Rizzo*, 564 F.2d 126, 148–50 (3d Cir. 1977); *Gallagher v. Magner*, 619 F.3d 823, 833–34 (8th Cir. 2010).

225. *Resident Advisory Bd. v. Rizzo*, 564 F.2d 126, 148–50 (3d Cir. 1977); *Gallagher v. Magner*, 619 F.3d 823, 833–34 (8th Cir. 2010).

226. 42 U.S.C. § 3604(f)(3)(B).

227. *Smith & Lee Assocs., Inc. v. City of Taylor, Mich.*, 102 F.3d 781, 799 (6th Cir. 1996) (holding that the City's denial of a reasonable accommodation of a group home in a single-family residential district was a violation of the Fair Housing Act); *compare with*, *Bryant Woods Inn, Inc. v. Howard Cnty., Md.*, 124 F.3d 597 (4th Cir. 1997) (holding that the County did not violate the FHA by its refusal to make a reasonable accommodation for a group home seeking to expand from eight to fifteen residents).

an equal basis as nondisabled persons.²²⁸ As an initial matter, to bring a reasonable accommodation claim, a plaintiff must actually have requested or attempted to request a reasonable accommodation.²²⁹ Before pursuing legal action, a group home operator, or its residents making a reasonable accommodation claim, must first request the accommodation through the local government's established procedures. In cases where a plaintiff intends to build a facility or group home and informs the local government that the prospective residents have one or more disabilities, the government is considered to have been given adequate notice.²³⁰

A plaintiff making a reasonable accommodation claim must first show that the desired accommodation is reasonable.²³¹ Although there is not a clear test for whether an accommodation is reasonable, courts generally rely on whether an accommodation is both efficacious and proportional to its implementation cost, and that the implementation costs are "reasonable."²³² When a group home requests an accommodation to operate in a residential single-family district, the request is typically considered reasonable.²³³ While legitimate public safety concerns can be considered when evaluating a group home's request, a local government cannot use testimony from neighbors opposing the group home as sufficient evidence to deem the accommodation unreasonable.²³⁴ Denying a group home's application due to public safety concerns must not be based on general stereotypes about disabled individuals, but rather, on specific concerns regarding individual residents who may pose safety risks.²³⁵

When courts consider the necessity of the accommodation, the plaintiff must demonstrate that without the accommodation, they will be denied an equal opportunity to obtain housing. By one court's definition, a reasonable accommodation involves "changing some rule that is generally applicable so as to make its burden less onerous on the handicapped individual."²³⁶ The challenge lies in defining what qualifies as equality of opportunity under the FHA. Often, equal opportunity for people with disabilities means the opportunity for those residents or group homes to reside in a residential neighborhood, just like other people without disabilities. In those instances, the plaintiff bears the responsibility of showing that group homes are not allowed in a specific district and that the defendant or local jurisdiction did not provide a reasonable accommodation in its zoning laws to enable the successful operation of the group home.²³⁷ The plaintiff must prove that the ordinance in

228. Connolly & Merriam, *supra* note 46, at 257.

229. *Id.* at 258.

230. *Id.*

231. *Id.*

232. *Id.* at 258–59.

233. *Smith & Lee Assocs., Inc. v. City of Taylor, Mich.*, 102 F.3d 781, 799 (6th Cir. 1996).

234. Connolly & Merriam, *supra* note 46, at 259.

235. *Id.*

236. *Oxford House, Inc. v. Twp. of Cherry Hill*, 799 F.Supp. 450, 462 n.25 (D.N.J.1992).

237. Connolly & Merriam, *supra* note 46, at 261.

question is a neutral rule that the local government failed to reasonably adjust to allow the group home to operate.²³⁸

The federal appellate courts are divided on which party bears the burden of showing the reasonableness or unreasonableness. Six circuits place the burden on the local government to demonstrate that the plaintiff's request is unreasonable or that the request would impose an undue hardship in some circumstances.²³⁹ Two circuits place the burden on the plaintiff, as a person with a disability or entity, to demonstrate affirmatively that the accommodation requested is reasonable.²⁴⁰ In determining whether an accommodation is reasonable, courts generally balance the competing interests of the group home and local government. To make this determination, courts generally rely on whether an accommodation is both efficacious for the governing board and its negative effects are proportional to its implementation on the group home.²⁴¹ Zoning regulations, variance procedures, and special use or conditional permit requirements may create additional challenges for group homes to succeed on a reasonable accommodation claim.²⁴²

C. Housing Claims Available for Reentry Group Homes

Reentry group home should likewise qualify for the FHA's protection under the "regarded as" prong of handicap. The intent and rationale of the "regarded as" prong third was to provide protection for people that may otherwise be treated adversely because of stigmatizing perceptions held by others.²⁴³ Since "handicap" encompasses individuals recovering from substance or alcohol abuse, sober living homes are protected under the FHA.²⁴⁴ Like the use of "regarded as" to prove handicap discrimination in cases regarding sober living homes, the same analysis could apply to group homes for previously incarcerated individuals. The opposition from local communities towards sober living homes reflects the challenges that reentry group homes encounter in residential neighborhoods, which would likewise create challenges for group

238. *Id.*

239. *Jackan v. New York State Dep't of Labor*, 205 F.3d 562, 566 (2d Cir.2000); *Lapid-Laurel, L.L.C. v. Zoning Bd. of Adjustment of Twp. of Scotch Plains*, 284 F.3d 442, 459 (3d Cir. 2002); *Oconomowoc Residential Programs v. City of Milwaukee*, 300 F.3d 775, 783-84 (7th Cir. 2002); *Fjellestad v. Pizza Hut of America, Inc.*, 188 F.3d 944, 950 (8th Cir.1999); *Vinson v. Thomas*, 288 F.3d 1145, 1154 (9th Cir. 2002); *White v. York Int'l Corp.*, 45 F.3d 357, 361 (10th Cir.1995).

240. *Bryant Woods Inn, Inc. v. Howard Cnty., Md.*, 124 F.3d 597, 604 (4th Cir. 1997); *Elderhaven, Inc. v. City of Lubbock, Tex.*, 98 F.3d 175, 178 (5th Cir. 1996).

241. *Connolly & Merriam*, *supra* note 46, at 257; *see Vande Zande v. State of Wis. Dep't of Admin.*, 44 F.3d 538, 543 (7th Cir. 1995) (discussing hardship in the context of reasonable accommodations in an ADA case).

242. *Connolly & Merriam*, *supra* note 46, at 261-63.

243. Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice's final admin. rule under the American with Disabilities Act).

244. *See, e.g., Gorman et al.*, *supra* note 22, at 608-09.

homes for the formerly incarcerated.

A lot can be learned from the case, *SoCal Recovery, LLC v. City of Costa Mesa*,²⁴⁵ where the City of Costa Mesa passed ordinances in 2014 that made it unlawful for sober living homes to operate without a permit. It required sober living homes to be located more than 650 feet away from any other sober living home or licensed drug and alcohol treatment center.²⁴⁶ The plaintiffs, SoCal Recovery, LLC, operated sober living homes in the City and submitted permit applications and reasonable accommodation requests so they could continue to operate their sober living homes, despite operating within 650 feet from other sober living home or licensed drug and alcohol treatment center.²⁴⁷ The City denied permits, denied reasonable accommodation requests, and issued citations to SoCal Recovery for violating the ordinances.²⁴⁸

SoCal Recovery sued the City, arguing that the ordinances and the City's enforcement practices discriminated against them on the basis of disability under the FHA.²⁴⁹ On appeal, the court reversed the district court's grant of summary judgment because the wrong legal standard was applied to analyze both the "actual disability" prong and "regarded as" prong.²⁵⁰ This court's analysis on the "regarded as" prong provides helpful insight; to establish disability under the "regarded as" disability prong, "the analysis turns on how an individual is perceived by others."²⁵¹ SoCal Recovery needed to show that the City "subjectively believed that all the residents (or even some specific residents) of [SoCal' Recovery's] sober living homes were disabled."²⁵² The appellate court found the language in the permit denial letters to describe the individuals as disabled.²⁵³ Also, the planning commission stated that the homes would be "'materially detrimental to other properties within the area,' 'to the health, safety and general welfare of the public,' and 'to the residential character of the City's neighborhoods' because '[t]he operation of a group home on contiguous parcels would result in the overconcentration of such facilities in [the] neighborhood.'"²⁵⁴ The City Council reasoned the denial of the permit on the grounds that the overconcentration of such facilities in the neighborhood "'could lead to negative impacts in the neighborhood.'"²⁵⁵ Additionally, the court found that City's actions were based on unfounded fears and stereotypes because of the oral testimony given at public hearings and written statements by

245. 56 F.4th 802, 802 (9th Cir. 2023).

246. *Id.* at 804–05.

247. *Id.* at 805.

248. *Id.*

249. *Id.*

250. *Id.* at 812.

251. *Id.* at 817.

252. *Id.*

253. *Id.*

254. *Id.*

255. *Id.*

community residents opposing the sober living homes.²⁵⁶ Some described the individuals living in the sober living homes as “‘capable of mayhem and violence,’ and as the cause of ‘[c]rime and homelessness,’” and in addition, sober living homes made people feel “‘uncomfortable.’”²⁵⁷ The appellate court decided that this type of evidence should be considered in a “regarded as” having a disability analysis.²⁵⁸ Also, the Sixth Circuit²⁵⁹ and Fourth Circuit²⁶⁰ have decided that this type of public speech about sober living home residents is evidence that the government regarded the individuals as having a disability.²⁶¹

This case’s analysis of the “regarded as” prong of disability provides a useful application to a similarly situated group that faces discrimination comparable to that experienced by previously incarcerated individuals. In *SoCal Recovery, LLC v. City of Costa Mesa*, discrimination was based on unfounded fears and stereotypes.²⁶² Like sober living homes, reentry group homes should fall within the FHA’s protections under the “regarded as” prong of handicap. For the same reasons, previously incarcerated individuals should also qualify for protection, as they are often “regarded as” having a disability.

D. Reentry Group Homes Should Qualify for the FHA’s Protections Under the “Regarded As” Prong of Handicap

Reentry housing, in the form of group homes, should qualify for the FHA’s protection under the “regarded as” prong of handicap. Many previously incarcerated individuals encounter housing discrimination based on mental health conditions that contributed to their involvement with the justice system, emerged while incarcerated, or developed post-release. Regardless of mental health conditions, previously incarcerated individuals should qualify for the FHA’s protection because they are “regarded as” having a disability. Following this reasoning, there should be housing protections available for individuals with criminal records.

To reiterate, the FHA defines “handicap” as: (1) a physical or mental impairment that substantially limits one or more of an individual’s major life activities; (2) a record of, or a history of, a physical or mental impairment; or (3) regarded as having such an impairment.²⁶³ If the mental health condition of a previously incarcerated individual does not meet, or are not considered to meet the first two prongs, then the third prong should apply. The intent and rationale of this third prong was to provide protection for people that may otherwise be

256. *Id.* at 819.

257. *Id.*

258. *Id.*

259. *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 342 (6th Cir. 2002).

260. *U.S. v. S. Mgt. Corp.*, 955 F.2d 914, 919 (4th Cir. 1992).

261. *SoCal Recovery, LLC v. City of Costa Mesa*, 56 F.4th 802, 819 (9th Cir. 2023).

262. *Id.* at 819.

263. 42 U.S.C. § 3602(h)(1)–(3).

treated adversely as a result of stigmatizing perceptions held by others. By including this third prong, “Congress acknowledged that society’s accumulated myths and fears about disability and diseases are as handicapping as are the physical limitations that flow from actual impairment.”²⁶⁴

“Regarded as” having an impairment could mean that an individual “[h]as a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward such impairment.”²⁶⁵ This specifically relates to stigma, biases, or beliefs of individuals. It plainly acknowledges the circumstances when a disability is a substantial limitation of a major life activity because of how others view the individual’s condition.

It is undisputed that society’s myths and fears about the mental state of previously incarcerated individuals are as debilitating as the actual mental health concerns that exist within this population. Thus, a previously incarcerated individual “who is denied services or benefits by a public entity because of myths, fears, and stereotypes associated with disabilities would be covered under this third [prong] whether or not the person’s physical or mental condition would be considered a disability under the first or second [prong] in the definition.”²⁶⁶

A formerly incarcerated individual is likely to have a mental impairment regardless of whether it results in a substantial limitation of a major life activity. To restate, major life activities “means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.”²⁶⁷ For example, a formerly incarcerated individual may be diagnosed with depression after being released from prison but is still able to care for one’s self and perform work tasks; their depression does not meet the severity of limiting a major life activity. However, this individual’s housing application might be denied because the landlord believed the individual was unable to perform basic tasks as a tenant, like cleaning or upkeeping the apartment. It does not matter that this individual has a condition that does not result in a substantial limitation of a major life activity; the landlord treated the individual as having a substantially limiting condition, which should qualify them for protection under the FHA.

The “regarded as” prong of the definition of handicap represents a broad approach that “would extend statutory protection to anyone who has been excluded or disadvantaged on the basis of a physical or mental impairment, whether real or perceived.”²⁶⁸ The statutory interpretations focus on how individuals are treated, rather than technical distinctions about the significance

264. *Arline*, 480 U.S. at 284; Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

265. 24 C.F.R. § 100.201 (2024).

266. Title II Regulations Supplementary Information, 54 Fed. Reg. 3232, 3245 (July 29, 1991) (Department of Justice’s final admin. rule under the American with Disabilities Act).

267. 24 C.F.R. § 100.201 (2024).

268. NAT’L COUNCIL ON DISABILITY, *supra* note 55, at 12.

or type of impairment that makes a person disabled. Instead, the focus is on whether discrimination exists, not on the characteristics of the person being discriminated against.

Previously incarcerated individuals face housing discrimination because of society's fears, stereotypes, or beliefs.²⁶⁹ These assumptions or beliefs are based on the concern that a previously incarcerated individual will harm property or other people, and the individual is viewed as lacking impulses or having uncontrolled behavior with a propensity for committing crimes. These beliefs or assumptions about previously incarcerated individuals are misconceptions about their mental state and future physical actions. Prospective tenants with criminal records face housing discrimination because of their mental health or assumptions about their mental health; whether the condition is actual or purported, these individuals face discrimination due to a perceived mental disability.

For formerly incarcerated individuals, stigma or stereotypes associated with their incarceration and criminal histories presents additional barriers to housing access. At the structural or policy level, individuals with a criminal record may be restricted from housing options.²⁷⁰ Socially, previously incarcerated individuals face stigmatizing perceptions or stereotypes from the general public, including assumptions that they are dangerous, dishonest, lazy, or unintelligent.²⁷¹ Such beliefs about this population may contribute to property owners' or discriminatory behaviors, such as denials of housing applications once mandatory criminal background checks reveal tenants' conviction histories.²⁷²

IV. CONCLUSION

Previously incarcerated individuals face housing discrimination not simply because of their criminal records, but because of deeply rooted fears, myths, and prejudices about their perceived mental state. These stigmatizing assumptions, whether grounded in actual or purported conditions, have enabled local governments and housing providers to justify exclusionary practices under the guise of public safety. Yet the "regarded as" prong of the FHA's definition of handicap exists precisely to guard against this form of discrimination, where perception, rather than diagnosis, drives unequal treatment. Mental health research reinforces this point, demonstrating that stereotypes about formerly incarcerated individuals meaningfully hinder access to stable housing. In

269. Danya Keene et al., *Stigma, Housing and Identity After Prison*, 66 SOCIOLOGICAL REV. 799–815 (2018).

270. Zoe Feingold, *The Stigma of Incarceration Experience: A Systematic Review*, 27 PSYCH., PUB. POL'Y & L. 550–69, at 550 (2021).

271. See Paul Hirschfield & Alex Piquero, *Normalization and Legitimation: Modeling Stigmatizing Attitudes Toward Ex-Offenders*, 48 CRIMINOLOGY 27–55, at 30 (2010).

272. See Danya Keene et al., *Stigma, Housing and Identity After Prison*, 66 SOCIOLOGICAL REV. 799–815 (2018); David Harding et al., *Making Ends Meet After Prison*, 33 J. OF POL'Y ANALYSIS & MGMT. 440–70 (2014).

practice, a criminal record operates as a proxy for perceived disability, creating substantial and unjustified barriers to housing regardless of an individual's actual condition.

These dynamics extend to reentry group homes, which face resistance rooted in the same unfounded fears that have long targeted sober living facilities. As a result, reentry housing is often excluded from FHA protections through assertions of "direct threat," despite a lack of individualized or evidence-based assessments. Notably, group homes framed around substance use recovery are more likely to survive legal and community scrutiny, while those designed specifically for reentry struggle to gain similar recognition. This disparity exposes a critical gap in existing FHA doctrine.

Although case law has yet to fully address the application of the FHA to reentry group homes, the statute's text and purpose strongly support their inclusion under the "regarded as" prong. Courts should recognize that discrimination against formerly incarcerated individuals is frequently rooted in perceived mental impairment, bringing such claims squarely within the FHA's protections. Interpreting the statute in this way would not expand the FHA beyond its intended scope but rather fulfill its core mandate: to eliminate discrimination driven by stigma and stereotype. Without such recognition, formerly incarcerated individuals will continue to face systemic barriers to housing, undermining both successful reentry and the broader goals of fair housing law.

DOES “NO” MEAN “NO?”: AN ANALYSIS OF INDIANA’S GUIDELINES ON INFORMED CONSENT TO HEALTH CARE FOR INCAPACITATED ADULTS UNDER GUARDIANSHIP

ALLISON ONOSZKO KRISHNAMOORTHY*

I. INTRODUCTION

A. Does “No” Mean “No?”

A.P. was a woman in her late twenties prescribed Invega Sustenna injections used to treat schizophrenia during her incarceration at the Marion County Jail.¹ In her relatively youthful state, A.P. didn’t fit the stereotypical “elderly” adult under guardianship. Rather, A.P. came under guardianship when the jail requested for a health care decision maker to be appointed on her behalf due to her complex mental status and healthcare needs.² The Center for At-Risk Elders (“CARE”) was appointed as legal guardian for A.P. in March of 2022 after the court determined that A.P. was mentally incapacitated and required a health care decision-maker despite her younger age.³ A.P.’s troubles at the detention center began shortly after CARE’s appointment.⁴

On June 16, 2022 the Marion Superior Court granted CARE’s request to voluntary transfer A.P. to Eskenazi Health’s Neuro Diagnostic Institute and Advanced Treatment Center for a mental health assessment.⁵ CARE sought transfer because the professionals were concerned that A.P.’s mental health was deteriorating during her incarceration and were uncertain if A.P. was receiving necessary medical care.⁶ Timely administrations of medication were paramount

* J.D. Candidate, 2026, Indiana University Robert H. McKinney School of Law. Allison would like to thank attorney Mollie Golden, the late Professor Priscilla Thomas-Keith, her husband, family, and friends for their unwavering support and thoughtful feedback during the drafting and editing process.

1. Complaint at 1, Ctr. for At-Risk Elders, Inc. v. Wellpath, LLC, No. 1:24-CV-983 (S.D. Ind. June 10, 2024), <https://static1.squarespace.com/static/5404c9f2e4b0a7034afd1a95/t/6668a7569d422d71fa1a79f3/1718134614742/1+-+Complaint.pdf> [https://perma.cc/3DES-DVRN] [hereinafter At-Risk Elders Complaint]. The complaint explains A.P. required medical treatments and received forced injections of Invega Sustenna, *id.* at 1, and A.P.’s prescription for Invega Sustenna and dosage is inferred from the complaint and conversations with her guardian.; Kristine Phillips & Tim Evans, *Marion County sheriff, contractor forced drug injections on mentally ill woman, suit says*, AOL (June 11, 2024), <https://www.aol.com/marion-county-sheriff-contractor-forced-184748240.html> [https://perma.cc/2F4S-M4H9] (identifying A.P.’s age and schizophrenia diagnosis); *Patient Website: Injections for Schizophrenia*, JOHNSON & JOHNSON, <https://www.injectionsforschizophrenia.com/> [https://perma.cc/5G73-CCKD] (last visited Mar. 8, 2026) (explaining the use of Invega Sustenna to treat schizophrenia).

2. See Petition for Appointment of Health Care Representative, *In re: The Guardianship of Adilah Patton*, No. 49D08-2111-GU-039784 (Marion Super. Ct. Nov. 30, 2021) (showing the Marion County Sheriff’s petition for the appointment of health care representative) [hereinafter Petition for Appointment of Health Care Representative].

3. At-Risk Elders Complaint, *supra* note 1, at 4.

4. See *id.*

5. *Id.* at 5.

6. *Id.* at 4.

in the management of A.P.'s symptoms from schizophrenia, and missing a dosage could have compounding effects on her mental health.⁷ However, the correctional facility was *not* authorized—by CARE, any court, or treating physician—to force these injections.⁸

The night before A.P. was going to be transferred to Eskenazi Health, Marion County Sheriff employees and/or agents and the facility's hired care provider, Wellpath, attempted to administer her Invega injection.⁹ When A.P. resisted, she was forcefully held down by a cell extraction response team while a nurse administered the injection against her will.¹⁰ CARE was never contacted, meaning no one had provided the necessary informed consent for A.P.'s injection.¹¹ The trauma didn't stop there. Making matters worse, it was not until the next day when A.P. arrived at Eskenazi that the medical team discovered that A.P.'s thumb had been painfully dislocated, likely while the agents held her down.¹² This wasn't the first time the injection had been forced by the detention center without consent from CARE.¹³ CARE later learned that two additional injections had been forced upon A.P. during her time at the detention center.¹⁴

A.P.'s case is just one example of the problems that arise from the complex intersection of Indiana's guardianship, criminal, and healthcare laws. A.P. desperately needed her injections, and the detention center was charged with providing her medical care—including said injections. However, Indiana's statutory framework fails to provide essential guidance for detention centers on providing proper care to adults under guardianship. Consequently, detention centers' policies and procedures neglect to advise staff on the appropriate measures to take when identifying and treating adults under permanent guardianship, particularly when it comes to obtaining informed consent to medical treatment. Additionally, although in this case the guardian, CARE, did

7. See *Invega Sustenna, Getting Started*, JOHNSON & JOHNSON, <https://www.invegasustenna.schizoaffective.com/getting-started/> [https://perma.cc/3P82-9U42] (last visited Mar. 2024). Invega Sustenna treats symptoms of schizophrenia rather than curing the condition. *Id.* Injections like Invega Sustenna are administered by health care professionals periodically and the medication is gradually released between the doses. *Id.* Missing an injection risks symptoms returning and disrupts the release of the medication in the body. *Id.*; *Understanding Schizophrenia, Living With Schizophrenia*, JOHNSON & JOHNSON, <https://www.injectionsfor.schizophrenia.com/> [https://perma.cc/MZX6-RYC8] (last visited Dec. 24, 2024). It is crucial for individuals undergoing treatment for schizophrenia to continue medication even when they are not experiencing symptoms. *Id.* Missed or untimely dosages can lead to relapses in symptoms and declines in physical and mental health. *Id.*

8. At-Risk Elders Complaint, *supra* note 1, at 6.

9. *Id.* at 5.

10. See *id.* The complaint explains that A.P. was held down by a cell extraction response team during administration of the injection of Invega Sustenna, *id.*, and an inference is drawn as to A.P.'s resistance leading to the forceful injection, *id.*

11. *Id.*

12. *Id.* at 5–6.

13. *Id.* at 4 (identifying an incident on May 16, 2022, in which the same nurse administered another injection against A.P.'s will and without CARE's consent).

14. *Id.* at 1.

not consent to the forced injections, another question arises from the ambiguity in Indiana’s treatment of adults under guardianship—just what can a court-appointed guardian consent to against the will of an incapacitated adult? For an adult under guardianship in Indiana, does “No” ever truly mean “No?”

B. *The Size of the Issue*

Adult guardianship in the United States remains somewhat of a mystery because there is currently no national database providing an estimate of the number of adults in the nation that are under guardianship due to an incapacitated status (also known as “protected persons”).¹⁵ Furthermore, state-specific requirements for guardianship databases vary, leaving aggregation of cases nearly impossible.¹⁶ As of 2017, the U.S. Senate Special Committee on Aging estimated that 1.3 million older adults and people with disabilities across the nation were under guardianship.¹⁷

The lack of guardianship data has been a growing concern across the nation, and many states are pushing for the adoption of a Guardianship Court Improvement Program (“GCIP”) providing funding and assistance for data collection.¹⁸ Guardianship standards as a whole have been analyzed as well.¹⁹ In 2021 alone, sixteen (16) states enacted thirty-seven (37) guardianship bills, and in the last decade, there have been nearly four hundred (400) similar bills.²⁰

In addition to the lack of macro-level data on the overall number of guardianship cases in the nation, there is a lack of micro-level data depicting the “who” and “why” of the guardianship cases.²¹ Specifically, there is a lack of data on the identity of the individuals under guardianship including their: age, race, sex, gender identity and expression, sexual orientation, ethnicity, immigration status, language(s) spoken, health issues, cognitive impairments, finances, housing, living conditions, and factors that led to their incapacitation status.²² Anecdotal evidence suggests that marginalized older adults, due to their

15. Kahli Zietlow et al., *Guardianship: Medicolegal review for clinicians*, 70 J. AM. GERIATRICS SOC’Y 3070, 3075 (2022) (“There is no centralized database capturing the number of guardians, individuals under guardianship, or data about the profession, experience, education, or other descriptions of existing guardians.”); see e.g., *Guardianship Oversight Task Force Final Report*, GUARDIANSHIP OVERSIGHT TASK FORCE 6 (2025), <https://www.in.gov/courts/iocs/files/guardianship-tf-report-2025.pdf> [<https://perma.cc/3LLZ-ZTRV>] (explaining “protected person” terminology).

16. Zietlow et al., *supra* note 15.

17. Casey, Braun Urge Examination of Guardianship Laws, U.S. SENATE SPECIAL COMM. ON AGING (May 31, 2023), <https://www.aging.senate.gov/press-releases/casey-braun-urge-examination-of-guardianship-laws> [<https://perma.cc/698J-D3J9>].

18. Elizabeth Moran, *2021 Guardianship Legislation: Highlights & Trends Effectuating Improved Processes & Outcomes in U.S. Guardianship Systems*, 43 BIFOCAL 102, 103 (2022).

19. *Id.* at 104.

20. *Id.*

21. Jim Berchtold, *Guardianship Data Reform*, JUSTICE IN AGING (Mar. 24, 2024), <https://justiceinaging.org/guardianship-data-reform/> [<https://perma.cc/5VFE-GF5X>].

22. *Id.*

increased risk of chronic disease, face an increased risk of being placed under guardianship.²³ This trend is in part due to health disadvantages caused by disparities related to race, ethnicity, gender, and socioeconomic status.²⁴ For example, Black adults make up a disproportionately high number of the individuals under CARE's guardianship as compared to Marion County census percentages of Black individuals.²⁵ This indicates that Black adults are at increased risk for placement under guardianship—at least in Marion County, Indiana.

Fortunately, Indiana is one of the few states that maintains a publicly accessible guardianship registry.²⁶ This online service is managed under the Adult Guardianship Office and provides: the name of the protected person; their appointed guardian; their birth year; the status of the guardianship case; the issuance of the guardianship letters; the county of issuance; and the guardianship cause number.²⁷ As an added benefit, the registry interfaces with Indiana's online case management system, Odyssey, thus courts and clerk staff only need to update the information once for both online databases to reflect changes.²⁸ However, even with the state-wide registry, guardianship statistics are not readily reported in Indiana as only eighty-seven (87) of Indiana's ninety-two (92) counties use the system as of 2025.²⁹ This information is not succinctly provided or analyzed outside of guardianship organizations. In their report published in 2026, Indiana's Guardianship Oversight Task Force recommended the state improve the registry by creating a guardianship data dashboard that would show the total number of guardianships in Indiana broken down by sex, age, and location among other guardianship data measures to provide up-to-date guardianship data to the public.³⁰ Nevertheless, Indiana state officials estimate that over 11,000 adults in the state are currently under permanent guardianship

23. *Id.*

24. *Id.*

25. See *QuickFacts Marion County, Indiana*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/fact/table/marioncountyindiana/PST045225> [https://perma.cc/7JLK-RSG2] (showing 30.3% of the population of Marion County as “Black alone”); *Cf.* CTR. FOR AT-RISK ELDER, NEW STUDENT PRESENTATION 4, available at <https://perma.cc/EL3H-94QN> (explaining that 37% of CARE's clients are Black) (last visited June 10, 2026).

26. See *Search Guardianship Registry*, ADULT GUARDIANSHIP OFF., <https://public.courts.in.gov/grp/> [https://perma.cc/CB4R-F2JL] (last visited Mar. 8, 2026).

27. *Adult Guardianship*, IN.GOV, <https://www.in.gov/courts/iocs/adult-guardianship/> [https://perma.cc/5XHF-5PQU] (last visited Mar. 8, 2026).

28. LaJuan Epperson, *INCite Project Overview Factsheet Guardianship Registry* (May 15, 2016), <https://www.in.gov/courts/iocs/files/ad-guard-registry-factsheet.pdf> [https://perma.cc/3BBQ-MX33]; See *Odyssey Case Management System*, IN.GOV, <https://www.in.gov/courts/admin/tech/odyssey/> [https://perma.cc/SXJ8-Z7XB] (last visited Jan. 31, 2025). Odyssey Case Management System (Odyssey) is an online, integrated case and financial management system utilized in Indiana to maintain court records, *see id.* Odyssey centralizes data across the state and provides information to entities including law enforcement agencies (including probation officers), state policy makers, and state and federal agencies, *see id.*

29. See OVERSIGHT TASK FORCE, *supra* note 15, at 28.

30. *See id.* at 31–32.

as of 2021.³¹ However, this estimate does not address the number of these protected persons who are also incarcerated. As exemplified by A.P.’s case, the presence of incapacitated individuals in correctional facilities creates difficult ethical and technical questions for informed consent to healthcare in Indiana for adults under guardianship.

Evidence supports the inference that the current dilemmas concerning adults who are both under guardianship and incarcerated will increase soon. Since 1970, the United States prison population has increased by 700%.³² An increasing rate of this population is either elderly and/or mentally ill.³³ This shift has been partly attributed to the increasing number of life sentences which has created an aging population in prisons.³⁴ Consequently, it is estimated that by 2030, more than one-third of the prison population will be adults over 55.³⁵

Furthermore, the incarcerated population disproportionately suffers from mental illness, disease, addiction, and other health conditions.³⁶ These health issues and mental health complications may be further compounded by the effects of confinement which can exacerbate pre-existing conditions.³⁷ While not every mentally ill or elderly person will be placed under guardianship, there is an overlap between mentally ill and/or elderly status and court-appointed guardianship.³⁸ Thus, as the number of incarcerated mentally ill and/or elderly people increases, the number incarcerated adults under court-appointed guardianship will likely increase as well.

Although guardianship, healthcare in correctional facilities, and informed consent have been considered as topics separately in publications, so far, the Indiana specific legislation at the intersection of these topics has yet to be formally analyzed. However, the state’s attention to the issue of constitutional and individual liberties in correctional facilities has been growing.

31. Carter Barrett, *Conservatorship system is slow to change, despite availability of less restrictive options*, WFYI INDIANAPOLIS (Nov. 22, 2021), <https://www.wfyi.org/news/articles/conservatorship-system-slow-change-despite-availability-less-restrictive-options> [https://perma.cc/5URS-S84Z].

32. Megan Cox, *U.S. Prison System: Pseudoscience in an Empirical World*, 16 LOGOS 9, 10 (2023), https://www.missouristate.edu/LOGOS/_Files/LOGOSVolume16WebVersionUPDATED.pdf#page=15 [https://perma.cc/WE5Q-FMWJ].

33. See Sarah Batbold et al., *Decision-Making for Hospitalized Incarcerated Patients Lacking Decisional Capacity*, 184 JAMA INTERNAL MED. 28 (Dec 2023) (discussing the rapidly aging prison population and increased prevalence of health conditions including mental health disorders).

34. See Meg Anderson, *The U.S. prison population is rapidly graying. Prisons aren’t built for what’s coming*, NPR (Mar. 11, 2024, 5:12 AM ET), <https://www.npr.org/2024/03/11/1234655082/prison-elderly-aging-geriatric-population-care> [https://perma.cc/54P5-RG6Y].

35. Batbold et al., *supra* note 33.

36. Joe Russo, *Caring for Those in Custody*, NAT’L INST. OF JUST. (Aug. 1, 2019), <https://nij.ojp.gov/topics/articles/caring-those-custody> [https://perma.cc/9DGY-4SVH].

37. *Id.*

38. See Berchtold, *supra* note 21.

C. Setting the Stage

This Note argues that Indiana's current statutory framework of both procedures for obtaining consent to healthcare for incarcerated adults under guardianship as well as regulation of guardians' authority to consent to healthcare on behalf of protected persons are insufficient to protect the autonomy of the individuals and to guide correctional facilities. Part II broadly explains the concept of informed consent to healthcare, provides an overview of Indiana's statutory scheme for adult guardianship, and introduces correctional facilities as healthcare providers. Part III provides an analysis of the statutory authority of guardians in Indiana to consent to healthcare on behalf of protected persons and the relevant procedures in place in the state's correctional facilities. This section then analyzes options for procedures correctional facilities may implement in obtaining informed consent to healthcare for adults under guardianship. This analysis ends with a comparison of states' limitations placed on guardians' authority to consent to healthcare on behalf of protected persons without court approval. Finally, Part IV concludes with a practical revision to Indiana law that will protect autonomy of adults under guardianship and support correctional facilities in providing healthcare to these individuals.

II. BACKGROUND INFORMATION

A. Informed Consent to Healthcare in Indiana

Informed consent as it is understood in the United States today began as a common law doctrine most notably established in the case of *Schloendorff v. Society of New York Hospital*.³⁹ In *Schloendorff*, a woman suffering from a stomach disorder consented to a non-surgical examination under anesthesia of a lump—which turned out to be a tumor—found by the physicians at the Society of New York Hospital.⁴⁰ The woman notified the physician attending to her case that she did not consent to any operation during the examination, however the lump was removed while she was unconscious during the examination.⁴¹ The court recognized that the physician's actions in this case went beyond mere negligence and that a *trespass* or *assault* had been committed against the woman in rendering treatment without consent.⁴²

The specific terminology of “informed consent” was first recognized in 1957 in *Salgo v. Leland Stanford Jr. University Board of Trustees*.⁴³ In this case,

39. Kim Dayton, *Standards for Health Care Decision-Making: Legal and Practical Considerations*, 2012 UTAH L. REV. 1329, 1331 (2012).

40. *Schloendorff v. Soc'y. of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (abrogated on other grounds by *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957)).

41. *Id.*

42. *Id.* (emphasis added).

43. Dayton, *supra* note 39, at 1332; see *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. App. 1st Dist. 1957).

Salgo was paralyzed during an aortography when his physician injected him with sodium urokon.⁴⁴ Salgo alleged that his physicians failed to inform him of the nature of his procedure thus failing to provide him the facts necessary for an informed consent to the procedure.⁴⁵ The court held that physicians have a duty to disclose any facts necessary for the patient to reach an “informed consent.”⁴⁶ Such facts include alternative courses of action and the risks attendant to procedures.⁴⁷ However, the necessary disclosures are subject to physician discretion as to when disclosure of facts will have a detrimental effect on the patient’s mental wellbeing.⁴⁸ A physician may not disclose facts if they determine the effect would have an adverse effect on the patient.⁴⁹ Following *Salgo*, the doctrine of informed consent has become cemented in American tort law and remains a frequent topic of scholarly attention.⁵⁰

Indiana case law has applied a similar doctrine of informed consent. In Indiana, informed consent to medical care is defined as “consent voluntarily given by an individual after a sufficient explanation and disclosure of the subject matter involved to enable that individual to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedure, and to make a knowing health care decision without coercion or undue influence.”⁵¹ Under Indiana’s standards of informed consent, the physician has the duty of disclosing information material to the proposed course of treatment to their patients.⁵²

In determining physician obligations for informed consent, Indiana follows the reasonably prudent physician standard requiring that the physician act as a reasonably prudent physician would “in taking a history, performing a physical examination, ordering appropriate tests, reaching a diagnosis, prescribing a course of treatment, and in discussing with the patient the medical facts of the proposed procedure, including the risks inherent in either accepting or rejecting the proposed course of treatment.”⁵³ Indiana statute codified these sentiments requiring explicitly that the information disclosed to the patient for purposes of obtaining informed consent include: (1) the general nature of the patient’s condition; (2) the proposed treatment, procedure, examination, or test; (3) the expected outcome of the treatment, procedure, examination, or test; (4) the

44. *See* *Salgo*, 317 P.2d at 173–75.

45. *See id.* at 181.

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Cruzan by Cruzan v. Dir., Missouri Dept. of Health*, 497 U.S. 261, 269 (1990) (“The informed consent doctrine has become firmly entrenched in American tort law.”); *see generally* Derek Kroft, *Informed Consent: A Comparative Analysis*, 6 J. INTL. L. & PRAC. 457 (1997); *see also* Dayton, *supra* note 39.

51. IND. CODE § 16-36-7-16 (2025).

52. *Perez v. Hu*, 87 N.E.3d 1130, 1134–35 (Ind. Ct. App. 2017).

53. *Id.* at 1135.

material risks of the treatment, procedure, examination, or test; and (5) the reasonable alternatives to the treatment, procedure, examination, or test.⁵⁴ Furthermore, informed consent is presumed (but rebuttable) when there is a written consent which is: (1) signed by the patient or the patient's authorized representative; (2) witnessed by an individual at least eighteen years of age; and (3) explained, orally or in the written consent, to the patient or the patient's authorized representative before a treatment, procedure, examination, or test is undertaken.⁵⁵

Any treatment performed without informed consent can be pursued as either a battery claim, if there has been a complete lack of consent, or as a specific form of negligence for a breach of the standard required of professional conduct.⁵⁶ For instance, CARE is pursuing a claim of battery against Wellpath, the Marion County Sheriff, and the nurse who administered the forced injections on A.P.⁵⁷ Notably, still missing from the Indiana landscape of informed consent are the specific obligations placed on physicians in obtaining informed consent from incarcerated protected persons.

B. Adult Guardianship in Indiana

A court-appointed guardian is a person who is a fiduciary and is appointed by a court to be a guardian or conservator responsible for the person or the property of an incapacitated person.⁵⁸ In Indiana, a "guardian" and a "conservator" are interchangeable, although this is not the case in every state.⁵⁹ To be deemed "incapacitated," it must be determined that a person is unable to comprehend and weigh relevant information and to make and communicate a reasoned health care decision.⁶⁰

The court must be petitioned for a guardian to be appointed to an incapacitated person.⁶¹ Such petition may be filed by any person and must state, among other factors, the nature of the incapacity, the particular limitations requested, the reasons the order is sought for, a description of the petitioner's efforts to use less restrictive alternatives, and the reason a less restrictive alternative is insufficient to meet the needs of the alleged incapacitated person.⁶² If the court determines it is in the best interests of the person to appoint a guardian, the court will issue the guardian letters of guardianship permitting

54. IND. CODE § 34-18-12-3 (2025).

55. IND. CODE § 34-18-12-2 (2025).

56. Perez, 87 N.E.3d at 1135.

57. At-Risk Elders Complaint, *supra* note 1, at 10. Notably, CARE also alleged a violation of A.P.'s 14th Amendment Due Process right to informed consent. *Id.* at 7–8.

58. IND. CODE § 29-3-1-6 (2025).

59. *Id.*

60. IND. CODE § 16-36-7-15 (2025).

61. IND. CODE § 29-3-5-2 (2025).

62. IND. CODE § 29-3-5-1 (2025).

them to act on behalf of the legally incapacitated person.⁶³ Notably, the court may remove a guardian upon a similar petition by the protected person or someone authorized to petition on their behalf, typically coupled with medical records to support the termination of the incapacitated status.⁶⁴

In selecting the individual or entity to be appointed as guardian for an incapacitated person, the court follows an ordered list of individuals provided by statute.⁶⁵ The order of these individuals and entities is as follows: (1) any person who is designated in a durable power of attorney; (2) a person who has been designated as a standby guardian; (3) the spouse of the incapacitated person; (4) an adult child of the incapacitated person; (5) the parent of an incapacitated person or a person nominated in the will of a deceased parent of the incapacitated person provided the will complies with wills formalities; (6) any person related to the incapacitated person by blood or by marriage whom the incapacitated person has resided with for more than six months before the filing of the petition; and (7) any person nominated by the incapacitated person who is caring for or paying for the care of the incapacitated person.⁶⁶ The court may pass over a person of a higher priority and appoint a person of lower priority if it determines this is in the best interest of the incapacitated person.⁶⁷

As the statute suggests, family members and friends are given priority for guardian status. However, the court may appoint private or public guardians if it is in the best interest of the incapacitated person.⁶⁸ Private guardians are paid professionals who receive fees out of the assets of the incapacitated person or through state funding.⁶⁹ These entities include individuals, non-profit, and for-profit agencies.⁷⁰ Public guardians are considered “guardians of last resort” and are often provided through a state or local public guardianship program.⁷¹ Indiana is one of the few states that do not currently have a state-supported public guardianship service.⁷² Rather, Indiana’s Adult Guardianship Office provides funding for Volunteer Advocates for Seniors and Incapacitated Adults (VASIA) programs across the state.⁷³ While private or public guardians are often appointed when an incapacitated person lacks other individuals to serve as their guardian, these entities may be appointed when the incapacitated

63. IND. CODE § 29-3-7-3 (2025).

64. IND. CODE § 29-3-12-1(c) (2025).

65. IND. CODE § 29-3-5-5 (2025).

66. *Id.*

67. *Id.*

68. *Guardianship Overview*, U.S. DEP’T OF JUST. (last updated Sep. 30, 2024), <https://www.justice.gov/elderjustice/guardianship-overview> [<https://perma.cc/P2UQ-97LU>].

69. *Id.*

70. *Id.*

71. *Id.*

72. *Guardianship*, VASIA, <https://indianavasias.org/guardianship> [<https://perma.cc/MV4V-H7MW>] (last visited Feb. 1, 2025).

73. *See Adult Guardianship*, IND. JUD. BRANCH, <https://www.in.gov/courts/iocs/adult-guardianship/> [<https://perma.cc/6YK2-NTDM>] (last visited Feb. 1, 2025).

person's relatives or friends are unable or unwilling to serve.⁷⁴ CARE, as a non-profit organization, serves as a private guardian for its constituents.⁷⁵ Many of these individuals are without family to step in as guardians, but others have involved family members who simply cannot take on the challenges and obligations associated with being a court-appointed guardian.

In Indiana, the legal authority for guardians to make decisions for incapacitated adults derives solely from state law.⁷⁶ The powers appointed to a guardian of an incapacitated adult include the power to consent to medical or other professional care.⁷⁷ However, the court may limit the scope of the guardianship to encourage the development of the incapacitated person's self-improvement, self-reliance, and independence.⁷⁸ This means that a guardian may not have control over a protected person's healthcare despite being their court-appointed guardian in financial situations. Specifically, Indiana differentiates between the guardian of the person, guardian of the estate, and guardian of both the person and estate.⁷⁹ A guardian of the person oversees living conditions and treatment, while a guardian of the estate oversees investment and financial affairs.⁸⁰ Furthermore, the guardian is charged with the responsibility of encouraging self-reliance and independence of the protected person as well as considering options relating to the appropriate standard of support, care, education, and training for the protected person.⁸¹ While this therapeutic model is a step in the right direction, it still leaves many intimate healthcare decisions for the protected person largely up to the discretion of the guardian.

C. Correctional Facilities as Healthcare Providers

The right to medical treatment for incarcerated individuals stems from the Supreme Court's decision in *Estelle v. Gamble* in 1976.⁸² In this decision, the Court held that prisoners have a right to adequate medical treatment during incarceration under the Eighth Amendment's protections against cruel and

74. U.S. DEP'T OF JUST., *supra* note 68.

75. See Who We Are, CTR. FOR AT-RISK ELDERS, <https://www.indianacare.org/who-we-are> [https://perma.cc/WRX4-GTX5] (last visited Mar. 9, 2026).

76. Dayton, *supra* note 39.

77. IND. CODE § 29-3-8-2 (2025).

78. IND. CODE § 29-3-5-3 (2025).

79. *Guardianship & Alternatives to Guardianship, What Is Limited Guardianship*, ARC OF IND., <https://www.arcind.org/future-planning/guardianship/> [https://perma.cc/23NZ-MUX8] (last visited June 6, 2026); see also GUARDIANSHIP OVERSIGHT TASK FORCE, *supra* note 15, at 41.

80. ARC OF IND., *supra* note 79.

81. IND. CODE § 29-3-8-3 (2025).

82. See *Estelle v. Gamble*, 429 U.S. 97 (1976); see also *Prisoners' Rights: Medical and Mental Health*, ACLU, <https://www.aclu.org/issues/prisoners-rights/medical-and-mental-health-care> [https://perma.cc/Z3F7-VLXF] (last visited June 6, 2026).

unusual punishment.⁸³ To succeed in a claim against a prison, the prisoner must show sufficiently harmful acts or omissions amounting to a deliberate indifference to serious medical needs that offends the “evolving standards of decency” as a violation of the Eighth Amendment.⁸⁴ When there is a deliberate indifference to the medical needs of an incarcerated individual, regardless of how evidenced, the incarcerated individual has a cause of action under 42 USCS §1983.⁸⁵ To make a successful claim of deliberate indifference, the prisoner must show that the maltreatment was sufficiently harmful and a “culpable state of mind on the part of prison officials.”⁸⁶

Conversely, the Supreme Court has held that the Fourteenth Amendment Due Process Clause creates a constitutional right to refuse medical care as well.⁸⁷ However, for incarcerated individuals, this right has been limited in certain instances where the Court has found under a “standard of reasonableness” that the state has a legitimate interest in prison safety and security and the state’s forced medication policy is a rational means of advancing these interests.⁸⁸ This line of reasoning has been applied in a number of cases, including issues such as forced psychotropic treatments.⁸⁹ The practical implications of this standard mean that prisoners’ rights to refuse medical treatment may be overridden by the interests of security and orderly operation of correctional institutions.⁹⁰

Importantly, the ability of prisoners to assert their rights is limited—or at least procedurally delayed—by the implications of the Prison Litigation Reform Act of 1996 (“PLRA”).⁹¹ The PLRA imposes the requirement on prisoners to “exhaust” all administrative remedies prior to filing a lawsuit.⁹² As such, the prisoner must first pursue all available administrative appeals before taking their grievance to court.⁹³ If the administrative remedies have not been exhausted prior to the filing of a lawsuit, the correctional facility may raise the failure to exhaust, and courts may dismiss the case without prejudice such that the lawsuit may only be filed again once the prisoner has exhausted the administrative

83. *Estelle*, 429 U.S. 97 at 116 (explaining that deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain).

84. *Id.* at 106.

85. *Id.* at 105.

86. Benjamin N. Parks, *Eighth and Fourteenth Amendment Concerns with the BoP Guidelines for Advance Directives*, 6 VOICES IN BIOETHICS 1, 1 (2020), <https://journals-test.library.columbia.edu/index.php/bioethics/article/view/5906> [<https://perma.cc/JH4U-WLAT>].

87. *Amdt14.S1.6.5.1 Right to Refuse Medical Treatment and Substantive Due Process*, CONST. ANNOTATED, https://constitution.congress.gov/browse/essay/amdt14-S1-6-5-1/ALDE_00000903/#ALDF_00019224 [<https://perma.cc/P45W-GV9B>] (last visited Mar. 9, 2026).

88. *Id.*

89. *Id.*

90. Parks, *supra* note 86.

91. 42 U.S.C.S. § 1997e; 28 U.S.C.S. § 1915; 18 U.S.C.S. § 3626.

92. 42 U.S.C.S. § 1997e; *The Prison Litigation Reform Act (PLRA)*, ACLU, https://www.aclu.org/sites/default/files/images/asset_upload_file79_25805.pdf [<https://perma.cc/TU2S-QUNQ>] (last updated Nov. 2002).

93. ACLU, *supra* note 92.

remedies, assuming the statute of limitations has not run.⁹⁴ The statute of limitations continues to run while the prisoner exhausts the administrative remedies.⁹⁵ While the PLRA was intended to discourage frivolous suits, it further complicates the remedies available for individuals under guardianship in incarceration and forces guardians to be even more proactive in their involvement with incarcerated incapacitated persons.⁹⁶

In Indiana, the right to healthcare in prison is codified at the state level.⁹⁷ Under Indiana law, a confined person is entitled to medical care, emergency treatment, and mental health care.⁹⁸ However, this care does not entitle inmates to substance abuse treatment or programming in the state.⁹⁹ Notably, the state's regulation of correctional facilities has not explicitly addressed considerations for incarcerated protected persons.

III. ANALYSIS

A. Indiana's Current Framework

1. Guardian's Responsibility in Providing Consent to Healthcare for a Protected Person

Indiana has codified its position on informed consent to healthcare for incapacitated individuals in its Health Care Consent Act.¹⁰⁰ Under the Health Care Consent Act, when a person's mental state raises concern as to whether they are able to manifest informed consent, a health care provider or any interested person may petition the probate court to make a health care decision, order health care for an individual incapable of consenting, or appoint a representative to act on behalf of the individual.¹⁰¹ Court action on behalf of an incapacitated person is established if the court finds: (1) a health care decision is required; (2) the individual is incapable of consenting; and (3) there is no authorized person readily available, willing to act, or already acting in the individual's best interest.¹⁰² Once the need is established, the court may order that health care be provided, appoint a representative to make health care decisions with or without limitations, or provide other appropriate remedies as

94. *Id.*

95. *Id.*

96. See Daniel Greenfield, Easha Anand, & Emily Clark, *How The Prison Litigation Reform Act Has Failed For 25 Years*, THE APPEAL (Apr. 26, 2021) <https://theappeal.org/the-lab/explainers/how-the-prison-litigation-reform-act-has-failed-for-25-years/> [https://perma.cc/DBY7-86HS].

97. See IND. CODE § 11-10-3-2 (2025).

98. *Id.*

99. Cohn v. Strawhorn, 721 N.E.2d 342, 349 (Ind. Ct. App. 1999).

100. IND. CODE § 16-36-1 et seq. (2025).

101. IND. CODE § 16-36-1-8 (2025).

102. *Id.*

it sees fit.¹⁰³ If a guardian has been appointed, informed consent of the guardian—rather than the protected person—is required to provide mental health treatment for patients who are deemed mentally incapacitated.¹⁰⁴ For instance, in A.P.’s case, the correctional facility served as the interested party who initiated the appointment of A.P.’s court-ordered guardian.¹⁰⁵

Indiana’s statutory framework broadly grants the guardian authority to consent to the “medical or other professional care and treatment for the [protected person’s] health and welfare.”¹⁰⁶ Notably, this statute simultaneously addresses guardians of minors and adults.¹⁰⁷ This authority is qualified first by a duty of the guardian to act in “good faith and in the best interest” of the protected person.¹⁰⁸ Furthermore, valid advance directives take precedence over a guardian’s decision.¹⁰⁹

Though guardians in Indiana are given significant latitude in healthcare decisions on behalf of a protected person, they must petition the court to change the protected person’s residence.¹¹⁰ As such, guardians need court approval to admit protected persons to a mental health facility or residential care facility, for example. Indiana otherwise allows the guardian to consent to quite controversial healthcare decisions so long as the guardian demonstrates good faith and consideration of the protected person’s best interests.¹¹¹ For instance, in one case, the Court of Appeals affirmed that the guardian may consent to tubal ligation on a protected person so long as the guardian exercises good faith and acts in the best interest of the individual.¹¹² Furthermore, Indiana does not explicitly restrict guardians’ ability to consent to involuntary medical treatment on behalf of the protected person. Guardians’ decisions remain subject to judicial scrutiny, however, as interested individuals may petition the court to terminate or limit the guardianship if the guardian has acted against the protected person’s best interests.¹¹³

What these standards mean for individuals under guardianship in Indiana is that there are very few limits on what their appointed guardian can consent to on their behalf. In cases in which the guardian meets the protected person only after they have been deemed incapacitated, determining the person’s prior

103. *Id.*

104. IND. CODE § 16-36-1.5-5 (2025).

105. *See* Petition for Appointment of Health Care Representative, *supra* note 2.

106. IND. CODE § 29-3-8-2 (2025).

107. *Id.* at (b) (explaining that the powers enumerated for the guardian of a minor are granted to guardians of incapacitated persons).

108. IND. CODE § 16-36-1-5(d) (2025).

109. IND. CODE § 16-36-7-42 (2025).

110. IND. CODE § 29-3-9-2 (2025).

111. *See, e.g.,* V.S.D. v. Williams-Huston (In re Guardianship of V.S.D.), 660 N.E.2d 1064, 1067 (Ind. Ct. App. 1996).

112. *See id.*

113. *See* IND. CODE § 29-3-12-4 (2025) (allowing interested parties to petition for removal as under outlined IND. CODE § 29-1-10-6 (2025) which permits removal where the guardian has failed to perform any duty imposed by law).

desires and personal values can be a difficult task. While Indiana law requires the guardian to become acquainted with the protected person if they did not know the individual personally, this process can be complicated.¹¹⁴ Additionally, many court-appointed guardians in the state of Indiana represent a multitude of incapacitated persons with whom they share no personal relationship. As such, individuals under guardianship in Indiana may be appointed a guardian who lacks knowledge of their wishes concerning their healthcare, despite the guardian's best attempts and intentions. Although guardians are still required to become acquainted with the person and to act in the best interest of the person regardless of their knowledge of the individual, this remains a gray area and a difficult task for guardians. With minimal, broad limitations on the scope of the ability of guardians to consent to care for protected persons, the true autonomy of these individuals is questionable.

These vague policies have created an uncertain task for guardians who intend to protect the individuals they serve. While the broad ability of the guardian to consent may provide for simpler, quicker access to care, it may also lead to extraordinary measures taken by the guardian who does not want to restrict their protected person's liberty to such an extent without a court order—or at least a second opinion. Some guardians may petition the court for approval before consenting to major health care decisions even when not legally obligated to do so rather than make extreme choices unilaterally.

2. Correctional Facilities' Responsibility to Adults Under Guardianship

Issues of informed consent for healthcare and autonomy of individuals under guardianship are only compounded for protected persons who are incarcerated in the state of Indiana. Currently, the Indiana Department of Corrections follows a Policy and Administrative Procedure Manual for Health Services ("Manual") which governs practices on healthcare of incarcerated individuals.¹¹⁵ The Manual outlines care for the physical and mental health of inmates providing incarcerated individuals access to treatment for "serious medical conditions."¹¹⁶ However, the Manual does not explicitly include a requirement of informed consent and does not contemplate obtaining consent from of incapacitated persons under guardianship.¹¹⁷ In fact, the Manual does not reference incapacitated persons under guardianship at all.¹¹⁸ Despite Indiana's codified status on health care during incarceration, the requirement of informed consent, and guidelines for obtaining consent from a guardian, there are no clear procedures for correctional facilities to follow when they provide

114. See IND. CODE § 29-3-8-1 (2025).

115. IND. DEP'T OF CORR., POL'Y & ADMIN. PROC. MANUAL OF POL'YS & PROCS., 01-02-101 (Apr. 1, 2022), <https://www.in.gov/idoc/files/01-02-101-Health-Services-4-1-2022.pdf> [<https://perma.cc/ALL2-J7QG>].

116. *Id.*

117. *Id.*

118. *Id.*

healthcare to protected persons. This leads not only to injustices against protected persons at the correctional facilities, but also to confusion among correctional facility staff who lack the regulatory guidance needed to act lawfully.

Furthermore, the Manual refers incarcerated individuals to another publication, “The Offender Grievance Process,” for information on the grievance process for claims of inadequate healthcare.¹¹⁹ Considering the implications of the PLRA on administrative remedies, this second procedure manual provides insight as to the process inmates must follow prior to pursuing any court remedies. Under the grievance policy, an offender must submit the grievance form within ten (10) business days of the incident giving rise to the complaint.¹²⁰ This form requires that the offender sign, date, and submit the grievance on their own behalf and specifies that another offender or staff member may write the grievance on behalf of the offender if they are unable to do so due to a “physical impairment, language impairment, or other obstacle.”¹²¹ While the policy does, therefore, contemplate the need for a surrogate for the inmate in some applications, it does not explicitly reference the abilities of the guardian of the individual.¹²² Rather, this grievance process places the burden of diligence upon the inmate without considering the complexities faced by incapacitated individuals at the facility.¹²³ For guardians, like CARE, who have a large caseload of protected persons they are serving, this ten-day window may be easily missed when the guardian sees each person maybe once per month. Problematically, much of the reporting duty in such instances is left to the protected person who lacks sufficient capacity to advocate on their own behalf when it comes to informed consent and/or financial instances. This further illustrates the state’s lack of consideration of protected persons within the criminal justice system.

B. Optional Approaches for Correctional Facilities in Obtaining Informed Consent to Healthcare from Guardians of Protected Persons

An analysis of state legislatures concerning healthcare for incarcerated individuals under guardianship shows that while many states have acknowledged the issue of the lack of procedures, no state seems to have found an adequate policy solution.¹²⁴ Although states such as Utah have started reforming policies concerning the responsibility of correctional facilities in

119. *Id.*

120. IND. DEP’T OF CORR., POL’Y & ADMIN. PROC. MANUAL OF POL’YS & PROCS., 00-02-301 (Apr. 1, 2022), <https://www.in.gov/doc/files/policy-and-procedure/policies/00-02-301-Offender-Grievance-Process-9-1-2020.pdf> [<https://perma.cc/29UF-HRTL>].

121. *Id.*

122. *Id.*

123. *Id.*

124. See generally M. Scott Smith et al., *Healthcare Decision-Making for Mentally Incapacitated Incarcerated Individuals*, 22 ELDER L.J. 175 (2014).

finding an appropriate decision-making surrogate for incarcerated individuals who may be unable to make their own informed decisions, the issue of how to interact with the existing guardian remains largely unaddressed.¹²⁵

One proposed method of reform that some states have considered implementing includes the use of written advance directives as a tool to determine the correctional facility's course of action and the desired guardian to be appointed for prisoners who may become incapacitated.¹²⁶ Ideally, creating these directives reduces the need for others to make healthcare decisions on behalf of prisoners who have become critically ill.¹²⁷ In such cases, the prisoner can determine their healthcare preferences and identify a potential surrogate decision-maker before becoming incapacitated.¹²⁸ However, complications with implementing such a procedure include a lack of inmate trust and cooperation necessary to create such objectives, insufficient prison resources, complications with prisoners who already lack decision-making capacity, and the complexities of having such an advance directive in instances where a public guardian becomes necessary.¹²⁹

Analyzing what notice correctional facilities should provide to the guardians of incarcerated individuals, one article examines the parallel notification procedures used for juveniles.¹³⁰ The authors note that guardians of juveniles are notified at certain stages of the juvenile proceedings in Texas.¹³¹ Specifically, any person "taking a child into custody [must] promptly give notice of the person's action and a statement of the reason for taking the child into custody, to the child's parent, guardian, or custodian; and the office or official designated by the juvenile board."¹³² Conversely, no such notification requirement exists for adults under guardianship who find themselves in custody.¹³³

Performing a similar comparison to Indiana's requirements for notification to guardians and consent to healthcare for juveniles in the criminal justice system may be beneficial in determining the appropriate measures for the state's treatment of adults under guardianship. While an adult under guardianship differs from a juvenile in the sense of individual autonomy and life experiences, correctional facilities may still glean guidance for notification and coordination of healthcare purposes from the juvenile correctional systems. Furthermore, this practice aligns with the state's current approach to guardianship as many of the

125. *See generally id.*

126. *Id.* at 191.

127. *Id.*

128. *Id.*

129. *Id.* at 191–93.

130. *See* Hon. Claudia Laird & Darlene Payne Smith, *Elder Abuse: Criminal Aspects Estates & Guardianships, and Mental Commitments*, 10 TEX. TECH EST. PLAN & CMTY. PROP. L.J. 225 (2018).

131. *Id.* at 282–83.

132. *Id.* at 282.

133. *Id.*

Indiana statutes governing guardianship address guardians of minors and adults simultaneously already.¹³⁴

When a child in Indiana is taken into custody, the law enforcement officer must immediately notify the child’s parent, guardian, or custodian.¹³⁵ Once a juvenile has been committed to the Indiana Department of Corrections, an assigned case manager establishes an Individual Growth Plan (IGP).¹³⁶ Indiana could use its policies regarding juveniles who come into custody as a basis for reforming policies concerning protected persons who come into custody. Requiring similar notifications to the guardian when adults under guardianship are taken into custody would first require the legislation to require that the correctional facility take measures to identify if a person who is brought into custody is under guardianship. Additionally, a similar individualized plan could be created once an adult under guardianship has been identified. This plan could include a procedure for obtaining informed consent from the guardian for any healthcare during the protected person’s incarceration. The individualized plan may also outline protocols for emergency situations as well as plans for providing care when the protected person is uncooperative. Unlike the advance directives being considered in other states, Indiana’s individualized plan could be made by the guardian, the protected person’s physician(s), and the correctional facility. This avoids the complications associated with an already incapacitated inmate making their own decisions while promoting a proactive process of administering care to the inmate. Thus, an individualized plan specific to inmates who have already been appointed a guardian may resemble a blend between the juvenile plan and an advance directive.

C. State Comparison of Limitations on Guardians in Providing Consent to Healthcare on behalf of a Protected Person

The issue of setting standards for when a guardian can provide informed consent on behalf of protected persons is a nationwide dilemma. States vary widely in their limitations on guardians’ ability to consent to certain healthcare procedures on behalf of a protected individual. These restrictions range in severity with some states granting guardians broad power to consent to almost any healthcare on behalf of a protected individual without court interference to extensive limitations requiring court approval for any decisions a protected

134. See, e.g., IND. CODE § 29-3-8-2 (2025) (addressing guardianship of minors and adults).

135. IND. CODE § 31-37-5-4 (2025).

136. Division of Youth Services, *Juvenile Programs, Treatment Programming & Mental Health Services*, IND. DEP’T OF CORR., https://www.in.gov/idoc/dys/juvenile-programs/#IDOC_Health_Services [<https://perma.cc/27ME-UXVL>] (last visited Nov. 24, 2024); see also IND. DEPT. OF CORR., YOUTH CASE MANAGEMENT (Feb. 15, 2026), <https://www.in.gov/idoc/files/policy-and-procedure/policies/03-02-115-Youth-Case-Mgmt-2-15-26.pdf> [<https://perma.cc/ALP9-3XU3>].

individual objects to.¹³⁷

In 2017, the Uniform Law Commission amended the Uniform Guardianship and Protective Proceedings Act of 1997 to the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (“UGCOPAA”).¹³⁸ Broadly, the UGCOPAA’s three goals are to: (1) prioritize “person-centered” guardianship rejecting the use of “ward” in reference to a protected person; (2) create legal rules ensuring implementation of the least restrictive means necessary in guardianship appointments allowing for limited guardianships; and (3) ease the burdens of all involved personnel through simplified petition requirements emphasizing access to information necessary to adopt limited guardianship.¹³⁹ Under the UGCOPAA, a guardian has the authority to consent to health or other care, treatment, or service on behalf of the protected person.¹⁴⁰ However, protected persons cannot be committed to mental health facilities without prior court approval as mandated by the state’s procedure for involuntary civil commitment.¹⁴¹ Furthermore, the UGCOPAA broadly requires the guardian to consider the needs, best interests, preferences, values, and prior directions of the protected person to the extent known or reasonably ascertainable in all of the guardian’s decisions regarding the protected person.¹⁴² Despite the noble efforts of the Uniform Law Commission in drafting the UGCOPAA, as of 2026 only nine states have enacted it or its predecessor.¹⁴³

Although Indiana has not enacted the UGCOPAA as of 2026, Indiana’s guardianship framework shares the main tenants of the Act. Like the UGCOPAA, Indiana places minimal limitations on the guardian’s ability to consent to healthcare on behalf of a protected person.¹⁴⁴ As such, Indiana is among minimally restrictive states granting guardians lenient authority to consent to healthcare on behalf of a protected person, generally only requiring court approval for the guardian to place the protected person in a mental health

137. See Karna Sandler, *A Guardian’s Health Care Decision-Making Authority: Statutory Restrictions*, 35 BIFOCAL 106 (2014), <https://www.americanbar.org/content/dam/aba/publications/bifocal/BIFOCALMarch-April2014.pdf> [<https://perma.cc/S34F-G2FN>].

138. See *The Uniform Guardianship, Conservatorship, and other Protective Arrangements Act: A Summary*, UNIF. LS. COMM’N, <https://www.guardianship.org/wp-content/uploads/2018/04/UGCOPAA-Summary-Oct-2017.pdf> [<https://perma.cc/D72B-9DPV>] (last visited Mar. 12, 2026).

139. *Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act*, NAT’L CONF. OF COMM’RS OF UNIF. STATE L. 1–2 (Apr. 3, 2020), <https://www.uniformlaws.org/viewdocument/final-act-77?CommunityKey=2eba8654-8871-4905-ad38-aabbd573911c&tab=librarydocuments> [<https://perma.cc/Q8TY-N8VE>].

140. *Id.* at 107.

141. *Id.* at 112.

142. *Id.* at 116.

143. *Guardianship, Conservatorship, and Other Protective Arrangements Act*, UNIF. L. COMM’N, <https://www.uniformlaws.org/committees/community-home?CommunityKey=2eba8654-8871-4905-ad38-aabbd573911c> [<https://perma.cc/K74D-9LTK>].

144. See *supra* notes 103–13 and accompanying text.

facility.¹⁴⁵ However, some states grant guardians even more leeway by allowing the guardian to place an incapacitated person in a mental health facility for a limited time period prior to getting court approval.¹⁴⁶ For instance, North Dakota permits a guardian to consent to commitment of an incapacitated person for forty-five (45) days without following the state’s civil commitment process.¹⁴⁷

As of 2014, a small trend has emerged in which states are restricting guardians’ authority to make healthcare decisions on behalf of a protected person.¹⁴⁸ Such statutes require the guardian to petition the court for approval to give consent to procedures that implicate the protected person’s “moral, ethical, or religious beliefs” where delegation of authority to the guardian alone poses a greater risk of undermining the individual’s autonomy.¹⁴⁹ States that follow this approach limit guardians’ authority to consent in one or more categories of healthcare including admissions to residential care facilities, invasive procedures, experimental treatment, withholding or withdrawing life sustaining treatment, and mental health treatment.¹⁵⁰ For instance, Maryland and Iowa require broader court approval before guardians may place protected persons in any residential settings more restrictive than their home.¹⁵¹ This includes placement within a nursing home facility. Similarly, California prohibits involuntary placement in a mental health treatment facility and administration of experimental drugs without court approval.¹⁵² Some states, such as Montana, also limit the guardian’s ability to withhold or withdraw from life-sustaining treatment and to sign a do not resuscitate form on behalf of a protected person.¹⁵³ Notably, Indiana’s statutory scheme is silent in each of these categories.

Several states have even greater restrictions limiting guardians’ authority in multiple categories of healthcare. Alaska, for example, requires court approval before the guardian may consent to abortion, sterilization, psychosurgery, removal of bodily organs, experimental medical procedures, and withholding of lifesaving medical procedures unless these procedures only prolong an individual’s death.¹⁵⁴ Similarly, New Hampshire, restricts the ability of the guardian to consent to psychosurgery, electro-convulsive therapy, sterilization, and experimental treatment of any kind without a court order.¹⁵⁵ Michigan takes another approach restricting guardians’ authority in categories of healthcare that

145. See Sandler, *supra* note 138, at 107 (explaining that all states required guardians to conform with the state civil commitment process for placing a protected person in a mental health-care institution).

146. *Id.*

147. N.D. CENT. CODE § 30.1-28-12 (2026).

148. Sandler, *supra* note 138, at 106.

149. *Id.* at 107–09.

150. *Id.*

151. *Id.*; MD. EST. & TRUSTS § 13-708 (2025); IOWA CODE § 633.635 (2025).

152. CAL. PROB. CODE § 2356 (Deering 2025).

153. MONT. CODE ANN. § 72-5-321 (2025); *see also* IOWA CODE § 633.6435 (requiring court approval for withholding or withdrawing life-sustaining procedures, abortions, and sterilization).

154. ALASKA STAT. § 13.26.316 (2025).

155. N.H. REV. STAT. ANN. § 464-A:25 (LexisNexis 2026).

encompass a wide variety of treatment. Specifically, Michigan requires court approval for any inpatient hospitalization and involuntary mental health treatment.¹⁵⁶

States with even greater restrictions on the guardian's ability to consent to healthcare on behalf of a protected individual require court approval for "involuntary" medical decisions which arise anytime the protected person objects to the guardian's intended treatment plan.¹⁵⁷ It is important to make a technical distinction between the protected person granting legal consent and being unwilling to undergo treatment. Specifically, these statutes refer to instances where the protected person is unwilling to undergo treatment and limit the guardian's ability to provide the legal consent to proceed with treatment. As such, A.P.'s refusal of her mental health injection would qualify as an involuntary medical treatment under these statutory schemes. Several states limit the guardian's ability to consent to certain involuntary procedures rather than prohibiting any involuntary medical decision without court approval. One such example is Michigan's restriction on involuntary mental health treatment.¹⁵⁸ Additionally, Wisconsin requires court consent for psychotropic medication when the protected person protests and defines "protest" as "mak[ing] more than one discernible negative response, other than mere silence, to the offer of, recommendation for, or other proffering of voluntary receipt of the medical examination, medication, or medical treatment."¹⁵⁹

Vermont is among the most restrictive states requiring court approval for *any* involuntary treatment or medication on a protected person's behalf.¹⁶⁰ Vermont also requires court approval for admitting a protected person into a nursing home or similar facility, consenting to a do-not-resuscitate order, sterilization, having a person committed to the state hospital, and withholding or withdrawing life-sustaining support.¹⁶¹ Vermont's revised statutory scheme for obtaining consent to involuntary treatment of protected persons was passed as part of a reform effort in Vermont occurring largely in 2006 and 2008.¹⁶² During this time period, Vermont introduced changes to the guardianship framework to better balance the need for protection with the dignity of self-determination.¹⁶³ In doing so, Vermont recognized the deprivation of individual

156. MICH. COMP. LAWS § 700.5314 (2025).

157. See Sandler, *supra* note 138, at 109

158. MICH. COMP. LAWS § 700.5314 (2025).

159. WIS. STAT. § 54.25 (2025).

160. VT. STAT. ANN. tit. 14, § 3074 (2026).

161. VT. STAT. ANN. tit. 14, § 3073 (2026); VT. STAT. ANN. tit. 14, § 3075(g)(1)(D) (2026); VT. STAT. ANN. tit. 14, § 3074 (2026); VT. STAT. ANN. tit. 14, § 3075(g)(1)(C) (2026); *Adult Guardianships, Limitations on a Guardian's Powers*, VT. JUDICIARY, <https://www.vermontjudiciary.org/probate/adult-guardianships> [<https://perma.cc/3FCK-ASTG>] (last visited Mar. 9, 2025).

162. Barbara W. Prine, *Guardianship Reform in Vermont: What You Need to Know*, 37 VT. B.J. 18, 18 (Spring 2011).

163. See generally *id.*

and civil rights that a person under guardianship faces.¹⁶⁴ The state further emphasized that guardianship cannot deprive a protected person of their constitutional rights—including the right to refuse medical treatment—and ordered that courts may only grant powers to the guardian in the least restrictive manner appropriate to the circumstances of the respondent.¹⁶⁵

IV. PROPOSED SOLUTION

A. Correctional Facilities Procedures on Guardianship

Based on the lack of policies available for Indiana correctional facilities to follow when it comes to incarcerated protected persons, Indiana would benefit from legislation providing guidance for state correctional facilities on procedures for identifying these individuals and obtaining consent to their healthcare while incarcerated.¹⁶⁶ Correctional facilities in Indiana must first use the state-wide online guardianship registry, which allows for correctional facility staff to determine whether a person is under guardianship as part of their intake process.¹⁶⁷ Once a protected person is identified, the facility should be required to contact the guardian to create an individualized plan for obtaining consent to any healthcare provided in the facility.¹⁶⁸ This individualized plan should include contingency plans for administering healthcare when the protected person is uncooperative and should detail the correctional facility’s obligations to notify the guardian immediately of any issues. Like advance directives for healthcare utilized in some states, these plans would avoid hastily made healthcare decisions made by the guardian on behalf of the protected person.¹⁶⁹ Furthermore, such plans should also include an explanation of the healthcare decisions that the guardian would need to obtain court approval before consenting to on their protected person’s behalf.

B. State Regulation of Involuntary Medical Treatment of Protected Persons

Once Indiana clarifies the procedures correctional facilities must follow to ensure that incarcerated individuals under guardianship are properly identified and adequate consent for medical care is obtained, the state should address its position on guardians’ ability to consent to involuntary medical treatment of protected persons. While guardians should maintain emergency decision authorization to avoid negative health outcomes driven by untimely care, the autonomy of the protected person would best be protected by requiring court

164. *See generally id.*

165. *Id.* at 19.

166. *See supra* notes 115–18 and accompanying text.

167. *See supra* notes 26–28 and accompanying text.

168. *See supra* note 136 and accompanying text.

169. *See supra* note 126 and accompanying text.

approval for involuntary medical treatment.

Status quo in Indiana requires only that the guardian take the protected person's prior wishes and personal desires into account when making medical decisions on their behalf.¹⁷⁰ However, a guardian only appointed after the protected person became incapacitated—which is often the case where there is no prior personal relationship—may not know the person's earlier wishes, despite their efforts to become “acquainted” with the individual.¹⁷¹ As such, the state legislation currently allows the guardian to consent to the involuntary medical treatment of incapacitated individuals with limited review of the guardian's decisions.

Requiring, as Vermont does, the guardian to obtain court approval for the authority to consent to involuntary medical treatment would create a safeguard for the autonomy of the protected person. Court approval before action requires the guardian to present a case providing reasoning and evidence which the court weighs before administering any treatment to a protected person against their will. Furthermore, a public defender would be assigned to defend the protected person against commitment, thus ensuring that all ramifications of the proposed authorization are adequately considered. When the court then makes its determination, it can weigh the circumstances as a whole and ensure that the rights of the individual are not being denied without sufficient, documented cause. While this creates an additional step for guardians to take before consenting to healthcare of protected persons, this step is crucial to protect individual liberties among a vulnerable population. These safeguards benefit guardians as well by alleviating some of the onus of making intimate healthcare decisions for protected persons. Many liberties and rights of protected persons are limited by their need for a court-appointed guardian, but their ability to say “no” to unnecessary healthcare does not have to be one of them.

C. The Plan in Action

What would A.P.'s outcome have looked like if Indiana had enacted the recommended legislation? First, A.P.'s status as a protected person would have been identified each time she encountered the correctional facility. As part of the intake process, the correctional facility would have searched the guardianship registry and found the contact information for A.P.'s guardian, CARE. Next, the correctional facility would have been required to attempt to contact CARE and create an individualized plan for A.P.'s medical care and other processes requiring consent. The plan would have proactively outlined a procedure to follow if A.P. refused necessary medical treatment rather than waiting until treatment timeliness became a concern. This collaborative plan developed by CARE, the correctional facility, and its physicians would have guaranteed a therapeutic administration of these necessary injections.

170. *See supra* notes 106–08 and accompanying text.

171. *See supra* note 114 and accompanying text.

When A.P. then refused to consent to her Invega Sustenna injections, CARE would have been contacted and required to petition the court to be able to consent to such involuntary injections if another solution could not be successfully implemented. The court would have made the ultimate decision as to whether injections could be “forced” after considering medical evidence and testimony from CARE and A.P.’s public defender. With the court’s approval, CARE, A.P.’s healthcare providers, and the correctional facility could have developed procedures for therapeutically administering the injections after CARE provided informed consent. With these safeguards in place, A.P. could have received medical care without the use of excessive force and ultimately could have avoided trauma and a dislocated thumb.

Guidance protects correctional facilities as well. Such regulations shield correctional facilities from the responsibility of making complicated healthcare decisions on behalf of incarcerated individuals under guardianship. Correctional facilities and staff, too, benefit from having a clear procedure for handling situations such as A.P.’s.

Furthermore, both guardians and protected persons benefit from legislation requiring court approval for guardians to consent to involuntary medical treatment of protected persons. Such regulation protects guardians from liability and responsibility in making major medical decisions on behalf of protected persons against their will. Most importantly, these safeguards guide guardians in protecting the interests of protected persons to the greatest extent possible.

Ultimately, comprehensive regulation and guidance benefit all stakeholders. This framework ensures that the protected person’s individual liberty and autonomy are protected to the best of the guardian’s, court’s, and correctional facility’s abilities despite the complexities such individuals face. Furthermore, these measures provide correctional facilities and guardians a team to rely on in making such pivotal decisions. This opportunity for collaboration among these entities further benefits the community at large.

Unfortunately, “no” might still not always mean “no” for incarcerated adults under guardianship. However, an updated framework can, at the very least, provide a documented procedure and collaborative rationale for overriding the wishes of the protected person centering the goal of upholding their best interests.

ENHANCING CORRECTIONAL HEALTH CARE: AN ADMINISTRATIVE APPROACH TO ELEVATING STANDARDS AND ACCESS

ALVIN D. OLIVER II*

Walter Jordan, a 67-year-old man incarcerated in Arizona, died in “excruciating needless pain” from a cancer that could have been treated if he received timely medical attention.¹ Nine days before his death, he sent a handwritten plea titled “Notice of Impending Death” to a federal court, warning that delays in his treatment left him with little time to live.²

Antonio Arnez Smith, a 45-year-old incarcerated man in Alabama, faced similar neglect.³ By the time he was granted medical furlough, he was severely emaciated, in extreme pain, and covered in bed sores.⁴ Smith’s condition had deteriorated to the point that he could not lift his head.⁵ He died just four days after his release, leaving his family questioning why he had not been provided earlier medical intervention.⁶

George Hawkins, Jr., a person with whom the author personally communicated, endured months of untreated dental pain in a Virginia prison.⁷ Despite following every proper step—seeking medical attention, documenting his suffering, and filing grievances—his condition worsened.⁸ By the time he was finally treated, his teeth were beyond repair and required extraction, a preventable outcome of prolonged neglect.⁹

Access to adequate health care in prisons remains a persistent challenge, often turning manageable conditions into life-threatening situations. These cases highlight systemic gaps in prison health care that lead to unnecessary suffering. Part I of this Note examines the constitutional and statutory framework governing inmates’ right to medical care and the historical evolution of correctional health standards. Part II analyzes the structural and systemic

* J.D. Candidate, 2026, Indiana University Robert H. McKinney School of Law; M.S. Candidate in Cybersecurity Risk Management, 2026, Indiana University Bloomington; B.S. in Business Administration, 2023, Seton Hall University. The author thanks his note advisors, the late Professor Priscilla Keith-Thomas and Professor Joel Schumm, as well as the many other individuals who helped along the way, for their generous support and constructive feedback throughout the drafting and editing process. The author also thanks the Indiana Health Law Review for its hard work in making this publication possible. Lastly, a special thank you to the author’s late mother and the rest of his family, who continue to push him to do wonderful things.

1. David Fathi, *How Poor Health Care Turned Walter Jordan’s Prison Sentence Into a Death Sentence*, ACLU (Jan. 11, 2018), <https://www.aclu.org/news/prisoners-rights/how-poor-health-care-turned-walter-jordans> [https://perma.cc/G2R6-S3UJ].

2. *Id.*

3. *Family Says Alabama Prison Failed to Provide Care for Dying Man*, EQUAL JUST. INITIATIVE (Dec. 14, 2023), <https://eji.org/news/antonio-arnez-smith-family-says-alabama-prison-failed-to-provide-care-for-dying-man/> [https://perma.cc/684K-8L58].

4. *Id.*

5. *Id.*

6. *Id.*

7. *Hawkins v. Allen*, 743 F.Supp.3d 765, 769–772 (E.D. Va. Aug. 5, 2024).

8. *Id.* at 771–72.

9. *Id.*

failures that persist under that framework, including chronic understaffing, inadequate oversight, and the public health consequences of incarceration. Part III examines the role of private health care contractors and the regulatory gaps that allow substandard care to persist despite constitutional mandates. Part IV proposes a comprehensive reform agenda grounded in administrative law, arguing that state legislatures and correctional agencies must mandate accreditation, expand technology-driven care delivery, and restructure financial incentives to align contractor behavior with the constitutional obligation to provide adequate health care. Part V concludes.

Correctional health care reform is not merely a matter of prison administration; it is a matter of public health infrastructure. State policymakers must move beyond reactive constitutional compliance and adopt administrative mandates that institutionalize accountability, transparency, and evidence-based care. Doing so protects not only incarcerated individuals, but also the communities to which they return.

I. INTRODUCTION

There are four basic purposes of criminal punishment: deterrence, incapacitation, just punishment, and rehabilitation.¹⁰ Among these objectives, rehabilitation is distinct in its focus on changing behaviors to reduce recidivism.¹¹ While the primary legal justification for providing medical care in correctional facilities stems from constitutional protections rather than rehabilitative goals, access to adequate health care can support rehabilitation by addressing physical and mental health conditions that might otherwise hinder reintegration into society.¹² “The U.S. Constitution requires [all] prison officials to provide all state and federal prisoners as well as pretrial detainees . . . with adequate medical care.”¹³ Yet, state and federal prisons have long struggled to provide sufficient medical care, resulting in preventable deaths that receive little scrutiny.¹⁴

In its 1976 decision, *Estelle v. Gamble*, the Supreme Court held that “deliberate indifference to serious medical needs” constitutes “cruel and unusual

10. U.S. SENT’G GUIDELINES MANUAL §1A1.2 (U.S. SENT’G COMM’N 2024).

11. See DORIS LAYTON MACKENZIE, SENTENCING AND CORRECTIONS IN THE 21ST CENTURY: SETTING THE STAGE FOR THE FUTURE 1 (2001), <https://www.ojp.gov/pdffiles1/nij/grants/189089.pdf> [<https://perma.cc/TD7J-4YCL>] (defining rehabilitation as the modification of offender behavior and thinking to prevent future crime).

12. Danielle Wallace & Xia Wang, *Does in-prison physical and mental health impact recidivism?*, 11 SSM POP. HEALTH 1, 1–2 (2020), <https://doi.org/10.1016/j.ssmph.2020.100569> [<https://perma.cc/KE4K-XRA6>].

13. COLUM. HUM. RIGHTS L. REV., A JAILHOUSE LAWS. MANUAL, YOUR RIGHT TO ADEQUATE MEDICAL CARE 706 (13th ed. 2024), <https://jlm.law.columbia.edu/files/2017/05/35.-Ch.-23.pdf> [<https://perma.cc/B8KB-QQ5T>].

14. *Prison Health Care Crisis Mounts as Incarcerated Population Age*, EQUAL JUST. INST. (May 14, 2024), <https://eji.org/news/prison-health-care-crisis-mounts-as-incarcerated-population-ages/> [<https://perma.cc/D6PH-6K48>] [hereinafter EJI].

punishment” under the Eighth Amendment.¹⁵ However, subsequent cases, such as *Farmer v. Brennan* (1994), have underscored that “deliberate indifference” requires a subjective recklessness standard: prison officials must be shown to have been aware of and consciously disregarded substantial risk to inmate health.¹⁶ Therefore, mere negligence is insufficient to meet this high burden.¹⁷

This Note examines how deficiencies in correctional health care persist under current legal and regulatory frameworks and proposes a comprehensive approach to enhance health care standards. While cases like those of Walter Jordan, Antonio Arnez Smith, and George Hawkins illustrate the human cost of systemic failures, the proposed framework emphasizes legislative reforms, accreditation mandates, and technology-driven solutions that transcend the challenging standard set by *Estelle*. This Note focuses on prisons rather than jails, as prisons hold individuals for longer periods, which provides a greater opportunity to implement systemic health care improvements and rehabilitative policies. By exploring constitutional and statutory shortcomings, analyzing the role of private health care providers, and focusing on public health and ethical obligations, this Note seeks to balance inmates’ health care rights with the practical realities of correctional facilities.

II. UNDERSTANDING HEALTH CARE IN CORRECTIONAL SETTINGS

This section explores the current state of health care in U.S. prisons by examining its evolution and the legal foundations that shape it today. By exploring these aspects, this section uncovers the challenges and opportunities in providing adequate health care to incarcerated individuals, as well as the broader implications for justice and public health.

A. Contemporary State of Health Care Delivery in U.S. Prisons

“Health care behind bars is bad even in the best scenarios.”¹⁸ With an aging prison population, the strain on these already failing systems continues to grow.¹⁹ Studies have shown that a fifty-nine-year-old in prison has the same morbidity rate as a non-incarcerated seventy-five-year-old, with earlier onset cognitive decline and higher mortality rates.²⁰ Many so-called “natural deaths” in prison have been linked to medical neglect rather than aging itself.²¹

Access to medical care in prisons is severely limited, in part due to the

15. *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976).

16. *See* 511 U.S. 825, 837–41 (1994).

17. *Id.* at 835.

18. EJI, *supra* note 14.

19. *Id.*

20. Farah Acher Kaikow et al., *Caring for the Rapidly Aging Incarcerated Population: The Role of Policy*, 49 J. GERONTOLOGICAL NURSING 7, 7–11 (2023); EJI, *supra* note 14.

21. *Id.*

exclusion of incarcerated individuals from Medicaid coverage.²² Additionally, prison medical personnel often face ethical and operational conflicts, where institutional policies sometimes override patients' health needs.²³ In some cases, this means clearing individuals for punitive measures, like solitary confinement, despite its well-documented adverse health effects.²⁴

1. Oversight and Accreditation Efforts

Organizations such as the National Commission on Correctional Health Care ("NCCHC") have established standards for correctional health care in an effort to improve oversight and accountability.²⁵ These standards address: governance and administration; health promotion, safety, and disease prevention; personnel and training; ancillary health care services; patient care and treatment; special needs and services, and medical-legal issues.²⁶ The NCCHC also offers a Certified Correctional Health Professional ("CCHP") certification for health care professionals working in correctional facilities.²⁷ In 2017, the NCCHC expanded access to its CCHP certification through nationwide computer-based testing sites.²⁸ The CCHP credential signifies a provider's mastery of NCCHC standards and commitment to quality patient care in correctional settings.²⁹ While accreditation establishes essential guidelines for correctional health care, the integration of innovative technologies, such as telemedicine and electronic health records ("EHR"), has become a crucial component in improving health care access and continuity for incarcerated individuals.

22. Sam McCann, *Health Care Behind Bars: Missed Appointments, No Standards, and High Costs*, VERA (June 29, 2022), <https://www.vera.org/news/health-care-behind-bars-missed-appointments-no-standards-and-high-costs> [https://perma.cc/XNM8-JXER].

23. *Id.*

24. *Id.*

25. Wendy Habert, *Standards for Health Services in Juvenile Detention & Confinement Facilities: What's New?*, NAT'L COMM'N ON CORR. HEALTH CARE (2022), <https://www.ncchc.org/wp-content/uploads/2022-Standards-for-Health-Services-Whats-New.pdf> [https://perma.cc/XNM8-JXER].

26. *Standards for Health Services in Jails/Prisons*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://www.ncchc.org/jails-and-prisons/> [https://perma.cc/2PGB-J2H6] (last visited Mar. 16, 2026).

27. *Certification as a Talent Management Strategy*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://ncchc.org/certification-as-a-talent-management-strategy/> [https://perma.cc/5MZQ-MY4] (last visited May 28, 2026).

28. *NCCHC Historical Time Line*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://www.ncchc.org/historical-time-line/> [https://perma.cc/9XS2-WVNF] (last visited Mar. 16, 2026) [hereinafter NCCHC Time Line].

29. *Id.*

2. Role of Telemedicine and Electronic Health Records (EHR)

a. Telemedicine

Telehealth serves as an alternative approach to conventional care across a range of health care disciplines, particularly for populations with limited access to health care services, such as those in rural and remote communities.³⁰ The term “telehealth” refers to the delivery of health services at a distance using information and communication technologies, encompassing patient and professional education, health care administration, and clinical services.³¹ Telemedicine, a subset of telehealth, specifically involves remote clinical care.³² It can operate in two primary forms: synchronous (real-time consultations using videoconferencing) and asynchronous (technologies that allow medical data, such as images and diagnostic test results, to be reviewed later).³³

Within correctional facilities, telemedicine has emerged as a viable solution for improving health care access, particularly in overcoming logistical and security barriers to in-person consultations.³⁴ Studies show that telehealth can be as effective as conventional care, offering benefits such as reduced transportation costs, improved access to specialists, and more timely medical interventions.³⁵ It provides remote consultations with medical professionals and is utilized for both routine and urgent care.³⁶ Research dating back to the 1990s demonstrated the effectiveness of telemedicine in correctional settings, and by 2011, it had been widely adopted across the United States, especially in rural or isolated areas.³⁷

Despite these benefits, telehealth implementation in prisons faces significant challenges. Many facilities struggle with technological limitations, inconsistent internet connectivity, and concerns about patient confidentiality.³⁸

30. *Telehealth and Health Information Technology in Rural Healthcare*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/telehealth-health-it> [https://perma.cc/SBK4-CBCR] (last visited Mar. 16, 2026) [hereinafter RHlhub].

31. Esther Jie Tian et al., *The impacts of and outcomes from telehealth delivered in prisons: A systematic review*, 16 PLOS ONE 1, 3 (2021).

32. *Id.*

33. *Id.*

34. RHlhub, *supra* note 30.

35. Tian et al., *supra* note 31, at 4, 11.

36. Aaron Timm, *The Role of Wearable Technology in Advancing Inmate Healthcare*, CORRECTIONAL NEWS (Aug. 5, 2024), <https://correctionalnews.com/2024/08/05/the-role-of-wearable-technology-in-advancing-inmate-healthcare/> [https://perma.cc/5H92-A8XZ].

37. PETER L. NACCI ET AL., NAT'L INST. OF JUST., IMPLEMENTING TELEMEDICINE IN CORRECTIONAL FACILITIES 16 (2002), <https://www.ojp.gov/pdffiles1/nij/190310.pdf> [https://perma.cc/Z3RF-TN4K]; KARISHMA A. CHARI ET AL., NAT'L CTR. FOR HEALTH STATS., PUB. NO. 96, NATIONAL SURVEY OF PRISON HEALTH CARE: SELECTED FINDINGS (2016), <https://www.cdc.gov/nchs/data/nhsr/nhsr096.pdf> [https://perma.cc/26W8-VWQ6].

38. RHlhub, *supra* note 30; Sarah Wurzburg, *Three Things to Know About Implementing Telehealth in Correctional Facilities*, COUNCIL OF STATE GOV'TS (Apr. 12, 2021),

Institutional hesitancy, inadequate infrastructure, and restrictive security protocols further limit its effectiveness.³⁹ Additionally, the success of virtual consultations depends on the willingness of both medical providers and incarcerated individuals to engage with telehealth systems.⁴⁰ While telehealth is not a complete replacement for in-person care, optimizing its use—through improved training, standardized procedures, and stronger institutional support—could help bridge critical gaps in correctional health care and ensure more equitable access to medical treatment.

b. Electronic Health Records (EHR)

The evolution of medical records in correctional health care reflects broader technological advancements in health care technology and standards. Historically, prisons relied on paper-based records, with physical files stored in cabinets and lab results manually attached to patient charts.⁴¹ However, the shift to EHRs has revolutionized correctional health care by improving accessibility, efficiency, and continuity of care.⁴² The NCCHC has supported this transition by updating its standards to emphasize the use of EHRs, ensuring compliance with privacy, security, and confidentiality regulations.⁴³ EHRs offer several advantages in correctional settings, including improved care coordination, reduced redundant testing, and better documentation.⁴⁴ While patient portals are widely available in free-world health care systems, incarcerated individuals often lack access to their own medical records, creating barriers to continuity of care upon release.⁴⁵

Despite these benefits, several challenges hinder the full implementation of EHRs in correctional facilities. A case study of the New York City jail system illustrates both the advantages and difficulties of adopting EHRs.⁴⁶ One major challenge is correctional institutions' reluctance to invest in health information infrastructure, largely due to concerns over legal liability, security risks, and financial constraints.⁴⁷ Furthermore, interoperability issues, specifically the ability of jail-based EHRs to integrate with external health care systems, remain

<https://csgjusticecenter.org/2021/04/12/three-things-to-know-about-implementing-telehealth-in-correctional-facilities/> [https://perma.cc/H36Y-C8JU].

39. Tian et al., *supra* note 31 (finding that implementation of prison telehealth is constrained by security restrictions, resource limitations, and local contextual barriers).

40. Wurzburg, *supra* note 38.

41. Pauline Marcussen, *A Brief History of Medical Records in Corrections*, NAT'L COMM'N ON CORR. HEALTH CARE (Sep. 15, 2023), <https://www.ncchc.org/a-brief-history-of-medical-records-in-corrections/> [https://perma.cc/U8LY-PFDR].

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.*

46. Michelle Martelle et al., *Meaningful Use of an Electronic Health Record in the New York City Jail System*, 105 AM. J. PUB. HEALTH 1752, 1752–54 (2015).

47. *Id.*

a significant barrier because they impede seamless tracking. Studies highlight that the lack of data sharing between jail and community health systems contributes to poor continuity of care, increased risk of recidivism, and preventable adverse health outcomes among formerly incarcerated individuals.⁴⁸

To fully leverage the benefits of EHRs in correctional health care, institutions must address security concerns, improve health information exchange, and ensure that incarcerated individuals have better access to their medical records upon release. Interoperability improvements between jail health systems and community providers have been shown to enhance reentry outcomes, reduce hospitalizations, and facilitate better care coordination.⁴⁹ Balancing security protocols with the need for effective, continuous health care is crucial to enhancing the quality of correctional health care.

3. The Consequences of Inadequate Prison Health Care

The failures of prison health care extend beyond incarceration and affect individuals post-release as well.⁵⁰ Studies indicate that incarceration significantly exacerbates health risks.⁵¹ For instance, cancer mortality rates are higher among incarcerated individuals compared to the general population, and formerly incarcerated individuals face an elevated risk of hospitalization and death from heart disease.⁵² Most critically, within the first two weeks of release, the risk of death is more than twelve times higher than that of non-incarcerated individuals.⁵³ These alarming health disparities highlight the longstanding deficiencies in correctional health care. To fully understand the challenges facing incarcerated individuals today, it is essential to examine the historical evolution of prison health care and the policies that have shaped its development.

B. Historical Evolution of Correctional Health Care Standards

Eighth Amendment prison litigation was largely absent before the 1960s

48. Geoffrey Glowallaa & Vignesh Subbianb, *Data Sharing between Jail and Community Health Systems: Missing Links and Lessons for Re-entry Success*, 290 MEDINFO 47, 47 (2021).

49. *Id.*

50. Leah Wang, *Chronic Punishment: The unmet health needs of people in state prisons*, PRISON POL'Y INITIATIVE (June 2022), <https://www.prisonpolicy.org/reports/chronicpunishment.html#insurance> [<https://perma.cc/V2DA-WNXE>].

51. *See infra* notes 52–53.

52. Wang, *supra* note 50; Christopher R. Manz, Varshini S Odayar & Deborah Schrag, *Disparities in cancer prevalence, incidence, and mortality for incarcerated and formerly incarcerated patients: A scoping review*, 10 CANCER MED. 7277 (2021); Emily Wang et al., *Cardiovascular Disease in Incarcerated Populations*, 69 J AM. COLL. CARDIOLOGY 2968, 2970 (2017).

53. Wang, *supra* note 50; Ingrid A. Binswanger et al., *Release from Prison — A High Risk of Death for Former Inmates*, 356 N ENG. J. MED. 157, 161 (2007).

due to several key legal barriers.⁵⁴ Prior to *Robinson v. California*, the Eighth Amendment did not apply to the states, meaning state prisoners could not challenge their conditions under federal constitutional law.⁵⁵ Additionally, *Monroe v. Pape* expanded the scope of 42 U.S.C. § 1983, allowing individuals to sue state officials for constitutional violations.⁵⁶ Lastly, *Cooper v. Pate* marked a shift in federal court involvement, permitting prisoners to bring constitutional claims against state prison officials, whereas earlier federal courts had generally deferred to state prison management.⁵⁷ These rulings dismantled the legal barriers that prevented prisoners from pursuing Eighth Amendment claims, setting the stage for a wave of prison litigation in subsequent decades.⁵⁸ However, the systematic deficiencies remained, especially with the Social Security Act (“SSA”) Amendments of 1965, which created Medicare and Medicaid but explicitly prohibited these federal programs from subsidizing health care in jails and prisons.⁵⁹ This omission was significant because it exempted correctional health care systems from quality oversight mandates.⁶⁰ Early anecdotal and scientific evidence studies found that incarcerated individuals often entered correctional facilities in poor health and that prisons lacked adequate health care to address their medical needs.⁶¹ As research on correctional health care began emerging around 1970, many early reports were often based on anecdotal evidence rather than experimental data.⁶² Moreover, the few studies that attempted to field-test issues in prison health care delivery were plagued by methodological flaws.⁶³ Despite these shortcomings, these studies consistently highlighted key findings: incarcerated individuals suffered from higher rates of chronic illnesses, substance use disorders, and mental health conditions compared to the general population.⁶⁴ Additionally, many facilities lacked even basic medical services, and the conditions within prisons and jails often exacerbated existing health problems. Although imperfect, these early studies were instrumental in exposing systemic deficiencies and shaping future discussions on prison health care reform.⁶⁵

54. *Eighth Amendment Prison Litigation*, FED. JUST. CTR., <https://www.fjc.gov/history/spotlight-judicial-history/eighth-amendment-prison-litigation> [https://perma.cc/GUP7-3ASW] (last visited Mar. 16, 2026) [hereinafter FJC].

55. *Robison v. California*, 370 U.S. 660 (1962); see FJC, *supra* note 54.

56. *Monroe v. Pape*, 365 U.S. 167, 167 (1961); see FJC, *supra* note 54.

57. *Cooper v. Pate*, 378 U.S. 546, 546 (1964); see FJC, *supra* note 54.

58. FJC, *supra* note 54.

59. James René Jolin et al., *Correctional Healthcare — an Engine of Health Inequity*, 38 J. GEN. INTERN. MED. 216, 216–18 (2022).

60. *Id.*

61. B. JAYE ANNO, NAT’L INST. OF CORR., CORRECTIONAL HEALTH CARE: GUIDELINES FOR THE MANAGEMENT OF AN ADEQUATE DELIVERY SYSTEM 10–11 (2001), <https://s3.amazonaws.com/static.nicic.gov/Library/017521.pdf> [https://perma.cc/SBW6-QC6D].

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

In the early 1970s, prominent organizations such as the American Public Health Association (“APHA”), the American Bar Association (“ABA”), and the American Medical Association (“AMA”) began advocating for improved prison health care standards.⁶⁶ Recognizing the growing urgency of these issues, the American Civil Liberties Union (“ACLU”) launched its National Prison Project in 1972 to address systemic deficiencies in correctional health care.⁶⁷ Two years later, the Commission on Accreditation for Corrections (“CAC”), the official accrediting body of the American Correctional Association (“ACA”), was established to promote accountability and quality in correctional facilities.⁶⁸ The CAC brought together a diverse group of professionals across various fields, including adult and juvenile corrections, probation, parole, and correctional health services.⁶⁹

After the Supreme Court’s decision in *Estelle v. Gamble*, efforts to reform correctional health care gained traction.⁷⁰ In 1977, the AMA held its first National Conference on Improved Medical Care and Health Services, now known as the National Conference on Correctional Health Care.⁷¹ This event set the stage for the publication of the AMA’s first set of health standards for prisons and juvenile confinement institutions in 1979.⁷² By 1983, the National Commission on Correctional Health Care (“NCCHC”) was established to develop standards and accreditation policies, further solidifying the foundation for improved correctional health care.⁷³ Later, in 1989, the Journal of Correctional Health Care was introduced, providing a peer-reviewed platform to advance research and best practices in this field.⁷⁴

C. Constitutional and Legislative Foundations of Prison Health Care

1. The Constitutional Basis for Prison Health Care

The Eighth Amendment of the U.S. Constitution prohibits cruel and unusual punishment, a principle that extends to the medical care of incarcerated

66. Susan Reverby, *Can There Be Acceptable Prison Health Care? Looking Back on the 1970s*, 134 PUB. HEALTH REP. 89, 90 (2019).

67. *American Civil Liberties Union (National Prison Project)*, BARBARA MCDOWELL SOC. JUST. CTR. (2011), <https://www.mcdowellsocialjusticecenter.org/grantees/american-civil-liberties-union> [<https://perma.cc/RCX8-NK5N>].

68. *Commission on Accreditation for Corrections*, AM. CORR. ASS’N, <https://www.aca.org/certifications-and-accreditation/commission-on-accreditation> [<https://perma.cc/2835-XF6D>] (last visited Mar. 16, 2026) [hereinafter CAC].

69. *Id.*

70. William J. Rold, *Thirty Years After Estelle v. Gamble: A Legal Retrospective*, 14 J. CORR. HEALTH CARE 11, 17–18 (2008).

71. NCCHC Time Line, *supra* note 28.

72. *Id.*

73. *Id.*; *About us*, NAT’L COMM’N ON CORR. HEALTH CARE, <https://ncchc.org/about-us/> [<https://perma.cc/UZK7-DJK6>] (last visited May 28, 2026).

74. Reverby, *supra* note 66.

individuals.⁷⁵ The Supreme Court first addressed this issue *Estelle v. Gamble*, a landmark case that set the constitutional standard for prison health care.⁷⁶ In *Estelle*, the Court ruled that deliberate indifference to a prisoner's serious medical needs constitutes cruel and unusual punishment under the Eighth Amendment.⁷⁷ However, the Court distinguished between medical malpractice and constitutional violations, emphasizing that negligence alone does not meet the constitutional threshold for an Eighth Amendment violation.⁷⁸

J.W. Gamble, an inmate of the Texas Department of Corrections, filed a lawsuit under 42 U.S.C. § 1983⁷⁹ arguing that prison officials violated his constitutional rights by providing inadequate medical care following an injury sustained during prison labor.⁸⁰ While the Court acknowledged that prisoners have a constitutional right to medical care, it found that Gamble's treatment did not rise to the level of deliberate indifference because medical personnel saw him multiple times.⁸¹ Justice Thurgood Marshall, writing for the majority, reaffirmed that the Eighth Amendment embodies "broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . .," against which penal measures must be evaluated.⁸² The Court relied on this reasoning to explain why prison health care must meet evolving standards of decency.⁸³ However, the ruling carefully limited the scope of constitutional claims, making it clear that not every instance of inadequate medical treatment constitutes an Eighth Amendment violation.⁸⁴

For a claim to succeed, an inmate must prove more than an accident, medical negligence, or an inadvertent failure to provide care.⁸⁵ The Court clarified that an accident, even if it causes suffering, does not constitute cruel and unusual punishment.⁸⁶ Likewise, an unintentional failure to provide medical care, no matter how harmful, does not meet the standard of "wanton infliction of unnecessary pain."⁸⁷ Medical malpractice claims are governed by state law, rather than the Eighth Amendment.⁸⁸ Thus, a complaint about a physician's negligence in diagnosing or treating a medical condition is not a valid claim of

75. U.S. CONST. amend. VIII; Gabriel B Eber, *Using the Constitution to Improve Prisoner Health*, 99 AM. J. PUB. HEALTH 1541, 1541–42 (2009), <https://pmc.ncbi.nlm.nih.gov/articles/PMC2724445/> [<https://perma.cc/W6TP-RNLN>].

76. Rold, *supra* note 70, at 13.

77. *Estelle v. Gamble*, 429 U.S. 97, 116 (1976).

78. *Id.* at 106.

79. The Civil Rights Act of 1871; *see infra* Part II.C.2.

80. *Estelle*, 429 U.S. at 98.

81. *Id.* at 97.

82. *Id.* at 102 (citing *Jackson v. Bishop*, 404 F.2d 571 (8th Cir. 1968)).

83. *Id.* at 102 (citing *Troop v. Dulles*, 356 U.S. 86, 101 (1958)).

84. *Id.* at 105.

85. *Id.* at 105–06.

86. *Id.* at 105.

87. *Id.* at 105–06.

88. *Id.* at 97.

medical mistreatment under the Eighth Amendment.⁸⁹ This distinction underscores why proving a Constitutional violation in the context of prison health care is particularly challenging. A prisoner must demonstrate that officials were aware of a serious medical need and deliberately failed to address it.

Another significant decision that broadens the scope of Eighth Amendment prison claims is *Helling v. McKinney*.⁹⁰ The Supreme Court held that McKinney could base his Eighth Amendment claim on the potential future health risks of exposure to environmental tobacco smoke.⁹¹ This ruling was pivotal in establishing that prison officials have a constitutional duty to address not only immediate health concerns but also conditions that pose a substantial risk of serious harm over time.⁹² By recognizing the importance of preventative measures, *Helling* reinforced the principle that deliberate disregard for an inmate's long-term well-being can constitute cruel and unusual punishment under the Eighth Amendment.

2. Statutory Barriers and Prisoners' Rights Litigation

Despite the constitutional protections recognized in *Estelle*, statutory barriers continue to complicate prisoners' ability to bring Eighth Amendment claims.⁹³ One of the primary legal mechanisms for asserting such claims is 42 U.S.C. § 1983, a statute originally enacted as part of the Ku Klux Klan Act of 1871 to combat racial violence and state-sanctioned civil rights violations during Reconstruction.⁹⁴ However, for much of the 20th century, § 1983 remained largely dormant as a tool for litigation against state officials. This changed with *Monroe*, in which the Supreme Court broadly interpreted the phrase "under color of state law" to include abuses of authority by public officials, even when their actions were not explicitly authorized by state law.⁹⁵ This ruling expanded access to federal courts for plaintiffs alleging constitutional violations by state actors, including prison commissioners and wardens.⁹⁶ Yet, despite this broader interpretation, prevailing on a § 1983 claim remains challenging, as plaintiffs must demonstrate that a state official deprived them of a constitutional right and substantiate their claim with specific factual evidence rather than conclusory allegations.⁹⁷

89. *Id.* at 106.

90. *Helling v. McKinney*, 509 U.S. 25 (1993).

91. *Id.*

92. *See id.*

93. Andrea Fenster & Margo Schlanger, *Slamming the Courthouse Door: 25 years of evidence for repealing the Prison Litigation Reform Act*, PRISON POL'Y INITIATIVE (Apr. 26, 2021), https://www.prisonpolicy.org/reports/PLRA_25.html [<https://perma.cc/9TKT-VM9H>].

94. FJC, *supra* note 54.

95. *Monroe v. Pape*, 365 U.S. 167 (1961).

96. *Id.*

97. *Jolly v. Klein*, 923 F. Supp. 931, 943 (S.D. Tex. 1996).

Congress first authorized federal oversight of prison conditions through the Civil Rights of Institutionalized Persons Act (“CRIPA”), which allows the Attorney General to bring civil actions against state institutions exhibiting a pattern or practice of egregious constitutional violations.⁹⁸ However, individual prisoners do not have a private right of action under CRIPA; instead, they must rely on 42 U.S.C. § 1983 for personal claims.⁹⁹ In 1996, Congress imposed significant restrictions on prisoner lawsuits by enacting the Prison Litigation Reform Act (“PLRA”), fundamentally altering how incarcerated individuals can bring constitutional claims.¹⁰⁰ The PLRA governs civil actions filed by incarcerated individuals regarding prison conditions. The Act imposes several procedural “constraints designed to prevent sportive filings in federal court.”¹⁰¹

Courts are required to conduct an early screening of prisoner complaints, dismissing those deemed “frivolous, malicious, or [that] fail to state a claim upon which relief may be granted.”¹⁰² Additionally, prisoners must fully exhaust all available administrative remedies before filing a federal lawsuit.¹⁰³ Even when grievances are ignored or delayed by prison officials, prisoners may still be required to navigate the full appeals process before their claims are considered properly exhausted.¹⁰⁴ Further, the statute imposes a physical injury requirement, barring claims for mental or emotional harm unless the prisoner can demonstrate a prior showing of physical injury or the commission of a sexual act—a restriction that significantly limits recovery for claims involving psychological trauma.¹⁰⁵

Another problematic provision of the PLRA relates to attorney’s fees.¹⁰⁶ The statute caps attorney compensation at 150% of the monetary judgment awarded, which can result in drastically low fees even in cases where a prisoner prevails on a meritorious constitutional claim.¹⁰⁷ This provision creates a disincentive for attorneys to take on prisoner rights cases, effectively reducing access to legal representation for incarcerated individuals wishing to challenge

98. *Amdt8.4.7 Conditions of Confinement*, CONST. ANNOTATED, https://constitution.congress.gov/browse/essay/amdt8-4-7/ALDE_00000966/ [<https://perma.cc/ZH7Y-A57L>] (last visited Mar. 9, 2025) [hereinafter *Constitution Annotated*]; 42 U.S.C. § 1997 et seq.

99. 42 U.S.C. § 1997e(a).

100. *Constitution Annotated*, *supra* note 98; 42 U.S.C. § 1997e.

101. *Skinner v. Switzer* 562 U.S. 521, 535 (2011); 42 U.S.C. § 1997e.

102. 28 U.S.C. § 1915A.

103. 42 U.S.C. § 1997e(a).

104. COLUMBIA HUM. RIGHTS L. REV., A JAILHOUSE LAWYER’S MANUAL ch. 14 (13th ed. 2024), <https://jlm.law.columbia.edu/a-jailhouse-lawyers-manual-13th-edition/> [<https://perma.cc/UEF3-EMSY>].

105. *See* 42 U.S.C. § 1997e(e); Haleigh Hoskins, *Access Denied: Amending the Prison Litigation Reform Act’s Administrative Remedy and Physical Injury Provisions for Cases of Sexual Assault*, CONG. BLACK CAUCUS FOUND., <https://www.cbccfinc.org/capstones/criminal-justice-reform/access-denied-amending-the-prison-litigation-reform-acts-administrative-remedy-and-physical-injury-provisions-for-cases-of-sexual-assault/> [<https://perma.cc/N5UA-GEZ6>] (last visited Mar. 16, 2026).

106. *See* Fenster & Schlanger, *supra* note 93; 42 U.S.C. § 1997e(d).

107. Fenster & Schlanger, *supra* note 93.

unconstitutional conditions.¹⁰⁸ In 2020, incarcerated civil rights plaintiffs were represented by counsel in only 7.6% of their cases, compared to 89.8% of civil cases not involving incarceration.¹⁰⁹

D. Indiana's Constitutional and Statutory Standards

While the Eighth Amendment and federal statutes like 42 U.S.C. § 1983 and the PLRA establish the constitutional and procedural framework for prison health care claims, state law plays a crucial role in defining correctional health care standards. In Indiana, these standards are shaped by both the state constitution and statutory regulations, which dictate how health care policies are implemented within correctional facilities.

Similar to the Eighth Amendment, Article I, § 16 of the Indiana Constitution states that “cruel and unusual punishments shall not be inflicted.”¹¹⁰ Indiana further refines its approach through Indiana Code § 11-12-4-1, which sets minimum requirements for prison health care, facility security, and public safety.¹¹¹ This statute emphasizes flexibility, allowing regulations to accommodate local needs while maintaining consistency with statewide correctional health care policies.¹¹² The Indiana Department of Health and the Fire Prevention and Building Safety Commission oversee the development and enforcement of these standards.¹¹³

In addition to statutory law, the Indiana Administrative Code (“IAC”) provides further specificity. Section 210 IAC 3-1-11 outlines health care standards for the Indiana Department of Correction (“IDOC”), while 210 IAC 7 governs offender health co-payment policies.¹¹⁴ These regulations help structure health care delivery within Indiana prisons, but modernizing procedures and integrating new technologies, such as electronic medical records or telehealth services, could further enhance compliance and improve health care outcomes for incarcerated individuals.

The case of *Stafford v. Carter* exemplifies the challenges of aligning correctional health care practices with both federal constitutional standards and Indiana’s statutory and regulatory framework.¹¹⁵ In this case, incarcerated individuals with chronic Hepatitis C Virus (“HCV”) alleged that IDOC and its

108. *Id.*

109. *Id.* (noting that all data were collected by Professor Margo Schlanger; prison and jail population data were obtained from the Bureau of Justice Statistics; court filing and outcome data were derived from the Federal Judicial Center’s Integrated Database; and court order coverage data were based on Bureau of Justice Statistics prison and jail censuses conducted periodically since 1983).

110. IND. CONST. art. 1, § 16.

111. IND. CODE § 11-12-4-1(a)(3) (2025).

112. IND. CODE § 11-12-4-1(b).

113. *Id.*

114. 210 IND. ADMIN. CODE 3-1-11 (2025); 210 IND. ADMIN. CODE 7 (2025).

115. See *Stafford v. Carter*, No. 1:17-cv-00289-JMS-MJD, 2018 WL 361639 (S.D. Ind. Sep. 13, 2018).

contracted medical providers systematically denied them access to life-saving direct-acting antiviral (“DAA”) drugs, violating their Eighth Amendment rights and state constitutional protections against cruel and unusual punishment.¹¹⁶ The court certified a class of all current and future IDOC inmates diagnosed with chronic HCV, allowing the plaintiffs to challenge IDOC’s policies on a systemic level.¹¹⁷ This case underscores the importance of ensuring that Indiana’s correctional health care policies not only meet minimum statutory requirements but also adhere to evolving medical standards and constitutional protections.

By aligning correctional health care practices with both Indiana statutes and administrative regulations, Indiana could strengthen its system while maintaining consistency with evolving legal and medical standards. Cases like *Stafford v. Carter* highlight the need for ongoing oversight and reform to ensure that incarcerated individuals receive adequate and timely medical care.

III. STRUCTURAL FAILURES AND REFORM IN CORRECTIONAL HEALTH CARE

A. Systemic Health Challenges in Correctional Settings

1. COVID-19

The COVID-19 pandemic exposed major weaknesses in prison health care by demonstrating the disproportionate impact of infectious diseases on incarcerated individuals, highlighting systemic vulnerabilities in correctional health care.¹¹⁸ Between April 2020 and April 2021, the mortality rate inside American jails was nearly 2.5 times the broader population.¹¹⁹ However, inconsistent reporting and data collection make it difficult to assess the full extent of the crisis.¹²⁰ These disparities reflect a broader lack of oversight and accountability in correctional health care, further perpetuating these inequalities.¹²¹ The pandemic also exacerbated resource shortages in correctional facilities, many of which were unable to handle the sharp surge in critically ill patients, leading to delays or denials of medical treatment.¹²² Chronic disease management suffered, with reports indicating that more than 50% of surveyed countries experienced disruptions in essential health care services, including

116. *Id.* at *1.

117. *Id.*

118. *COVID-19 in Prisons and Jails*, PRISON POL’Y INITIATIVE (July 2024), <https://www.prisonpolicy.org/virus/> [<https://perma.cc/VK6T-36Q4>].

119. Jolin et al., *supra* note 59, at 216 (citing Marquez N, Ward et al., *COVID-19 Incidence and Mortality in Federal and State Prisons Compared with the US Population*, 326 JAMA 1865, 1865–1867 (2021)).

120. *Id.*

121. *Id.*

122. Abdul Rahman Jazieh, *COVID-19 Pandemic as a Catalyst for Healthcare Transformation: Finding the Silver Lining in a Global Catastrophe*, 3 GLOB. J. ON QUALITY & SAFETY IN HEALTHCARE 117, 117 (2020).

treatments for hypertension, diabetes, and/or cardiovascular conditions.¹²³ While the pandemic devastated correctional health care systems, it also prompted calls for reform, highlighting the urgent need for preventive health care models, improved infection control, and better integration of prison health services with broader public health frameworks.¹²⁴

2. Social Determinants of Health (SDOH) and Incarceration

Incarceration is deeply connected to broader public health and social inequities. The health challenges begin before imprisonment and persist after release.¹²⁵ Preexisting health disparities, combined with the stressors and environmental conditions of incarceration, contribute to poorer health outcomes among incarcerated populations.¹²⁶ Additionally, the social and economic consequences of incarceration—such as employment barriers, housing instability, and lack of post-release medical care—create long-term public health concerns that extend beyond prison walls.¹²⁷ The Social Determinants of Health (“SDOH”) framework helps explain how socioeconomic instability, limited health care access, and marginalized backgrounds contribute to the health disparities seen in incarcerated populations.¹²⁸ By viewing incarceration itself as a social determinant of health, policymakers and health care providers can better understand the structural changes needed to improve health outcomes in correctional settings.

According to the World Health Organization (“WHO”), social determinants of health are the non-medical factors that influence health outcomes.¹²⁹ These factors include “the conditions in which people are born, grow, live, work, and age.”¹³⁰ The five key areas of SDOH are health care access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environment.¹³¹

Incarceration itself has been considered a social determinant of health, as it

123. *Id.*

124. See generally *id.*; Newton E. Kendig et al., *Infection Prevention and Control in Correctional Setting*, 30 EMERGING INFECTIOUS DISEASES S88, S88, S91 (2024).

125. Louise Reagan et al., *Health equity for people living in correctional facilities: Addressing bias, stigma, and dehumanization*, 47 RSCH. NURS. & HEALTH 359, 359 (2024).

126. *Id.* at 359–60.

127. ROBERT WOODS FOUND., MASS INCARCERATION THREATENS HEALTH EQUITY IN AMERICA 3 (2019), <https://www.rwjf.org/en/insights/our-research/2019/01/mass-incarceration-threatens-health-equity-in-america.html> [<https://perma.cc/FX8Y-6Y93>]; Dora M. Dumont et al., *Public Health and the Epidemic of Incarceration*, 33 ANNU. REV. PUB. HEALTH 325, 331–34 (2012).

128. Shivani Nishar et al., “It’s a revolving door”: understanding the social determinants of mental health as experienced by formerly incarcerated people, 11 HEALTH JUST. 1, 1, 3–5 (2023).

129. *Social Determinants of Health (SDOH)*, U.S. CTRS. FOR DISEASE CTRL. & PREVENTION (Jan. 17, 2024), <https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html> [<https://perma.cc/B2GG-7JQD>].

130. *Id.*

131. *Id.*

disrupts nearly every aspect of an individual's social and economic stability.¹³² Incarcerated individuals disproportionately come from marginalized communities with existing social and structural inequities, which incarceration often exacerbates.¹³³ Limited resources and the isolating nature of prison life can lead to deteriorated health over time.¹³⁴ Moreover, the stigma of incarceration reinforces these structural inequities during reentry, creating additional barriers to employment, housing stability, and post-release health care.¹³⁵ Addressing incarceration as a social determinant of health requires systemic reforms that extend beyond the prison walls. Adopting holistic, cross-sector public health approaches to criminal justice policy, improving access to health care, and addressing the structural inequities that lead to incarceration are essential to mitigating their long-term impact on individual and community health.¹³⁶

3. *Consequences of Underfunded Medical Services*

Correctional health care has long been viewed as a paradox—facilities are expected to provide meaningful medical services, yet the very nature of incarceration often undermines health.¹³⁷ As one scholar explains, “Understanding the connection between prisons and health requires us to hold both of these ideas at the same time: prisons can undermine health and provide meaningful health care services, and they operate in an environment that insists on both.”¹³⁸

Structural deficiencies in prison health care systems increase this tension, leading to long waits for care, missed appointments, and inadequate treatment.¹³⁹ In some facilities, chronic understaffing and the absence of consistent administrative leadership further strain medical services, with reports of nurses working extended shifts and insufficient personnel to ensure continuity of care.¹⁴⁰ This systemic neglect fundamentally contrasts the rehabilitative mission of

132. Lauren Brinkley-Rubinstein & David H. Cloud, *Mass Incarceration as a Social-Structural Driver of Health Inequities: A Supplement to AJPH*, 110 AM. J. PUB. HEALTH S14, S14-15 (2020).

133. *Id.*

134. Lauren Brinkley-Rubinstein, *Incarceration as a catalyst for worsening health*, 1 HEALTH JUST. 1, 5, 7–8 (2013).

135. Brinkley-Rubinstein & Cloud, *supra* note 132.

136. STEVE OLSON & KAREN M. ANDERSON, THE EFFECTS OF INCARCERATION AND REENTRY ON COMMUNITY HEALTH AND WELL-BEING: PROCEEDINGS OF A WORKSHOP ch. 3 (2020), <https://www.nationalacademies.org/read/25471/chapter/4> [<https://perma.cc/MZW3-597Y>].

137. Jason Schnittker, Michael Massoglia & Christopher Uggen, *The ‘Paradox’ of Receiving Health Care in Prison*, UNIV. OF PENN. (Jan. 6, 2023), <https://penntoday.upenn.edu/news/Penn-sociologist-Jason-Schnittker-paradox-receiving-health-care-prison> [<https://perma.cc/XUZ8-59XR>].

138. *Id.*

139. McCann, *supra* note 22.

140. *Overworked and Understaffed Nurses at JCCC: A Resident’s Point of View*, MO. PRISON REFORM (June 12, 2024), <https://moprisisonreform.org/overworked-and-understaffed-nurses-at-jccc-a-residents-point-of-view/> [<https://perma.cc/KM8J-2YY8>].

correctional institutions. Prisons are intended to prepare individuals for reintegration in society, yet conditions behind bars frequently contribute to chronic illness, worsen mental health, and are associated with reduced life expectancy.¹⁴¹ This poses a broader public health challenge, as individuals returning to their communities often do so in worse health, increasing burdens on social services and health care systems.

Research indicates that continuity of health care during and after incarceration plays an important role in recidivism reduction.¹⁴² When treatment initiated in prison is continued after release—through mechanisms such as Medicaid enrollment, medication continuity, and provider linkages—the public health and recidivism-reduction benefits of correctional health programs are preserved.¹⁴³ Conversely, when care is disrupted at the point of reentry, those benefits may be undermined, increasing instability and adverse outcomes that complicate reintegration.¹⁴⁴

Addressing these issues requires systemic reforms that prioritize health and wellness within correctional facilities. Administrative solutions, such as improved funding allocation, accreditation standards, and expanded health care services, could help extend life expectancy among incarcerated individuals while ensuring they reenter society in better health, ready to contribute as productive members of their communities.

B. Legal and Policy Barriers to Effective Health Care

1. Administrative Law's Role in Shaping Prison Health Care Standards

Administrative law serves as the backbone for establishing and regulating health care standards in correctional facilities by defining rules that provide systemic guidelines supplementing constitutional protections.¹⁴⁵ Unlike the reactive nature of Eighth Amendment claims, administrative regulations proactively address the delivery and quality of care, emphasizing consistency and efficiency across correctional systems.¹⁴⁶ Sub-regulatory policies, such as agency manuals, guidance documents, and policy statements, further shape these standards by interpreting and implementing broader regulatory mandates

141. Nazish Dholakia, *Mass Incarceration Is a Public Health Crisis*, VERA (June 17, 2025) <https://www.vera.org/news/mass-incarceration-is-a-public-health-crisis> [<https://perma.cc/9TX4-6HZW>].

142. Matt McKillop, *After Prison Protects Investments and Progress*, PEW CHARITABLE TRS. (June 22, 2018), <https://www.pew.org/en/research-and-analysis/articles/2018/06/22/health-care-continuity-after-prison-protects-investments-and-progress> [<https://perma.cc/C98S-9X9F>].

143. *Id.*

144. *Id.*

145. See *Administrative Law*, LEGAL INFO. INST. CORNELL L. SCH., https://www.law.cornell.edu/wex/administrative_law [<https://perma.cc/NA3T-K766>] (last visited Mar. 16, 2026).

146. Rold, *supra* note 70, at 18 (noting that the prospect of litigation prompted corrections officials to develop professional standards proactively, rather than waiting to be sued).

without undergoing the full rulemaking process.¹⁴⁷ Accreditation standards and policy guidance often function to standardize procedures and clarify expectations, even where they are not legally binding.¹⁴⁸ Their flexibility enables agencies to adapt to evolving challenges while maintaining oversight that aligns with constitutional and statutory requirements.

Under the doctrine of *Chevron* deference, courts historically deferred to an agency's reasonable interpretation of ambiguous statutes, recognizing that agencies possess subject-matter expertise in their respective fields.¹⁴⁹ This principle allowed agencies, including those overseeing correctional health care, to establish and implement standards without excessive judicial interference. However, the recent limitation of *Chevron* deference raises questions about the extent of discretion prison medical providers and regulatory agencies now have in setting health care standards.¹⁵⁰ Without *Chevron*, courts are more likely to scrutinize agency decisions, requiring a clearer statutory basis for administrative rules. This shift increases the burden on agencies to ensure that correctional health care policies are explicitly authorized by legislation, making them more vulnerable to legal challenges if they lack clear congressional backing. For example, Indiana Administrative Code § 210-3-1-11 outlines specific health care standards for the Department of Correction, ensuring that medical services provided to incarcerated individuals align with state-mandated requirements.¹⁵¹ The Indiana Department of Correction's Health Service Policy, outlined in Policy 01-02-101, establishes additional guidelines to safeguard the mental and physical health of incarcerated individuals.¹⁵² These policies emphasize that care must be tailored to address serious medical conditions, prioritizing medically necessary treatment to prevent loss of life, disability, or significant pain.¹⁵³ The policy further mandates the use of clinical judgment by licensed medical professionals, with the Chief Medical Officer holding ultimate clinical authority.¹⁵⁴ By setting clear standards within Indiana's regulatory framework, these policies reinforce the state's responsibility to provide constitutionally

147. Hannah L. Cross & Lester J. Perling, *The Return of Subregulatory Guidance Reliance*, NELSON MULLINS (Sep. 7, 2021), https://www.nelsonmullins.com/insights/blogs/healthcare_essentials/regulatory_compliance/the-return-of-subregulatory-guidance-reliance [https://perma.cc/53ZB-LK5R].

148. *Policies and Procedures*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://ncchc.org/q-a/policies-and-procedures/> [https://perma.cc/H7RR-2GAK] (last visited May 28, 2026).

149. *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 865 (1984); Michael R. Blumenthal et al., *The End of Chevron Deference: What Does It Mean, and What Comes Next?*, AM. BAR ASS'N. (Aug. 16, 2024), https://www.americanbar.org/groups/business_law/resources/business-law-today/2024-august/end-chevron-deference-what-does-it-mean-what-comes-next/ [https://perma.cc/BDV5-QX82].

150. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024).

151. *See* 210 IND. ADMIN. CODE 3-1-11 (2025).

152. *See* IND. DEP'T OF CORR., POL'Y & ADMIN. PROC. MANUAL OF POL'YS & PROCS., 01-02-101 (Apr. 1, 2022), <https://www.in.gov/idoc/files/01-02-101-Health-Services-4-1-2022.pdf> [https://perma.cc/ALL2-J7QG] [hereinafter Indiana Health Services Policy].

153. *Id.*

154. *Id.*

adequate health care while maintaining state-level administrative oversight.¹⁵⁵ Administrative regulations in correctional health care also interface with accreditation standards set by organizations like the NCCHC, further emphasizing the collaborative role of administrative frameworks in raising the quality of inmate health care.¹⁵⁶ Moving forward, administrative solutions must carefully balance flexibility, cost-efficiency, and accountability to ensure that regulations are both effective and legally defensible in a post-*Chevron* landscape.

However, administrative policies are only as effective as the resources available to implement them. Recent federal decisions, such as the hiring freeze imposed by the Trump administration, have exacerbated chronic staffing shortages within the Bureau of Prisons, leading to severe gaps in medical care.¹⁵⁷ At FMC Devens, a federal medical center, 24% of Health Services positions remain vacant, and 39% of Psychology Services roles are unfilled.¹⁵⁸ Such shortages limit access to necessary medical treatment, undermining the very administrative safeguards designed to ensure adequate health care. These deficiencies highlight the fragile balance between administrative oversight and resource allocation, raising concerns about the sustainability of correctional health care policies in the face of bureaucratic and political shifts.

2. Privatization's Negative Impact on Correctional Health Care

The privatization of correctional health care has raised serious concerns about quality, accountability, and financial incentives. Many state and local governments contract private companies to provide medical services in prisons and jails, often prioritizing cost-saving measures over patient care. This model has led to issues such as understaffing, inadequate medical treatment, and avoidable deaths. Additionally, private health care providers often operate with limited oversight, and indemnification clauses shield government entities from legal liability, reducing incentives for meaningful reform.

a. Challenges in privatized health care

Incarcerated individuals have no say in who provides their medical care, as

155. *Id.*

156. See *Standards: A framework for quality*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://ncchc.org/standards/> [<https://perma.cc/H6GW-9RA4>] (last visited Mar. 16, 2026).

157. Walter Pavlo, *Sweeping Changes for the Bureau of Prisons Under the Trump Administration*, PRISONOLOGY (Jan. 23, 2025), <https://www.prisonology.com/blog/sweeping-changes-for-the-bureau-of-prisons-under-the-trump-administration> [<https://perma.cc/Rf8D-FKSV>].

158. *Id.* (citing Press Release, U.S. Dep't of Just. Off. of the Inspector Gen., DOJ OIG Releases an Inspection of the BOP's Federal Medical Center Devens (Dec. 11, 2024), <https://oig.justice.gov/news/doj-oig-releases-inspection-bops-federal-medical-center-devens> [<https://perma.cc/RXB3-WF7A>]).

health care services are determined entirely by contracts between private companies and state or local governments.¹⁵⁹ These contracting decisions are often driven by budgetary considerations rather than care quality, and because contracts frequently shield government entities from legal liability, officials have little incentive to address patient or worker complaints when renewing them.¹⁶⁰

In 2015, only seventeen states had self-operated correctional health care systems, and thirty-two states contracted at least a portion of their health services to an outside vendor.¹⁶¹ Correctional health care in the U.S. is a multibillion-dollar industry dominated by a handful of large companies, including private equity-owned Wellpath and YesCare (f/k/a Corizon Health).¹⁶² The dominance of private equity-owned firms in the market significantly limits the options available to local governments when selecting providers for correctional health care services.¹⁶³ Private equity's dominance in prison and jail health care services can be traced back to the industry's shift toward privatization in the 1970s.¹⁶⁴ By 2009, approximately 40% of correctional health care, amounting to \$3 billion annually, was managed by private companies.¹⁶⁵ One of the main reasons that prisons and jails turn to private health care providers is to limit legal liability.¹⁶⁶ This structure is often implemented through indemnification provisions that make the health care company responsible for costs, expenses, and liabilities associated with correctional health care, requiring it to compensate care-related costs and liabilities incurred by its government-entity client.¹⁶⁷ While state administrative regulations set standards for correctional health care, private contractors may not always be subject to the same requirements, particularly if contracts lack enforcement mechanisms or oversight provisions.¹⁶⁸ This regulatory gap allows private providers to operate with varying levels of accountability. In Kansas and Missouri alone, Corizon held nearly \$2 billion in contracts, yet Missouri's contract contained no performance penalties or bonuses, and the state collected

159. Michael Fenne, *Privatized prison healthcare seeks profit at patients' expense*, PRIV. EQUITY STAKEHOLDER PROJECT (Oct. 17, 2023), <https://pestakeholder.org/news/privatized-prison-healthcare-seeks-profit-at-patients-expense/> [https://perma.cc/QJ7P-9NY5].

160. *Id.*

161. PEW CHARITABLE TRS., STATE PRISONS AND THE DELIVERY OF HOSPITAL CARE: HOW STATES SET UP AND FINANCE OFF-SITE CARE FOR INCARCERATED INDIVIDUALS 4 (July 2018), https://www.pewtrusts.org/-/media/assets/2018/07/prisons-and-hospital-care_report.pdf [https://perma.cc/D4UE-RJGV].

162. Fenne, *supra* note 159.

163. *Id.*

164. Reverby, *supra* note 66.

165. Fenne, *supra* note 159.

166. *Id.*

167. Fenne, *supra* note 159.

168. Jolin et al., *supra* note 59; Jason Szep et al., *Dying Inside The Hidden Crisis in America's Jails Part Two*, REUTERS (Oct. 26, 2020), <https://www.reuters.com/investigates/special-report/usa-jails-privatization/> [https://perma.cc/8WTB-DMT2].

no data on inmate health outcomes, leaving legislators with little ability to evaluate the contractor's performance.¹⁶⁹ Contracts with private providers often lack quantified standards for care, such as staffing requirements or protocols governing hospitalization decisions.¹⁷⁰ The structure of these arrangements has drawn criticism for allowing government officials to deflect responsibility onto private contractors, further complicating efforts to ensure consistent health care standards across facilities.¹⁷¹

b. Financial incentives and service cuts

The structure of private correctional health care contracts creates powerful financial incentives that can work against patient care. The primary objective of a private equity-owned company is profit maximization, and one of the principal mechanisms for achieving that goal is cost reduction.¹⁷² This dynamic is particularly evident in correctional health care, where most contracting states rely on capitated payment models that provide fixed per-person rates regardless of the volume or intensity of care delivered.¹⁷³ Under a capitated structure, vendors receive a fixed payment per individual and bear financial risk when costs exceed that amount; when spending falls below the rate, contractors retain the difference.¹⁷⁴ This model places a premium on economizing and requires states to be vigilant in oversight to ensure that savings are not the product of poor or inadequate care.¹⁷⁵

One documented consequence of cost-driven management is understaffing. A CNN investigation found that amid a corporate focus on growth and cost containment, Correct Care Solutions, which now operates as Wellpath, repeatedly relied on undertrained workers, provided minimal training, and left facilities short-staffed across dozens of states.¹⁷⁶ A former nurse at a Washington State facility described a medical unit where patient requests went unanswered and medication errors occurred due to chronic understaffing; these were conditions she attributed directly to the company's cost-cutting culture.¹⁷⁷ The investigation concluded that these failures contributed to substandard care and

169. Andy Marso, *What is \$2 billion buying Kansas and Missouri in prison health care? Few people know*, THE STAR (Jan. 21, 2018), <https://www.kansascity.com/news/politics-government/article195673934.html> [<https://perma.cc/QV47-D7PA>].

170. Szep et al., *supra* note 168.

171. *Id.*; Marso, *supra* note 169.

172. Fenne, *supra* note 159.

173. PEW CHARITABLE TRS., PRISON HEALTH CARE: COSTS AND QUALITY 12 (Oct. 2017), https://www.pewtrusts.org/~media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf [<https://perma.cc/DK2F-R38C>].

174. *Id.* at 12–13.

175. *Id.* at 13.

176. Blake Ellis & Melanie Hicken, *CNN Investigates: 'Help me before it's too late'*, CNN (June 25, 2019), <https://www.cnn.com/interactive/2019/06/us/jail-health-care-ccs-invs/> [<https://perma.cc/8YFL-UF6B>].

177. *Id.*

preventable deaths.¹⁷⁸

Private contractors have also reduced costs by assigning workers to perform tasks beyond the scope of their training and licensure.¹⁷⁹ In 2015, Corizon Health entered into a settlement following the death of an inmate under its care, agreeing to stop using licensed vocational nurses to perform the work of registered nurses.¹⁸⁰ Attorneys in the case estimated that for every licensed vocational nurse deployed in a registered nurse role, Corizon saved approximately 35% in labor costs.¹⁸¹

c. Accountability and political influence

The relationship between private correctional health care companies and the public officials who award their contracts has drawn scrutiny from journalists, watchdog organizations, and federal prosecutors.¹⁸² From 2008 to 2016, Corizon Health held a contract with Alameda County, California worth more than \$264 million, which the Board of Supervisors renewed three times without a competitive bidding process, each time on the recommendation of the county sheriff.¹⁸³ During that same period, public disclosure records show that Corizon donated more than \$110,000 to the sheriff's reelection campaigns.¹⁸⁴ It was his single largest campaign donor in each year the company contributed, a pattern watchdogs argued created at minimum the appearance of a conflict of interest.¹⁸⁵ Wellpath has similarly made political contributions to sheriff campaigns across multiple states, including Louisiana, Texas, Georgia, and others, through its political action committee.¹⁸⁶ The most egregious example of this dynamic resulted in a federal criminal conviction. In February 2022, Gerard Boyle, founder of Correct Care Solutions, was sentenced to three years in federal prison after pleading guilty to a twelve-year bribery scheme involving cash, gifts, travel, and campaign contributions exchanged for contract extensions and inside

178. *Id.*

179. Dan Levine, *Prison health provider agrees to changes in California*, REUTERS (Feb. 10, 2015), <https://www.reuters.com/article/us-usa-prison-settlement-idUSKBN0LE2KT20150210> [<https://perma.cc/Z6JB-P83S>].

180. *Id.*

181. *Id.*

182. MICHAEL FENNE, PRIVATE EQUITY FIRMS REBRAND PRISON HEALTHCARE COMPANIES, BUT CARE ISSUES CONTINUE 17–21 (Priv. Equity Stakeholder Project, 2022), https://pestakeholder.org/wp-content/uploads/2022/11/Wellpath_HIG_12-2022.pdf [<https://perma.cc/FGR2-PF3E>].

183. Simon Aponte, 2 *Investigates: Jail medical company Corizon loses Alameda Co. contract*, FOX2KTVU (Aug. 5, 2016), <https://www.ktvu.com/news/2-investigates-jail-medical-company-corizon-loses-alameda-co-contract> [<https://perma.cc/DZ6U-N9HP>].

184. Simon Aponte, 2 *Investigates: Questions Surround Jail Contractor's Donations to Sheriff's Campaign*, FOX2KTVU (Sep. 4, 2015), <https://www.ktvu.com/news/2-investigates-questions-surround-jail-contractors-donations-to-sheriffs-campaign> [<https://perma.cc/FE3T-XULU>].

185. *Id.*

186. FENNE, *supra* note 182, at 17–21.

bidding information worth more than \$3 million per year.¹⁸⁷

IV. A FRAMEWORK FOR REFORM: MANDATORY ACCREDITATION, ENFORCEABLE STANDARDS, AND PUBLIC ALTERNATIVES

A. Privatization, Accreditation, and the Path to Reform

The structural failures and accountability deficits documented in Part III make clear that litigation alone cannot drive meaningful reform. Critics of privatized correctional health care have argued that the structure of private contracting can distort incentives away from patient care and toward cost containment and liability management.¹⁸⁸ Regardless of the specific company involved, the profit motive in private correctional health care has been associated with service reductions and staffing constraints that raise concerns about care quality.¹⁸⁹

Indiana illustrates the continuing reliance on private contractors. In July 2021, Centurion Health began a four-year contract with the Indiana Department of Administration to provide comprehensive physical health, mental health, transitional health, and related support services to approximately 25,000 incarcerated individuals across twenty-one state facilities.¹⁹⁰

By contrast, several jurisdictions have shifted toward publicly administered models. In 2015, New York City declined to renew its private contract with Corizon and transferred management of correctional health services to the public Health and Hospitals Corporation, citing direct public accountability, improved oversight, and continuity of care as central goals.¹⁹¹ Los Angeles County similarly operates correctional health services through its Department

187. Fenne, *supra* note 159; *see also* Press Release, U.S. Dep't of Just., U.S. Att'y's Off., E.D. Va., CEO Sentenced for Bribing Former Norfolk Sheriff (Feb. 25, 2022), <https://www.justice.gov/usao-edva/pr/ceo-sentenced-bribing-former-norfolk-sheriff-0> [<https://perma.cc/G69L-F6WZ>].

188. Fenne, *supra* note 159.

189. *Id.*

190. *Centurion Health Provides Correctional Health for Indiana Department of Correction*, CENTURION (July 12, 2021), <https://teamcenturion.com/newsroom/centurion-to-partner-with-indiana-doc-to-provide-comprehensive-healthcare-services/> [<https://perma.cc/FSU3-FC3U>] (noting that the four-year contract included two two-year renewal options).

191. Press Release, NYC Health and Hospitals, Health and Hospitals Corporation To Run City Correctional Health Service (June 10, 2015), <https://nychealthandhospitals-appservice-east-us.azurewebsites.net/pressrelease/health-and-hospitals-corporation-to-run-city-correctional-health-service/> [<https://perma.cc/72K6-EUES>] [hereinafter NYC Health Services Press Release] (archived version confirms transfer of correctional health management from Corizon to the public Health and Hospitals Corporation); *Correctional Health Services*, NYC HEALTH & HOSPS., <https://www.nychealthandhospitals.org/correctional-health-services/> [<https://perma.cc/8S36-7DL5>] (last visited May 29, 2026) (describing the public correctional health division established in 2016 after the city declined to renew its contract with private provider Corizon).

of Health Services.¹⁹² Other jurisdictions rely on community- or university-based models to deliver correctional health care.¹⁹³

Accreditation of correctional health care facilities in the United States remains voluntary, unevenly distributed, and legally unenforceable as a minimum standard of care.¹⁹⁴ Two primary bodies offer accreditation in this space. The American Correctional Association, through its Commission on Accreditation for Corrections, accredits more than 1,300 facilities across the United States and internationally under its general operational standards.¹⁹⁵ The NCCHC offers a separate program focused specifically on health care quality, and its standards have been recognized by courts as among the most rigorous benchmarks for constitutionally adequate correctional health care; further, these standards have documented benefits, including reduced liability exposure, enhanced patient safety, continuous quality improvement, and greater public accountability.¹⁹⁶ Yet no federal law mandates that correctional facilities obtain health care-specific accreditation, leaving care quality to vary significantly from one facility to another.¹⁹⁷

Indiana provides a telling example of how this regulatory gap operates in practice; its continued reliance on private health care contractors, in the absence of health care-specific accreditation requirements or enforceable contract performance standards, reflects the broader structural deficiencies this Note seeks to address.¹⁹⁸ While IDOC policy directs staff to consider NCCHC standards when developing health care directives, neither Indiana statute nor administrative regulation requires facilities to obtain NCCHC accreditation.¹⁹⁹

192. *Correctional Health Services (CHS)*, L.A. CNTY. DEPT. OF HEALTH SERVS., <https://dhs.lacounty.gov/correctional-health-services/our-services/correctional-health-services/> [https://perma.cc/GL46-ZAZP] (last visited May. 29, 2026) (describing Los Angeles County's publicly operated Correctional Health Services division within the Department of Health Services) [hereinafter LA Correctional Health Care Services].

193. See, e.g., *University Correctional Health Care*, RUTGERS UNIV. BEHAV. HEALTH CARE, <https://ubhc.rutgers.edu/clinical/uchc/overview.xml> [https://perma.cc/BA6T-TKK8] (last visited May 29, 2026) (describing a university-based correctional healthcare program emphasizing clinical excellence, compassionate care, and health equity); see also *Unity Health Care Awarded DOC Inmate Comprehensive Medical Services Contract*, CISION PR NEWswire (Apr. 16, 2019), <https://www.prnewswire.com/news-releases/unity-health-care-awarded-doc-inmate-comprehensive-medical-services-contract-300832653.html> [https://perma.cc/88ZE-4TP7].

194. McCann, *supra* note 22.

195. CAC, *supra* note 68.

196. Thomas J. Weber & Tommy Williams, *The Many Benefits of Accreditation*, NAT'L COMM'N ON CORR. HEALTH CARE (June 20, 2024), <https://www.ncchc.org/the-many-benefits-of-accreditation/> [https://perma.cc/M79G-MUFY].

197. McCann, *supra* note 22.

198. See IND. CODE § 11-12-4-1 (2025) (setting minimum health care requirements for IDOC without mandating accreditation); 210 IND. ADMIN. CODE 3-1-11 (2025) (outlining health care standards for IDOC without requiring NCCHC or equivalent health care-specific accreditation).

199. Indiana Health Services Policy, *supra* note 152, at 3, 7–8 (directing staff to “take into consideration” ACA and NCCHC standards when preparing health care directives but imposing no accreditation requirement).

As a result, compliance with those standards remains aspirational rather than legally enforceable. Although some IDOC facilities hold general operational accreditation through the American Correctional Association, the documented pattern of care failures across successive private contractors in Indiana underscores that facility-level ACA accreditation alone is insufficient to ensure health care quality.²⁰⁰ The experiences of New York City and Los Angeles County suggest that publicly administered models may offer greater structural accountability, though the relative effectiveness of public versus private models depends heavily on oversight, funding, and institutional commitment.²⁰¹ Because constitutional litigation is reactive, durable reform must come through proactive administrative mandates. Even where full public administration is not politically or fiscally feasible, state legislatures must, at minimum, mandate health care-specific accreditation, enforce measurable contract performance standards, and restructure financial incentives to reduce contractors' incentives to limit or deny necessary care.²⁰² Indiana, which already benefits from a robust medical school infrastructure through Indiana University School of Medicine, might consider exploring a university-affiliated model similar to those operating in New Jersey and other states as a longer-term alternative to exclusive reliance on private contractors.²⁰³

B. Technology-Driven Health Care Innovations

1. Mandating Telehealth Expansion in Correctional Facilities

Telehealth has emerged as an important tool in correctional health care, improving access to medical services and reducing certain operational costs.²⁰⁴ By minimizing the need for resource-intensive transfers to external medical facilities, telehealth enhances both security and efficiency while ensuring incarcerated individuals receive timely care.²⁰⁵ Research indicates that telehealth implementation can reduce offsite transports and facilitate improved monitoring

200. Press Release, Ind. Dep't of Corr., National Organization Recommends Indiana Prison for Reaccreditation (Sep. 18, 2018), <https://www.in.gov/idoc/files/National-Organization-Recommends-Indiana-Prison-for-Reaccreditation.pdf> [<https://perma.cc/A547-WWYS>].

201. NYC Health Services Press Release, *supra* note 191; LA Correctional Health Care Services, *supra* note 192.

202. *See* Marso, *supra* note 168; *see also* Pew Charitable Trs., *supra* note 173.

203. *See e.g.*, *University Correctional Health Care*, *supra* note 193; *see also* *Student Outreach Clinic*, IND. UNIV. SCH. OF MED., <https://medicine.iu.edu/indianapolis/service-learning/outreach-clinic> [<https://perma.cc/45H2-724M>] (last visited May 29, 2026).

204. *See supra* notes 36–39 and accompanying text; *see also* Saif Khairat et al., *Assessment of Stakeholder Perceptions and Cost of Implementing a Telemedicine Specialty Program at Correctional Facilities in North Carolina*, 27 PERMANENTE J. 49, 49 (June 2023).

205. *Telehealth in Correctional Facilities (2025)*, NAT'L COMM. ON CORR. HEALTHCARE, <https://ncchc.org/position-statements/telehealth-in-correctional-facilities-2025/> [<https://perma.cc/4VFP-VCTD>] (last visited May 29, 2026).

of chronic conditions.²⁰⁶ Beyond correctional settings, telehealth technologies have become widely adopted for their cost-effectiveness and ability to expand health care access.²⁰⁷ The documented cost savings from technology-driven delivery further strengthen the case for mandated integration. For example, a statewide specialty care telemedicine program in North Carolina's prison system reduced health care expenses by \$416,020 within the first six months and projected net savings of over \$1.1 million within the first year.²⁰⁸ Because constitutional litigation does not compel modernization and administrative policy currently treats telehealth as optional, leaving its implementation to institutional discretion, states must mandate baseline telehealth integration as part of health care-specific accreditation requirements.²⁰⁹

2. Requiring EHR Adoption to Improve Care Continuity

A well-integrated EHR system could alleviate inefficiencies in correctional health care by streamlining medical data management and improving continuity of care before, during, and after incarceration.²¹⁰ Currently, many correctional facilities still rely on manual recordkeeping despite the fact that records must be retained for up to twenty years after a patient's release—a long-term administrative obligation that electronic systems are better designed to manage.²¹¹

For more than a decade, EHR technology has become a cornerstone of health care in the United States, offering transformative benefits such as improved care continuity, adherence to evidence-based practices, and reduced medical errors.²¹² The Centers for Medicare and Medicaid Services ("CMS") have advanced these objectives through its Medicaid and Medicare EHR Incentive Program, commonly referred to as meaningful use ("MU").²¹³ This program provides financial incentives to health care providers to adopt, implement, or upgrade to certified EHR systems and demonstrate their effective

206. *Id.*

207. Shilpa N. Gajarawala & Jessica N. Pelkowski, *Telehealth Benefits and Barriers*, 17 J. NURSE PRACS. 218, 218 (2020).

208. Khairat et al., *supra* note 204.

209. Telehealth in Correctional Facilities (2025), *supra* note 205.

210. DANIEL SALAZAR, JR., NAVAL POSTGRADUATE SCH., THE AMERICAN CORRECTIONAL HEALTHCARE SYSTEM IS AILING: TECHNOLOGY INNOVATION AS A PRESCRIPTION FOR PENAL SYSTEM HEALTHCARE DELIVERY 82–83 (June 2022), <https://calhoun.nps.edu/server/api/core/bitstreams/53632e26-5c5e-42b5-b1a2-c0976539dce5/content> [https://perma.cc/N96N-5J8J].

211. *EHRs and Data Archiving for Correctional Health*, HARMONY HEALTHCARE IT, <https://www.harmonyhit.com/ehrs-and-data-archiving-for-correctional-health/> [https://perma.cc/P6SJ-56LK] (last visited Mar. 9, 2025).

212. See Michelle Martelle et al., *Meaningful Use of an Electronic Health Record in the New York City Jail System*, 105 AM. J. PUB. HEALTH 1752 (Sep. 2015).

213. *Id.* at 1752.

use in improving patient outcomes.²¹⁴ Notably, a 2012 regulatory amendment extended eligibility under this program to correctional health providers, meaning that states operating publicly administered correctional health systems may already be positioned to participate.²¹⁵ Extending similar incentive structures more broadly to correctional facilities, including those operated through private contractors, could reduce disparities in care between incarcerated populations and the general public.²¹⁶ Because constitutional litigation does not compel technological modernization and existing policy leaves EHR adoption to institutional discretion, states must mandate baseline EHR integration as part of health care-specific accreditation requirements, with federal incentive funding serving as the mechanism to accelerate compliance.

3. *Wearable Technology as a Supplement to Systemic Reform*

Recent innovations in wearable technology have introduced new opportunities for real-time health monitoring in correctional settings, with some correctional facilities adopting biometric wristbands and remote monitoring systems capable of tracking heart rate, blood oxygen levels, skin temperature, and location data.²¹⁷ Some facilities have moved beyond general surveillance tools toward clinically oriented applications. For example, a Florida county jail is piloting Vivalink's mobile cardiac monitoring solution to address the needs of an inmate population frequently presenting with cardiac complaints that its on-site infirmary lacked the equipment to assess.²¹⁸ These technologies hold genuine potential as continuous vital sign monitoring can reduce the likelihood of undetected medical emergencies and enable faster responses to acute health crises.²¹⁹ However, implementation has been uneven and, in some cases, counterproductive. The Fulton County Jail spent \$7.4 million on a biometric wristband system that was ultimately described as a failure, in part because the same facility lacked a full-time health care provider, which illustrates that wearable technology cannot substitute for adequate staffing and basic care infrastructure.²²⁰ Additionally, the data privacy implications of biometric wearables in correctional settings remain largely unresolved, as it is unclear whether all correctional technology contractors handle protected health

214. *Id.*

215. *Id.*

216. See *Ending Mass Incarceration: The Need for Federal Incentives*, EQUAL JUST. INITIATIVE (Jan. 29, 2016), <https://eji.org/news/need-federal-incentives-to-end-mass-incarceration/> [https://perma.cc/Q6H7-4LBQ].

217. Danielle Dorchester, *Wristwatched: A New Frontier of Health Monitoring in Prisons*, ELEC. PRIV. INFO. CTR. (Aug. 22, 2024), <https://epic.org/wristwatched-a-new-frontier-of-health-monitoring-in-prisons/> [https://perma.cc/FDK9-SLPQ].

218. Timm, *supra* note 36.

219. *Id.*

220. Dorchester, *supra* note 217.

information in full compliance with HIPAA.²²¹ HIPAA's Privacy Rule applies to incarcerated individuals and extends to health care services provided both inside correctional facilities and at outside providers, which means correctional technology contractors that collect or process protected health information are subject to its requirements regardless of how they characterize their products.²²² Additionally, liability for any breaches could be assigned to the company providing the EHR services, ensuring accountability and compliance with both legal and ethical obligations. Accordingly, states that authorize or fund wearable health monitoring programs in correctional facilities must establish clear regulatory frameworks governing data use, patient consent, and HIPAA compliance. Further, they must ensure that technology deployment supplements—rather than substitutes for—adequately staffed and accredited health care programs.

C. Financial and Legislative Reforms

Private contractors currently face a structural financial disincentive to provide timely medical care because, under capitated contract models, they bear responsibility for external hospital costs, which means that every avoidable hospitalization reduces their profit margin.²²³ States should shift financial responsibility for external hospital costs to the state rather than the private contractor, removing the profit-based incentive to delay or deny care and aligning the contractor's financial interests with better patient outcomes.²²⁴

Indiana illustrates both the scale of the problem and the feasibility of reform. Indiana has an incarceration rate of 721 per 100,000 people, higher than any independent democratic country, with approximately 46,000 residents currently behind bars.²²⁵ Yet Indiana's Medicaid program already serves nearly two million residents, meaning that expanding state-supported health care frameworks to cover the costs of care for its incarcerated population would represent a marginal increase in the state's existing health care infrastructure relative to the population it already serves.²²⁶

Strategic investment in technology would further reduce long-term costs by

221. *Id.*

222. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 42 U.S.C.); 45 C.F.R. § 164.512(k)(5) (2024); Caitlin Anthoney, *Does HIPAA apply to incarcerated individuals?*, PAUBOX (Apr. 8, 2024), <https://www.paubox.com/blog/does-hipaa-apply-to-incarcerated-individuals> [https://perma.cc/NNG3-58DX].

223. PEW CHARITABLE TRS., *supra* note 173, at 12–13.

224. PEW CHARITABLE TRS., *supra* note 161.

225. *Indiana Profile*, PRISON POL'Y INITIATIVE, <https://www.prisonpolicy.org/profiles/IN.html> [https://perma.cc/2XQV-7DX7] (last visited May 29, 2026).

226. Whitney Downard, *Medicaid rolls higher than pre-pandemic enrollment as unwinding continues*, IND. CAP. CHRON. (May 15, 2024), <https://indianacapitalchronicle.com/2024/05/15/medicaid-rolls-higher-than-pre-pandemic-enrollment-as-unwinding-concludes/> [https://perma.cc/T853-FPUT]; Indiana Profile, *supra* note 225.

shifting the system from reactive to preventive care. Wearable health monitors currently being piloted in correctional facilities across the country provide real-time tracking of vitals, alerting staff to abnormal readings, medication reactions, or signs of distress before conditions escalate into costly emergencies.²²⁷ EHR integration similarly reduces duplicative testing and ensures continuity of care across transfers and reentry.²²⁸ While initial implementation requires investment, the North Carolina telemedicine data already discussed demonstrates that technology-driven solutions generate measurable net savings within the first year of deployment.²²⁹ A state-supported financial model combined with technology-driven early detection would lower overall health care costs, improve medical outcomes, and reduce the public health burden that falls on communities when incarcerated individuals reenter society with unmet medical needs.

V. CONCLUSION

The cases of Walter Jordan, Antonio Arnez Smith, and George Hawkins are not anomalies. They are the predictable product of a system that has long treated constitutional minimums as a ceiling rather than a floor. The Eighth Amendment's deliberate indifference standard was never designed to guarantee adequate health care; it was designed to prohibit the worst abuses. The gap between that constitutional floor and genuinely adequate care is where the failures documented throughout this Note have accumulated, and it is precisely the gap that administrative law must fill.

This Note has argued that durable reform requires more than litigation. It requires state legislatures to mandate health care-specific accreditation through bodies like NCCHC, enforce measurable contract performance standards with real consequences for noncompliance, and restructure the financial incentives that currently reward private contractors for denying care. It requires investment in telehealth, EHR systems, and wearable monitoring technology, not as substitutes for adequate staffing and accreditation, but as tools to extend the reach and consistency of care within facilities that already meet minimum standards. And it requires states like Indiana, which incarcerates its residents at a rate higher than any independent democratic country on earth, to reckon honestly with the gap between the aspirational language of its administrative policies and the documented failures of its contracted health care providers.

The path forward is not without obstacles. Political resistance, fiscal constraints, and the deeply embedded profit incentives of the private correctional health care industry will not yield easily to reform. But the framework proposed here does not require the abolition of private contracting

227. Bobeth Yates, *Fulton County Jail starts to use wristbands to monitor inmates' health*, 11ALIVE (Sep. 22, 2023), <https://www.11alive.com/article/news/local/fulton-county-jail-wristbands-inmate-safety/85-025b12b7-a7f3-480e-8b6f-b715c9851106> [https://perma.cc/4Z23-3UC4].

228. *See supra* notes 212–13 and accompanying text.

229. *See supra* note 210 and accompanying text.

or a wholesale restructuring of state correctional systems. It requires accountability: mandatory accreditation, enforceable standards, transparent oversight, and a financial model that stops rewarding contractors for the very failures the system was designed to prevent.

By addressing these issues, society upholds basic human dignity, reduces the public health burden that follows incarcerated individuals into their communities upon release, and builds a correctional system that prepares people to reenter society in better health, not worse.

FROM *PLYLER* TO PUBLIC HEALTH: THE EQUAL PROTECTION ARGUMENT FOR MEDICAID ACCESS FOR UNDOCUMENTED CHILDREN AND PREGNANT INDIVIDUALS

MEGHAN O'SULLIVAN*

I. INTRODUCTION

Dr. Meredith Grey, one of television's most beloved fictional doctors, encounters a heartbreaking situation when she discovers a ten-year-old girl, Nadia, sitting alone and in excruciating pain.¹ Upon further investigation, Dr. Grey and her fellow doctors at Grey Sloan Memorial Hospital find a life-threatening 7.8-pound mass in Nadia's abdomen.² As the doctors prepare to treat Nadia, they discover a worrying truth: Nadia and her mother are undocumented immigrants, and are terrified that their mere presence at Grey Sloan Memorial will result in their deportation.³ This fear, rooted in their immigration status, led Nadia's mother to delay seeking essential care, even as her child's condition worsened.⁴

Nadia's mother delayed seeking care for her daughter due to her fear of the unknown. In her mind, the risk of seeking treatment far outweighed the potential consequences of inaction.⁵ Her decision-making was compounded by her belief that bringing Nadia to the hospital would lead to their separation.⁶ Unable to reconcile her fear of deportation with Nadia's need for medical intervention, Nadia's mother chose to ignore her daughter's condition, and instead desperately hoped the problem would resolve on its own.⁷ She clung to the hope that if she could just survive without drawing attention, things might improve.⁸

This fictional scenario displays a painful reality: an immigrant mother's decisions are not driven by negligence or neglect, but by the all-consuming fear that seeking healthcare would result in the loss of everything she has worked to build for her family. It illustrates the deep vulnerabilities faced by undocumented individuals—particularly parents—who are forced to navigate a healthcare system that is not built for their use. The reason such an illustration was used in place of a real-life story is due to the difficulty and rarity of undocumented immigrants sharing their experiences with those outside their community. This further exemplifies the difficulties undocumented immigrants

* JD Candidate, 2026, Robert H. McKinney School of Law. The author would like to thank her advisors, Professor Sarah Thompson Parks and attorney Jaron Bentley for their advice and unending patience, as well as the *Indiana Health Law Review* editorial team for their support. She also extends her eternal gratitude to her sister-in-law, Hannah Fiewig, for her invaluable research assistance. Finally, the author thanks her stalwart companion Fenway Quesadilla, without whom this Note would have been completed much earlier and with fewer teeth marks.

1. *Grey's Anatomy: Only Mama Knows* (ABC television broadcast Oct. 16, 2014).

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

have when accessing healthcare and how those barriers can impact our own understanding of the issue. Despite many other countries guaranteeing access to healthcare, the United States chooses to impose legal barriers that prevent vulnerable populations from receiving vital care. This purposeful exclusion undermines our country's public health goals, exacerbates health disparities, and increases the cost of healthcare for all.

In *Plyler v. Doe*, the United States Supreme Court set a foundation for expanding healthcare access to undocumented children and pregnant individuals by ruling that the Equal Protection Clause applies to *all* persons within the jurisdiction of the United States.⁹ While *Plyler* dealt with education, its principles should extend to other fundamental public services—particularly healthcare. Just as education is essential for personal and societal advancement, access to healthcare is essential for ensuring a population not only survives but thrives.

The United States' Medicaid Program has long served as a crucial safety net for millions of low-income individuals and families, and expanding it to include undocumented children and pregnant individuals is long overdue.¹⁰ This Note argues that the exclusion of undocumented children and pregnant individuals from Medicaid coverage is a policy failure that contradicts the core objectives of the program and the Equal Protection Clause of the Fourteenth Amendment.¹¹ By examining legal frameworks, public health implications, and economic realities, affecting undocumented immigrant populations, this Note demonstrates that comprehensive federal reform expanding health care access for this underserved population is both necessary and achievable. This proposal not only aligns with the principles of human dignity and the universal right to healthcare but is also required under the Equal Protection Clause. A federal expansion of Medicaid is not only a compassionate approach, but it also represents sound public policy that promotes healthier communities and a more equitable healthcare system.

Part I of this Note explains the historical and legal foundation for expanding Medicaid coverage to undocumented children and pregnant individuals. It examines the history of immigration in the United States and the current demographics of undocumented populations. It also explores the purpose and evolution of Medicaid, including current restrictions on Medicaid eligibility for undocumented individuals under federal law, and the negative outcomes of current policies and legislation that impact undocumented individuals' access to healthcare.

Part II discusses the legal and policy justifications for Medicaid expansion. It applies *Plyler's* Equal Protection principles to the healthcare context, showing parallels between how the Court's decision to allow undocumented children access to education in *Plyler* can be applied to healthcare access for undocumented children and pregnant individuals. This part then explores

9. *Plyler v. Doe*, 457 U.S. 202, 210 (1982).

10. 42 U.S.C. §§ 1396 to 1396w-8 (2018).

11. U.S. CONST. amend. XIV, § 1.

comparative models, evaluating international and state-level approaches to providing healthcare for undocumented populations. Specifically, it examines Thailand and France's approaches and rationale that highlight alternative frameworks for healthcare inclusion. Additionally, this part reviews state-led initiatives, such as California and Illinois's Medicaid expansions, demonstrating that successful models already exist within the United States. These comparative examples, coupled with the reasoning from *Plyler*, illustrate the societal and economic benefits of expanding Medicaid access.

Part III outlines actionable policy recommendations for Medicaid expansion at both the federal and state levels, outlining a path towards comprehensive reform. This part first details specific legislative action, such as amending the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA") and expanding the Affordable Care Act ("ACA"). It then discusses state-level measures that can serve as interim solutions until federal reform is enacted. Additionally, this part argues for why expansion is necessary, using the legal reasoning from *Plyler* to demonstrate that healthcare access—like education—is essential to preventing the creation of a permanent underclass and assisting those who had no say in their status. It further strengthens the case for reform by drawing on economic and public health rationales. Finally, this section addresses counterarguments, refuting common claims about the financial burden and potential for incentivized immigration.

II. MEDICAID, IMMIGRATION, AND THE IMPACT OF EXCLUSION

Undocumented children and pregnant individuals face systemic challenges in accessing healthcare due to legal restrictions, historical exclusions, and economic barriers. These challenges are rooted in two histories. The history of Medicaid, a program founded as a vital safety net program, then reshaped by later amendments and expansions that impacted the delivery of services. The second is the history of immigration in the United States, including current demographics, motivations, and realities many undocumented individuals face. Together, these histories produce the negative outcomes and consequences of current exclusions, which fall into three key areas: economic impact, public health impact, and individual impact.¹²

A. History of Medicaid

Congress established Medicaid in 1965 under Title XIX of the Social Security Act with the intent of providing health coverage to low-income individuals and families, with a focus on those who could not afford private

12. See *infra* Part II. A–C.

health insurance.¹³ This included populations such as low-income children, the elderly, and the disabled.¹⁴ At its conception, Medicaid assisted eligible individuals and families in attaining or retaining their independence and ability for self-care, but only to those deemed to be the “deserving poor.”¹⁵

The Patient Protection and Affordable Care Act of 2010, commonly known as the ACA or Obamacare, provided a significant expansion for Medicaid eligibility.¹⁶ With this expansion, Medicaid now covers nearly all low-income children and adults under sixty-five, regardless of their family status or disability.¹⁷ With the ACA expansion, Medicaid covers approximately eighty-three million low-income individuals and is the largest source of “medical and health-related services” in the United States.¹⁸

Medicaid is a joint federal-state program, with the federal and state governments both having roles in determining an individual’s eligibility.¹⁹ The federal government sets minimum eligibility standards related to financial need or other characteristics that all states must follow.²⁰ This ensures that certain vulnerable groups are covered. The federal government also funds a portion of each state’s Medicaid program.²¹ States have considerable flexibility to determine specific eligibility criteria within the federal framework.²² States may also set additional income limits, expand to cover additional populations, and choose extra benefits beyond those required by the federal government.²³

Under this current framework, states are allowed to expand Medicaid access

13. 42 U.S.C. §§ 1396 to 1396w-8 (2018); Shannon Schumacher et al., *Understanding the U.S. Immigrant Experience: The 2023 KFF/LA Times Survey of Immigrants*, KFF (Sep. 17, 2023), <https://www.kff.org/racial-equity-and-health-policy/kff-la-times-survey-of-immigrants/#d53efe98-31a4-48f1-944f-b1b1aff36c06> [https://perma.cc/YD76-BNVR]; CONG. RSCH. SERV., R43357, *MEDICAID: AN OVERVIEW* 5 (2023); Barbara S. Klees, Christian J. Wolfe & Catherine A. Curtis, *Annual Statistical Supplement, 2015*, SOC. SEC. ADMIN., <https://www.ssa.gov/policy/docs/statcomps/supplement/2015/medicaid.html> [https://perma.cc/8C3G-DWSW] (last visited Oct. 9, 2024).

14. Klees et al., *supra* note 13.

15. BRIETTA R. CLARK ET AL., *HEALTH LAW CASES, MATERIALS, AND PROBLEMS* 639 (9th ed. 2022) (Historically, society has differentiated between those who were poor through no fault of their own, such as elderly or children, as opposed to those perceived as able-bodied).

16. Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001; Jennifer Sullivan et al., *Entering Their Second Decade, Affordable Care Act Coverage Expansions Have Helped Millions, Provide the Basis for Further Progress*, CTR. BUDGET & POL’Y PRIORITIES, <https://www.cbpp.org/research/health/entering-their-second-decade-affordable-care-act-coverage-expansions-have-helped> [https://perma.cc/YD2M-9ANC] (last updated Mar. 25, 2024).

17. Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001; Sullivan et al., *supra* note 16.

18. Klees et al., *supra* note 13; Rudowitz et al., *10 Things to Know About Medicaid*, KFF (Feb. 18, 2025), <https://www.kff.org/medicaid/10-things-to-know-about-medicaid/> [https://perma.cc/5YDZ-U8GR].

19. CONG. RSCH. SERV., *supra* note 13.

20. *Id.* at 4–5.

21. Rudowitz et al., *supra* note 18; CONG. RSCH. SERV., *supra* note 13, at 1.

22. Klees et al., *supra* note 13.

23. CONG. RSCH. SERV., *supra* note 13, at 4.

to undocumented immigrants.²⁴ However, without a federal requirement, states must fund coverage for populations that federal law excludes, such as undocumented immigrants, using state-funds alone.²⁵ If federal expansion is implemented, states will be required to provide the minimum level of assistance set by the federal government, but they will have the benefit of federal funds to assist in subsidizing the care of an additional population.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”), also referred to as the Welfare Reform Act, codified significant limitations on access to public benefits for undocumented immigrants.²⁶ Section 401 of PRWORA explicitly bars undocumented immigrants from receiving federally funded public health benefits, which includes Medicaid coverage.²⁷ However, the Emergency Medical Treatment and Labor Act of 2010 (“EMTALA”) required hospitals to provide emergency medical care to any patient, regardless of immigration status or ability to pay.²⁸ Medicaid then reimburses the hospital for the emergency services provided to such individuals.²⁹ Under this requirement, a hospital is only required to stabilize a patient.³⁰ Once a patient is stabilized, EMTALA imposes no further obligation, even where the original injury requires long-term treatment or additional procedures.³¹

B. History of Immigration

The United States is a nation built by immigrants, which has shaped the country’s demographics and economic landscape. As of 2023, there are close to fifty million foreign-born individuals in the United States, accounting for approximately 14.3% of the United States population.³² Most of these immigrants are documented, but there are an estimated ten to eleven million

24. See Tanya Broder, *Medical Assistance Programs for Immigrants in Various States (Table)*, NAT’L IMMIGR. L. CTR. (Mar. 6, 2025), <https://www.nilc.org/resources/medical-assistance-various-states/> [perma.cc/FWA2-TL5X] (noting a number of states and the District of Columbia have expanded their Medicaid programs to include undocumented children and pregnant individuals without federal assistance. Several also allow undocumented pregnant individuals to access Medicaid for prenatal and/or postnatal care, but do not allow undocumented children access).

25. *Id.*

26. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2261–62 (codified as amended at 8 U.S.C. § 1611).

27. 8 U.S.C. § 1611.

28. Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd(a)–(b) (2010).

29. *Id.*

30. *Id.* at § 1395dd(b).

31. *Id.* at § 1395dd(a)–(b).

32. Mohamad Moslimani & Jeffery S. Passel, *What the data says about immigrants in the U.S.*, PEW RSCH. CTR. (Sep. 27, 2024), <https://www.pewresearch.org/short-reads/2025/08/21/key-findings-about-us-immigrants/> [https://perma.cc/8RX8-MLJ7].

undocumented immigrants present in the United States.³³ There are many reasons these immigrants come to the United States. Most come for more or better opportunities for themselves and their children, including better educational opportunities and better economic opportunities.³⁴ Many immigrants also seek more personal rights and freedoms, and some flee unsafe or violent conditions.³⁵

Undocumented immigrants come to the United States from a wide variety of origin countries. It is estimated that the current largest undocumented immigrant populations originally hail from Mexico, El Salvador, and India.³⁶ Additionally, the vast majority of immigrant households are “mixed status.”³⁷ This means that both undocumented and lawfully present or United States-born residents reside together in the same household.³⁸

In recent years, the immigration enforcement landscape has shifted drastically. Since the start of the second Trump administration in January 2025, interior immigration enforcement has intensified, with the number of deportations from within the United States increasing roughly five times their late 2024 levels and ICE arrests quadrupling.³⁹ This enforcement surge has heightened fear within immigrant communities, including among the lawfully present and U.S.-born members of mixed-status households.⁴⁰ As of 2025, 41% of immigrant adults reported worrying that they or a family member could be detained or deported, up from 26% in 2023.⁴¹ That fear carries direct consequences for healthcare access: one in five immigrant parents reported that they or a family member had avoided seeking medical care since January 2025 because of immigration-related concerns, twice the rate of adults without children. This reluctance is compounded by the administration’s reversal of prior policy limiting immigration enforcement at “sensitive locations” such as

33. Moslimani & Passel, *supra* note 32; Mohammad M. Fazel-Zarandi et al., *The number of undocumented immigrants in the United States: Estimates based on demographic modeling with data from 1990 to 2016*, 13 PLOS ONE 9, 2 (2018) (noting that while typical studies estimate the number of undocumented immigrants to hover around eleven million, an alternative approach to estimating the number of undocumented immigrants reveals there may be a much higher undocumented population than previously thought).

34. Schumacher et al., *supra* note 13.

35. *Id.*

36. Moslimani & Passel, *supra* note 32.

37. *Id.*

38. *Id.*

39. See Graeme Blair & David Hausman, *One Year of Immigration Enforcement Under the Second Trump Administration*, DEPORTATION DATA PROJECT (Apr. 7, 2026), <https://deportationdata.org/analysis/immigration-enforcement-first-year.html> [<https://perma.cc/KNF8-26GZ>].

40. Akash Pillai, Drishti Pillai & Samantha Artiga, *Potential Impacts of Mass Detention and Deportation Efforts on the Health and Well-Being of Immigrant Families*, KFF (Feb. 6, 2025), <https://www.kff.org/racial-equity-and-health-policy/potential-impacts-of-mass-detention-and-deportation-efforts-on-the-health-and-well-being-of-immigrant-families/> [<https://perma.cc/KG8M-CXAU>].

41. *Key Facts on Health Coverage of Immigrants*, KFF (May 19, 2026), <https://www.kff.org/racial-equity-and-health-policy/key-facts-on-health-coverage-of-immigrants/> [<https://perma.cc/VL8G-X2R8>].

hospitals.⁴² As discussed below, this dynamic deepens the very barriers to care that Medicaid exclusion already imposes on undocumented children and pregnant individuals.

C. Negative Outcomes of the Status Quo

Excluding undocumented children and pregnant individuals from Medicaid has consequences that extend far beyond those directly affected. The harms fall into three areas. Economically, exclusion drives up overall healthcare spending by shifting care to costlier emergency and uncompensated services.⁴³ From a public health standpoint, it raises the risk of outbreaks, deepens health inequities within vulnerable communities, and undermines federal public health initiatives.⁴⁴ At the individual level, the lack of preventive care leads to worse maternal and infant outcomes, along with developmental delays and untreated conditions in children.⁴⁵

1. Economic Impact of Exclusion from Healthcare

The economic rationale for expanding healthcare access is compelling. Individuals with access to healthcare experience improved health outcomes, greater financial stability, and better access to preventive care.⁴⁶ Healthy workers—of which there are approximately 8.3 million in the United States—are better equipped to maintain steady employment, contribute to the economy, and support their families.⁴⁷ Conversely, individuals denied access to healthcare are more likely to suffer chronic conditions, resulting in lost productivity, higher healthcare costs, and greater reliance on social safety nets.⁴⁸

Long-term, inclusive healthcare policies generate substantial returns on the initial investment.⁴⁹ Healthier populations contribute more to the workforce, pay

42. Drishti Pillai et al., *Health and Health Care Experiences of Immigrant Parents and Their Children During the Second Trump Term*, KFF (Mar. 2, 2026), <https://www.kff.org/immigrant-health/health-and-health-care-experiences-of-immigrant-parents-and-their-children-during-the-second-trump-term/> [https://perma.cc/JEE6-7K2T].

43. See *infra* Part II.C.1.

44. See *infra* Part II.C.2.

45. See *infra* Part II.C.3.

46. See Thomas Buchmueller et al., *Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024*, ASPE ISSUE BRIEF No. HP-2024-11 (June 7, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK611354/> [https://perma.cc/QZL7-3EGZ]; see also *Report: The Importance of Health Coverage*, AM. HOSP. ASS'N, <https://www.aha.org/guides-reports/report-importance-health-coverage> [https://perma.cc/LB4B-DP7J] (last visited Nov. 5, 2024).

47. *Id.*; Kevin Appleby, *The Importance of Immigrant Labor to the US Economy*, CTR. FOR MIGRATION STUD. (Sep. 2, 2024), <https://cmsny.org/importance-of-immigrant-labor-to-us-economy/> [https://perma.cc/BT8K-22FW].

48. AM. HOSP. ASS'N, *supra* note 46.

49. See Rebecca Masters et al., *Return on investment of public health interventions: a systematic review*, 71 J. EPIDEMIOLOGY & CMTY. HEALTH 827 (2017).

taxes, and stimulate economic growth, while reducing the financial burden of treating advanced illnesses.⁵⁰ Policymakers in other countries have recognized this benefit and have implemented universal healthcare systems that prioritize access for all residents, including undocumented individuals.⁵¹ These programs demonstrate that the initial costs of expanding healthcare access are later offset by savings in emergency care and long-term social benefits.

Denying Medicaid coverage to undocumented children and pregnant individuals does not eliminate their need for healthcare—it merely shifts the cost burden to emergency services and uncompensated care, which are far more expensive and less efficient.⁵² Emergency departments are required under EMTALA to provide stabilizing care to all patients, regardless of their ability to pay or immigration status.⁵³ However, this care is limited to emergencies and does not address the long-term management of chronic conditions or preventive care, leading to repeated hospital visits and escalating healthcare costs.

Providing preventive care is significantly less costly than relying on emergency services.⁵⁴ A single visit to the emergency room for a preventable condition can cost several thousand dollars, compared to a few hundred dollars for a routine doctor's visit.⁵⁵ Thus, excluding undocumented children and pregnant individuals from Medicaid increases a state's healthcare costs by neglecting preventive measures.

2. Public Health Impact of Exclusion from Healthcare

Excluding undocumented immigrants from healthcare access poses significant risks to public health. Denying care to undocumented children and pregnant individuals escalates the risk of communicable diseases spreading within vulnerable communities.⁵⁶ By incorporating undocumented children and pregnant individuals into Medicaid, society would be better able to shoulder and reduce the spread of disease while also promoting healthier, more stable communities.

Furthermore, the exclusion of these populations exacerbates health inequities rooted in the social determinants of health. Immigrant communities

50. AM. HOSP. ASS'N, *supra* note 46.

51. See Wudan Yan, *Only One Country Offers Universal Health Care to All Migrants*, NPR (Mar. 31, 2016), <https://www.npr.org/sections/goatsandsoda/2016/03/31/469608931/only-one-country-offers-universal-health-care-to-undocumented-migrants> [<https://perma.cc/L7PC-WV6Q>]; Jean-Marie André & Fabienne Azzedine, *Access to healthcare for undocumented migrants in France: a critical examination of State Medical Assistance*, 37 PUB. HEALTH REV. 5 (2016); See *infra* Part III.B.

52. AM. HOSP. ASS'N, *supra* note 46.

53. Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1396b (2010).

54. Shirley Musich et al., *The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures*, 19 POP. HEALTH MGMT. 389 (2016).

55. AM. HOSP. ASS'N, *supra* note 46.

56. Jean Edward, *Undocumented Immigrants and Access to Health Care: Making a Case for Policy Reform*, 15 POL'Y, POL., & NURSING PRAC. 5, 8 (2014).

are disproportionately affected by barriers to healthcare access.⁵⁷ Poverty, unstable housing, limited access to nutritious food, and unsafe working conditions already place undocumented immigrant communities at a higher risk of poor health outcomes.⁵⁸ Denying undocumented children and pregnant individuals healthcare only deepens their vulnerabilities, potentially creating a public health crisis that could be avoided, and leaving immigrants with significantly worse health outcomes than their non-immigrant counterparts.

Denying Medicaid coverage also impedes the federal government's ongoing efforts to achieve health equity.⁵⁹ Numerous federal initiatives seek to reduce disparities in maternal and child health.⁶⁰ However, these reforms remain incomplete when entire communities are systematically excluded from care—and recent policy developments have only widened that gap. In 2025, the Department of Health and Human Services underwent a significant restructuring, and its proposed budget paired new funding for the “Make America Healthy Again” initiative with deep cuts to maternal health programs.⁶¹ This reprioritization underscores that federal commitment to maternal and child health equity remains uneven, and that commitment will stay unfulfilled so long as undocumented children and pregnant individuals are excluded from coverage. Addressing the gap in coverage is therefore not only a moral imperative, but a necessary step in creating a more equitable healthcare system.

3. *Individual Impact of Exclusion from Healthcare*

Access to healthcare for undocumented children and pregnant individuals is fundamental to improving their health outcomes. Comprehensive prenatal care monitors the health of both the pregnant individual and the developing child, and reduces risks such as preterm birth, low birth weight, and maternal complications.⁶² Without it, the risks rise sharply; research consistently links

57. WHO report shows poorer health outcomes for many vulnerable refugees and migrants, WHO (July 20, 2022), <https://www.who.int/news/item/20-07-2022-who-report-shows-poorer-health-outcomes-for-many-vulnerable-refugees-and-migrants> [https://perma.cc/8WPZ-6UKU].

58. See Samantha Artiga & Olivia Pham, *Addressing Health and Social Needs of Immigrant Families: Lessons from Local Communities*, KFF (Oct. 28, 2019), <https://www.kff.org/racial-equity-and-health-policy/addressing-health-and-social-needs-of-immigrant-families-lessons-from-local-communities/#19129c39-80db-4496-933f-4be87fe080d0> [https://perma.cc/XF5M-6UJG]; WHO, *supra* note 57.

59. See U.S. DEP'T OF HEALTH & HUM. SERV., SURGEON GENERAL'S CALL TO ACTION TO IMPROVE MATERNAL HEALTH (2020), <https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf> [https://perma.cc/UYX6-STCA] [hereinafter Surgeon General's Call to Action].

60. See U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTHY WOMEN, HEALTHY PREGNANCIES, HEALTHY FUTURES: ACTION PLAN TO IMPROVE MATERNAL HEALTH IN AMERICA (2020), <https://aspe.hhs.gov/topics/public-health/hhs-initiative-improve-maternal-health> [https://perma.cc/H5B7-85TP]; see also Surgeon General's Call to Action, *supra* note 59.

61. See Press Release, U.S. Dep't of Health & Human Servs., HHS Announces Transformation to Make America Healthy Again (Mar. 27, 2025), <https://www.hhs.gov/press-room/hhs-restructuring-doge.html> [https://perma.cc/8FR6-UBXL].

62. Surgeon General's Call to Action, *supra* note 59.

inadequate prenatal care to higher rates of maternal and infant mortality.⁶³ Early childhood care, which includes regular pediatric visits, vaccinations, and developmental screenings, is also critical to a child's physical, cognitive, and emotional growth during formative years.⁶⁴

While undocumented pregnant individuals may go to a hospital emergency department to deliver their child, the care is subject to serious limitations.⁶⁵ EMTALA classifies a pregnant individual experiencing contractions as an emergency medical condition, but treatment is only required *after* doctors have determined that there is not adequate time to transfer the parent to another hospital or that the transfer could endanger the "health or safety" of the parent or unborn child.⁶⁶ These rules, coupled with the ethical and economic considerations doctors will grapple with when an undocumented individual presents for care, could result in a delay of care when a pregnant individual has a critical need. Quality and immediate care for pregnant individuals during birth is essential to the continued health and wellness of both the parent and child, and delaying this care can result in negative consequences for both.⁶⁷

The consequences of denying healthcare do not end at birth. The absence of regular medical check-ups and early interventions during critical periods can lead to delays in cognitive and motor development.⁶⁸ This reality places an undue burden on not only the children and their families, but also on the entire healthcare system, which must eventually address more serious health problems that could have been prevented through early care. The constitutional guarantee of birthright citizenship for U.S.-born children, regardless of their parents' immigration status, derives from the Fourteenth Amendment's Citizenship Clause.⁶⁹ In January 2025, Executive Order 14160 sought to limit birthright citizenship for children of parents lacking lawful status; the order has been enjoined by every court to consider it, and the Supreme Court heard argument on its constitutionality in *Trump v. Barbara* on April 1, 2026, with a decision expected by summer 2026.⁷⁰

63. See Cristina Novoa, *Ensuring Healthy Births Through Prenatal Support*, CTR. FOR AM. PROG. 20 (Jan. 31, 2020), <https://www.americanprogress.org/article/ensuring-healthy-births-prenatal-support/> [https://perma.cc/Q2BX-P5R9]; see also NAT'L ACAD. SCI., ENG'G., & MED., VIBRANT AND HEALTHY KIDS: ALIGNING SCIENCE, PRACTICE, AND POLICY TO ADVANCE HEALTH EQUITY 311 (2019).

64. See Paul H. Lipkin & Michelle M. Macias, *Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening*, 145 AM. ACAD. PEDIATRICS 1, 2 (2020); see NAT'L ACADEMIES SCI., ENG'G., & MED., *supra* note 63.

65. 42 U.S.C.A. § 1395dd(e)(1).

66. *Id.* at § 1395dd(e)(1)(A)–(B)(ii).

67. Novoa, *supra* note 63.

68. Lipkin & Macias, *supra* note 64.

69. See U.S. CONST. amend. XIV, § 1; *United States v. Wong Kim Ark*, 169 U.S. 649 (1898).

70. *Trump v. Barbara*, 146 S. Ct. 879 (2025) (granting certiorari); *Trump v. Barbara (Birthright Citizenship)*, SCOTUSBLOG, <https://www.scotusblog.com/cases/trump-v-barbara/> [https://perma.cc/6MBK-SSBM] (last visited June 1, 2026).

III. ANALYSIS OF LEGAL AND POLICY FRAMEWORKS FOR MEDICAID EXPANSION

Expanding Medicaid to include undocumented children and pregnant individuals requires both legal justification and policy implementation. The constitutional foundation for expansion lies in *Plyler v. Doe*, whose equal-protection reasoning should extend from education to healthcare.⁷¹ Comparative studies reinforce the case: the healthcare systems of Thailand and France, international human-rights principles, and state-level expansions in California and Illinois all demonstrate that extending coverage to undocumented populations is both workable and beneficial.⁷²

A. The Legal Framework for Medicaid Expansion

In *Plyler v. Doe*, the United States Supreme Court held that the Equal Protection Clause of the Fourteenth Amendment applies not just to United States citizens, but to all “persons” within the jurisdiction of the United States, including undocumented immigrants.⁷³ This case established a precedent that discriminatory treatment based solely on immigration status is subject to an intermediate level of scrutiny and should be narrowly tailored to further a substantial state interest.⁷⁴ The core holding of *Plyler* was that undocumented children are entitled to equal protection under law, specifically in the context of access to public education, and denying them access to education did not further any substantial state interest.⁷⁵ The Court recognized that excluding undocumented children from basic educational opportunities—based solely on their immigration status—violated their right to equal protection.⁷⁶

The Equal Protection Clause requires that states treat individuals in similar situations alike.⁷⁷ When a state action classifies individuals based on certain characteristics, courts will apply varying levels of scrutiny: strict, intermediate, or rational basis.⁷⁸ Strict scrutiny is applied to classifications involving fundamental rights or suspect classes, such as race or national origin.⁷⁹ The state must show that the action serves a compelling state interest and is narrowly tailored to achieve that interest.⁸⁰ Intermediate scrutiny is applied to

71. See *infra* Part III.A.

72. See *infra* Part III.B.1–4.

73. *Plyler v. Doe*, 457 U.S. 202, 210–12 (1982).

74. *Id.* at 217–18; see *infra* notes 84–90 and accompanying text (explaining the tiers of constitutional scrutiny).

75. *Plyler*, 447 U.S. at 202, 230.

76. *Id.* at 221–22.

77. U.S. CONST. amend. XIV, § 1.

78. *Equal Protection*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/equal_protection [<https://perma.cc/SXY5-7JZF>] (last updated Nov. 2022).

79. *Strict Scrutiny*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/equal_protection [<https://perma.cc/GK9U-6SXS>] (last updated July 2025).

80. *Id.*

classifications such as gender or legitimacy.⁸¹ Under intermediate scrutiny, the state must show that the action serves an important government interest and is substantially related to achieving that interest.⁸² Rational basis review is applied to all other classifications.⁸³ Under this test, there must be a legitimate state interest, and it must be rationally related to the statute's goals.⁸⁴

Plyler focused solely on providing education to undocumented children. The Court considered whether Texas could deny undocumented children free public education that it also provides to citizen children.⁸⁵ The Texas legislature revised its education laws in 1975 to withhold state funds “for the education of children who were not ‘legally admitted’ into the United States.”⁸⁶ A class action suit was filed on behalf of school-aged children who were unable to establish their legal admittance into the country.⁸⁷ A district court ruled in favor of the children, deciding that the children were entitled to equal protection under the Fourteenth Amendment, and that the Texas law violated the Supremacy Clause, as immigration policy is a matter of federal authority.⁸⁸ The Fifth Circuit upheld the decision with respect to equal protection, but decided the District Court had erred regarding the Supremacy Clause.⁸⁹ The Supreme Court then granted certiorari.⁹⁰

The Court began their evaluation by determining whether undocumented children were considered “persons” for purposes of the Fourteenth Amendment.⁹¹ The Court ruled that undocumented children were “persons” in the ordinary sense, and that legal precedent had long recognized them as such.⁹² Furthermore, the Court rejected Texas’ argument that even if the undocumented children were “persons,” they were not afforded protections under the Equal Protection Clause.⁹³ The Court reiterated previous decisions, stating that the provisions of the Equal Protection Clause are universal to all persons within the borders of a State.⁹⁴

Next, the Court evaluated the nature of the burden imposed on the undocumented children and the lack of control they have over their immigration status. The Court reasoned that while undocumented status was the result of unlawful action, holding this misconduct against children, who lacked power or

81. *Intermediate Scrutiny*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/intermediate_scrutiny [<https://perma.cc/285B-N4YS>] (last updated June 2023).

82. *Id.*

83. *Rational Basis Test*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/rational_basis_test [<https://perma.cc/46TZ-2EXX>] (last updated Mar. 2024).

84. *Id.*

85. *Plyler v. Doe*, 457 U.S. 202, 205 (1982).

86. *Id.*

87. *Id.* at 206.

88. *Id.* at 207–08.

89. *Id.* at 208–09.

90. *Id.* at 210.

91. *Id.*

92. *Id.*

93. *Id.* at 211.

94. *Id.* at 212.

control over their status or how it came to be, would go against “fundamental conceptions of justice.”⁹⁵ Furthermore, it would be difficult to have a legitimate justification for imposing such a discriminatory burden on the children when they have no control over their status.⁹⁶

The Court next considered the significance of education in our society and the potential costs of denying access to education.⁹⁷ While education is not considered a right under the Constitution, the Court recognized its fundamental role in maintaining the fabric of society and reasoned that the deprivation of education would impact a child for their entire life.⁹⁸ The Court further reasoned the denial of education would be an affront to the Equal Protection Clause, as it would create an unreasonable obstacle to individual advancement.⁹⁹ Finally, the Court acknowledged that access to education benefits all of society, and preventing access to tools to better oneself negatively impacts the fabric of society.¹⁰⁰

The Court continued by determining the proper level of scrutiny to be applied, and what additional considerations were needed.¹⁰¹ The Court determined that undocumented children were not a suspect class, and that education was not a fundamental right, meaning the Texas law was not subject to strict scrutiny.¹⁰² Instead, Texas was required to demonstrate how its statute furthered a legitimate state interest to the extent necessary to overcome intermediate scrutiny.¹⁰³ Texas argued that the undocumented status of the children itself justified their exclusion from public education,¹⁰⁴ but the Court found that this reasoning did not align with any federal immigration policies and did not further Texas’ interest in preserving state resources.¹⁰⁵

Texas argued it needed to preserve resources for the education of lawful residents, but this argument was quickly dismissed by the Court.¹⁰⁶ First, there was no evidence suggesting that undocumented immigrants severely burdened Texas’ economy.¹⁰⁷ In fact, the evidence suggested that undocumented immigrants “underutilize[d] public services,” and actually contributed to the state economy through labor and taxes.¹⁰⁸ Second, the court found no support for the claim that barring undocumented children from schools improves the quality of education.¹⁰⁹ Undocumented children were considered “basically

95. *Id.* at 220.

96. *Id.*

97. *Id.* at 221–222.

98. *Id.* at 221.

99. *Id.* at 221–22.

100. *Id.* at 221.

101. *Id.* at 223–24.

102. *Id.* at 223.

103. *Id.* at 224–25.

104. *Id.* at 224.

105. *Id.* at 227.

106. *Id.*

107. *Id.* at 228.

108. *Id.*

109. *Id.* at 229.

indistinguishable” from lawful residents.¹¹⁰

Finally, the Court dismissed the idea that the transient nature of the children leads to their education not benefitting the state.¹¹¹ The Court determined there was nothing to suggest *any* child educated in the State of Texas would use their education for the benefit of another state, and that many undocumented children would likely remain in Texas indefinitely, so any alleged savings from refusing them education would be insubstantial.¹¹²

Plyler was decided under intermediate scrutiny, recognizing the unique circumstances of undocumented children and the role of education in society.¹¹³ While *Plyler* established a critical precedent for the educational rights of undocumented children, its direct application beyond K-12 education has been limited.¹¹⁴ Additionally, based on the ideological leanings of the current Supreme Court, it is difficult to say whether *Plyler* would be decided the same today. However, the underlying principles of *Plyler*, which emphasize the dangers of creating a permanent underclass and that children should not be penalized for their parents’ actions, should be applied in many other fields, including healthcare.

B. Comparative Studies

Several states and other countries have implemented policies that provide healthcare access to undocumented populations. Thailand and France both extend health care to undocumented immigrants, though care under different frameworks. International human-rights law reinforces the principle that the International Covenant on Economic, Social, and Cultural Rights treats healthcare as a fundamental right, offering a useful model for reform. California and Illinois have already expanded coverage to undocumented children and pregnant individuals using state funds alone, which demonstrates that workable models of reform already exist within the United States.¹¹⁵

1. Thailand’s Migrant Health Insurance Scheme and Migrant Fund

Only one nation provides healthcare to all, regardless of immigration status and time in-country.¹¹⁶ Thailand views healthcare as a universal right and a cornerstone of public welfare, and this influenced their broad policy on access

110. *Id.*

111. *Id.* at 230.

112. *Id.*

113. *Id.* at 217–18.

114. See *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 459 (1988) (quoting *Plyler v. Doe*, 457 U.S. 202, 239 (Powell, J., concurring)) (recognizing that *Plyler* applied only to the “unique circumstances” of undocumented children, which include (1) penalizing children for their parents’ illegal conduct, and (2) risking significant and enduring adverse consequences to the child).

115. See *infra* Part II.B.

116. Yan, *supra* note 51.

to healthcare.¹¹⁷ Thailand has a long history of relying on migrant labor, particularly from neighboring countries such as Myanmar, Cambodia, and Laos.¹¹⁸ Recognizing the need to provide healthcare access to these populations, the Thai government has implemented various health insurance schemes to cover undocumented migrants.¹¹⁹ These broad policies are a collaborative effort between the public and non-profit sectors, with the aim of caring for a vulnerable and critical population.¹²⁰ The Migrant Health Insurance Scheme (“MHIS”) and The Migrant Fund (“M-FUND”), are the insurance options available to undocumented migrants in Thailand.¹²¹

Both MHIS and M-FUND are designed to be relatively affordable for undocumented migrants. The annual premium for MHIS is approximately 11 USD for children and 49 USD for adults, making it one of the lowest-cost insurance options in the region.¹²² However, enrollees must also pay a one-time medical check-up fee ranging from 15–27 USD, which can be a financial burden for some.¹²³ M-FUND operates on a different model, financed primarily through donor contributions and individual payments rather than government support.¹²⁴ Monthly premiums range up to 10 USD, depending on the level of coverage selected.¹²⁵

Costs are low for both programs, with MHIS’s annual premium only amounting to 11 USD for children and 49 USD for adults.¹²⁶ M-FUND, being donor and contributor financed, does not cost more 10 USD a month depending on the specific coverage obtained.¹²⁷ Unlike MHIS, M-FUND does not require a lump-sum annual payment, making it even more accessible to migrants who cannot afford upfront costs.¹²⁸

Eligibility for MHIS is tied to employment status and documentation

117. *Id.*

118. *Id.*

119. See INT’L LAB. ORG., SOCIAL PROTECTION IN ACTION: BUILDING SOCIAL PROTECTION FLOORS FOR ALL, EXTENDING SOCIAL HEALTH PROTECTION IN THAILAND: ACCELERATING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE (2021), <https://www.social-protection.org/gimi/gess/gess/Media.action?id=18734> [<https://perma.cc/BL25-6WEP>]; Tuangratananon et al., *In Thailand, Noncitizen Health Matters*, THINK GLOB. HEALTH (Sep. 16, 2020), <https://www.thinkglobalhealth.org/article/thailand-noncitizen-health-matters> [<https://perma.cc/NZM3-QDLE>].

120. Yan, *supra* note 51; Tschirhart et al., *Including undocumented migrants in universal health coverage: a maternal health case study from the Thailand-Myanmar border*, 21 BMC HEALTH SERV. RSCH. 1315 (2021); Tangcharoensathien et al., *Implementing health insurance for migrants, Thailand*, 95 BULL. WORLD HEALTH ORG. 146, 147 (2017).

121. Tschirhart et al., *supra* note 120.

122. Tuangratananon et al., *supra* note 119.

123. *Id.*

124. See Nareerut Pudpong et al., *Assessment of a Voluntary Non-Profit Health Insurance Scheme for Migrants along the Thai–Myanmar border: A Case Study of the Migrant Fund in Thailand*, 16 INT’L J. ENV’T. RSCH. & PUB. HEALTH 2581 (2019).

125. *Id.*

126. Tuangratananon et al., *supra* note 119.

127. Pudpong et al., *supra* note 124.

128. *Id.*

efforts.¹²⁹ Migrants must be over 18 years old and in the process of obtaining a work permit to qualify.¹³⁰ This means that those who do not intend to legalize their status or cannot secure employment sponsorship may eventually lose access to the program. However, MHIS may also cover dependents of adults who qualify.¹³¹ In contrast, M-FUND is open to all undocumented migrants, regardless of work status.¹³² There are no residency or employment requirements, making it an easy alternative for those unable to meet MHIS criteria.¹³³ Dependents, including children, can also be covered under M-FUND for a small fee.¹³⁴

While these programs expand healthcare access beyond the norm, there are some challenges migrants might face when attempting to enroll. One of the most significant barriers is the documentation required for MHIS enrollment.¹³⁵ Undocumented migrants must begin the process of obtaining a work permit and legal presence to remain eligible.¹³⁶ In contrast, M-FUND does not require any legal status or documentation, but it is not available in every Thai province, limiting its availability.¹³⁷ However, it is available in border provinces, which are high entry points for migrants.¹³⁸

Additionally, MHIS and M-FUND are entirely voluntary, meaning that undocumented migrants are not automatically enrolled and must be proactive in obtaining coverage.¹³⁹ Because enrollment is not compulsory, some migrants remain uninsured, either due to lack of awareness, financial constraints, or distrust of government-affiliated programs.¹⁴⁰ Despite inconsistent coverage among migrant populations, both programs have improved healthcare access and migrant health in Thailand.¹⁴¹

2. France's Aide Médicale d'État Program

France also offers broad access to health insurance for undocumented immigrants through its Aide Médicale d'État program, also known as State Medical Aid ("SMA"). SMA ensures that undocumented immigrant individuals

129. INT'L LAB. ORG., *supra* note 119, at 5.

130. *Id.*

131. *Id.*

132. Pudpong et al., *supra* note 124.

133. Pudpong et al., *supra* note 124 (with no residency or employment requirements, M-FUND aims to "leave nobody behind" based on citizenship or ethnic status, which supports the move towards Universal Health Coverage).

134. *Id.*

135. INT'L LAB. ORG., *supra* note 119.

136. *Id.*

137. König et al., *The impact of the health microinsurance M-FUND on the utilization of health services among migrants workers and their dependents in Thailand: A case-control study*, 9 J. MIGRATION & HEALTH 100236 (2024).

138. *Id.*

139. Tuangratananon et al., *supra* note 119.

140. *See supra* note 119 and accompanying text.

141. König et al., *supra* note 137; Tschirhart et al., *supra* note 120.

residing in France can access health medical services without financial barriers.¹⁴² France's rationale for allowing such broad access is rooted in the recognition that "for health and humanitarian reasons," access to healthcare is required.¹⁴³ Furthermore, these moral and practical justifications both emphasize and acknowledge that denying healthcare to undocumented immigrants would not only violate basic human rights, but pose significant health risks to the entire population.¹⁴⁴

SMA is entirely free for eligible individuals, with no premiums or out-of-pocket charges.¹⁴⁵ As a public program, it is funded by the government.¹⁴⁶ To be eligible, applicants must not earn more than €756 per month and must have resided in France for at least three months.¹⁴⁷ Recipients of SMA remain enrolled for one year, after which they must reapply.¹⁴⁸ However, access to SMA is not automatic, and is instead entirely voluntary.¹⁴⁹ Thus, there is a risk that eligible individuals will not receive aid if they are unable to enroll.

Despite being free, SMA does have strict eligibility requirements that may present a barrier to entry for some individuals. The application process requires undocumented immigrants to prove their residency and income,¹⁵⁰ which could be difficult for a transient population. With the annual renewal requirement, some recipients could lose their coverage if they are unable to provide the required documentation year after year.

Even with potentially burdensome barriers to care, the SMA program's outcomes cannot be denied. SMA has significantly improved healthcare access for undocumented immigrants by ensuring they receive medical care and reducing the strain on emergency departments.¹⁵¹ The program also benefits France's public health efforts by preventing the spread of infectious diseases and allowing early treatment of chronic conditions.¹⁵²

3. *International Covenant*

International human rights law also underscores the importance of healthcare access for all. The International Covenant on Economic, Social, and Cultural Rights ("ICESCR"), adopted by the United Nations General Assembly

142. Marsaudon et al., *Patients like any others? Providing coverage to undocumented migrants in France: effects on access to care and usual source of care*, 34 EUR. J. PUB. HEALTH 1157–1162 (2024).

143. André & Azzedine, *supra* note 51; Johann Caihol et al., *French political bargaining over undocumented migrants' health*, 403 THE LANCET 140, 140 (2024).

144. JUSOT ET AL., ACCESS TO STATE MEDICAL AID BY UNDOCUMENTED IMMIGRANTS IN FRANCE: FIRST FINDINGS OF THE "PREMIERS PAS" SURVEY 2 (2019).

145. Marsaudon et al., *supra* note 142.

146. *Id.*

147. *Id.*

148. *Id.*

149. JUSOT ET AL., *supra* note 144.

150. Marsaudon et al., *supra* note 142.

151. Caihol et al., *supra* note 143; Marsaudon et al., *supra* note 142.

152. André & Azzedine, *supra* note 51; Caihol et al., *supra* note 143.

in 1966 and in force since 1976, establishes key economic, social, and cultural rights that states must realize.¹⁵³ ICESCR contains provisions regarding health and the protection of families, which establish a baseline for their treatment in each country that has ratified the agreement.¹⁵⁴

ICESCR recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” under Article 12.¹⁵⁵ Full realization of this includes taking steps to reduce the stillbirth rate, lower infant mortality, and encourage healthy development of children.¹⁵⁶ Additionally, nations must aim to improve hygiene and prevent, treat, and control diseases.¹⁵⁷ Finally, nations must ensure access to medical services and health care.¹⁵⁸ In sum, Article 12 establishes health as a fundamental human right and requires nations to work towards universal healthcare, sanitation, and access to essential medicines.¹⁵⁹

ICESCR also recognizes the protection of family as a “fundamental group unit of society” under Article 10.¹⁶⁰ It requires special assistance to be given to families, mothers, and children, including special protection for mothers before and after childbirth.¹⁶¹ Additionally, “protection and assistance” should be given to all children regardless of their “parentage or other conditions.”¹⁶² This Article stresses the importance of family stability and the protection of vulnerable groups, including children and pregnant individuals.¹⁶³

The United States has signed, but not ratified ICESCR.¹⁶⁴ Signature without ratification signals an intent to comply with the principles but does not create any obligation to implement the provisions.¹⁶⁵ Furthermore, since the United States has not ratified the ICESCR, it is not legally bound by the covenant’s provisions.¹⁶⁶ Essentially, the United States has acknowledged the importance

153. International Covenant on Economic, Social and Cultural Rights, United Nations General Assembly, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976), https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtmsg_no=IV-3&chapter=4, [<https://perma.cc/SC9S-TBYW>].

154. *Id.*

155. *Id.* at Art. 12.

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.* at Art. 10.1.

161. *Id.*

162. *Id.*

163. *Id.* at Art. 10.

164. *See Status of Treaties*, U.N. TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-3&chapter=4&clang=_en#top [<https://perma.cc/2TC5-8ECD>] (last visited Feb. 3, 2025).

165. *Glossary*, U.N. TREATY COLLECTION, https://treaties.un.org/pages/Overview.aspx?path=overview/glossary/page1_en.xml#accession [<https://perma.cc/UW6J-9A8R>] (last visited Mar. 8, 2025) A signature is a step in the ratification process but cannot bind a party to the requirements of the treaty. *Id.*

166. *Id.* (noting that ratification indicates consent to be bound to a treaty, but a “signature does not establish the consent to be bound”).

of the rights contained in ICESCR but has refrained from committing to fully implementing them and thus cannot be held accountable for lack of compliance.

4. *Comparative State-Level Actions from California and Illinois*

California has one of the most comprehensive healthcare access programs for undocumented individuals in the United States.¹⁶⁷ The state provides full Medi-Cal coverage to all children under eighteen, regardless of immigration status, if they reside in California and meet the income standards.¹⁶⁸ In recent years, California has also expanded the Medi-Cal coverage for undocumented pregnant individuals, ensuring access to healthcare during pregnancy and for a period of time after birth.¹⁶⁹ To qualify for these programs, an individual's income must be at least 138% below the federal poverty level, which amounts to approximately \$21,597 of income per year for a single person.¹⁷⁰ Furthermore, to reduce any further financial strain for those who are eligible, Medi-Cal coverage is provided free or at low-cost.¹⁷¹

Despite the broad coverage afforded by Medi-Cal, undocumented immigrants do face several barriers to enrollment. The most significant barrier is distrust of the government.¹⁷² Prior to Trump's reelection, fearing a return of stricter immigration enforcement, many undocumented immigrants were concerned about public charge rules and whether the information provided during enrollment could expose their immigration status.¹⁷³

Even with barriers to entry, there has been success in improving the health of undocumented children and pregnant individuals.¹⁷⁴ California has seen an improvement in health status for undocumented children after expansion, with

167. Paulette Cha and Patricia Malagon, In First-in-Nation State Law, All Low-Income Residents Qualify for Medi-Cal, PUB. POL'Y. INST. OF CAL. (Jan. 3, 2024), <https://www.pplic.org/blog/in-first-in-nation-state-law-all-low-income-residents-qualify-for-medi-cal/> [https://perma.cc/2GZC-XFQN].

168. SB 75 – *Medi-Cal for All Children*, DEP'T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SB75Children.aspx> [https://perma.cc/WV8M-PQ25] (last visited Feb. 3, 2025).

169. Medi-Cal Benefits, Pregnancy, DEP'T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/medi-cal/benefits/?tab=pregnancytab-4> [https://perma.cc/N7GS-CURC] (last visited June 16, 2026).

170. Eligibility by Federal Poverty Level, DEP'T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/medi-cal/qualify/qualify-for-medi-cal-eligibility-chart/> [https://perma.cc/45FE-YUN2], (last visited June 16, 2026).

171. Apply for Medi-Cal, STATE CAL., [https://perma.cc/V8KA-EBVB], last updated Nov. 21, 2024).

172. Jasmine Aguilera, *Fears Over Past Immigration Policies Chill Medi-Cal Enrollment*, CAL. HEALTH CARE FOUND. (Oct. 1, 2024), <https://www.chcf.org/resource/chilling-effect-medi-cal-enrollment-fears-over-past-immigration-policies/> [https://perma.cc/6FKU-4AJZ].

173. *Id.*

174. See Miller et al., *Covering Undocumented Immigrants: The Effects of a Large-Scale Prenatal Care Intervention*, NAT'L BUREAU OF ECON. RSCH., Working Paper No. 30299, (July 2022), https://www.nber.org/system/files/working_papers/w30299/w30299.pdf [https://perma.cc/3622-WTQU].

the proportion of undocumented children who report being in excellent health raising from 20% to 30%.¹⁷⁵ Furthermore, pregnant individuals with access to Medicaid coverage have higher rates of prenatal care, longer gestation lengths, and higher birth weights, all key indicators of a healthy pregnancy.¹⁷⁶

Illinois also provides critical coverage to undocumented children and pregnant individuals. It operates the “All Kids” Program, which provides coverage to all children in the state, regardless of immigration status.¹⁷⁷ Under All Kids, there are also two programs for pregnant individuals, regardless of immigration status: Medicaid Presumptive Eligibility (“MPE”) and “Moms & Babies.”¹⁷⁸ MPE offers immediate, but temporary, coverage for outpatient care, while Moms & Babies covers pregnant individuals while they are pregnant and for up to a year following birth.¹⁷⁹

For all Medicaid programs open to undocumented immigrants, the costs are low or nonexistent.¹⁸⁰ Under MPE and Moms & Babies, pregnant individuals are not required to pay premiums or co-payments.¹⁸¹ All Kids is free for some families, while some pay premiums and co-payments based on their income level.¹⁸² However, certain services, such as vaccinations and regular check-ups, are free for every child enrolled in All Kids, regardless of parental income.¹⁸³ The income standard for children under All Kids is approximately 318% of the federal poverty level, while the income standard for pregnant individuals is 213%.¹⁸⁴

175. Monica Saucedo & Adriana Ramos-Yamamoto, *California Sees Health Gains for Undocumented Residents After Medi-Cal Expansion*, CAL. BUDGET & POL’Y CTR. (Oct. 2024), <https://calbudgetcenter.org/resources/california-sees-health-gains-for-undocumented-residents-after-medi-cal-expansion/> [<https://perma.cc/VLK7-2ZSZ>] (drawing on 2013–2019 California Health Interview Survey data showing the share of non-citizen children reporting excellent health rose from 20% to 30% following the expansion, while citizen children saw no comparable change).

176. Miller et al., *supra* note 174.

177. *Information for Providers*, ILL. DEP’T HEALTHCARE & FAM. SERVS., <https://hfs.illinois.gov/medicalprograms/allkids/providerinfo.html>. [<https://perma.cc/R9CU-LZPA>] (last visited Oct. 10, 2024).

178. *See Moms and Babies*, ILL. DEP’T HEALTHCARE & FAM. SERVS., <https://hfs.illinois.gov/medicalprograms/allkids/momsandbabies.html> [<https://perma.cc/M5B2-4WX2>] (last visited Feb. 3, 2025) [hereinafter *Illinois Moms and Babies*].

179. *Id.*

180. *Illinois Moms and Babies*, *supra* note 178; *About All Kids*, ILL. DEP’T HEALTHCARE & FAM. SERVS., <https://hfs.illinois.gov/medicalprograms/allkids/about.html> [<https://perma.cc/6RK5-5PU4>] (last visited Feb. 3, 2025) [hereinafter *Illinois All Kids*].

181. *See Illinois Moms and Babies*, *supra* note 178.

182. *See Illinois All Kids*, *supra* note 180.

183. *Id.*

184. *Medical Programs*, ILL. DEP’T HUM. SERVS., <https://hfs.illinois.gov/medicalclients/medicalprograms.html> [<https://perma.cc/EGZ7-5WQM>] (last visited June 16, 2026).

IV. RECOMMENDATIONS FOR MEDICAID EXPANSION AND THE LEGAL AND POLICY BASIS

Ensuring Medicaid access for undocumented children and pregnant individuals requires significant reforms of the current system. These reforms are both achievable and necessary. Policymakers can expand access by amending PRWORA, expanding the ACA, and supporting interim state-level measures.¹⁸⁵ The case for these reforms draws on *Plyler*'s equal-protection reasoning, comparative and international models, and the economic and public-health benefits of inclusion¹⁸⁶

A. What Should Happen

Expanding Medicaid on a federal level requires a multi-faceted approach that addresses both legal barriers and systemic gaps. First, the government should amend PRWORA.¹⁸⁷ Amending the PRWORA to exempt undocumented children and pregnant individuals from its bar on federally funded public benefits—which currently excludes them from Medicaid coverage—would address critical gaps in healthcare access for some of the most vulnerable populations. By allowing Medicaid coverage for prenatal care and pediatric services, the federal government could ensure better health outcomes for parents and children, ultimately reducing healthcare costs by avoiding more severe health issues from developing in the future.

Second, the government should expand the ACA to provide subsidized coverage for undocumented children and pregnant individuals.¹⁸⁸ This would bridge a critical gap in the healthcare system, but recent legislation has moved in the opposite direction. The One Big Beautiful Bill Act of 2025 restricted ACA Marketplace subsidies, including for many immigrants, meaningful reform would require reversing those cuts and extending subsidized coverage to undocumented children and pregnant individuals.¹⁸⁹ Expanding access therefore remains essential. This could involve allowing undocumented immigrants to purchase insurance on ACA marketplaces, with subsidies based on income levels. Alternatively, the government could create special ACA provisions that prioritize parent and child healthcare for undocumented populations.

Thirdly, Congress should implement broader immigration reform to address the intersection of immigration status and healthcare access. Legislative proposals such as the HEAL for Immigrant Families Act should expand

185. *See infra* Part IV.A.

186. *See infra* Part IV.B.

187. *See supra* Part II.A.

188. *Id.*

189. One Big Beautiful Bill Act of 2025, Pub. L. No. 119-21 (2025); Ortaliza et al., *How Will the One Big Beautiful Bill Act Affect the ACA, Medicaid, and the Uninsured Rate?*, KFF (June 18, 2025), <https://www.kff.org/affordable-care-act/how-will-the-2025-budget-reconciliation-affect-the-aca-medicaid-and-the-uninsured-rate/> [<https://perma.cc/LG2Y-8J2Q>].

Medicaid and CHIP eligibility for undocumented immigrants.¹⁹⁰ A more comprehensive approach should integrate healthcare access into the framework of immigration reform, recognizing that the health of immigrant populations, especially children and pregnant individuals, is vital to public health and economic stability. Such reforms should include pathways to documented status for undocumented individuals while ensuring immediate access to healthcare services.

Additionally, states should follow suit and use their own funds to expand healthcare coverage for these populations. Encouraging more states to provide care for undocumented children and pregnant individuals is essential to addressing healthcare disparities. States should expand Medicaid to include undocumented children and pregnant individuals, especially in cases where federal legislation is still pending. Through executive orders, state legislation, and budget allocations, states can play a crucial role in filling gaps left by federal inaction.

While federal and state-level Medicaid reforms are essential, community health programs and state-funded safety nets can serve as temporary solutions to address the healthcare needs of undocumented children and pregnant individuals. Federally qualified health centers (“FQHCs”) and other community-based clinics already provide healthcare to underserved populations, including undocumented immigrants, often at reduced costs or for free. Expanding these programs and increasing funding for state-level safety net initiatives would help bridge the healthcare gap while longer-term reforms are pursued.

Comprehensive reform requires the integration of immigration and healthcare policies. Current immigration policies exacerbate disparities by creating barriers to access based on legal status. Policymakers should consider long-term strategies that address immigration reform and healthcare access. For example, healthcare policies could be crafted and revised to ensure that access to essential services is decoupled from immigration status, recognizing that public health is an interconnected issue that affects every person, regardless of residency or documentation.

B. Why Expansion Should Happen

Expanding Medicaid to include undocumented children and pregnant individuals is not just a compassionate policy choice—it is a necessity. The constitutional framework supports expansion, because under *Plyler* immigration status alone is not a sufficient justification for denying fundamental public services.¹⁹¹ Comparative and international experience reinforces the case, as expanded programs already in place and show that the United States is more

190. HEAL for Immigrant Families Act of 2023, H.R. 5008, 118th Cong. (2023) (proposing to expand healthcare access for all immigrants by removing barriers to coverage, recognizing that health insurance is essential in reducing inequities).

191. See *infra* Part IV.B.1.

than equipped to follow.¹⁹² And the economic and public health evidence confirms that restrictive policies only harms the economy and public health instead of protecting it.

1. Fourteenth Amendment Basis for Expansion

The Supreme Court's decision in *Plyler v. Doe* established a critical precedent for applying the Equal Protection Clause of the Fourteenth Amendment to undocumented children.¹⁹³ The Court recognized that immigration status alone is not a sufficient justification for depriving children of a service that is essential for personal development and wellbeing, particularly when such deprivation of public education would relegate them to a permanent underclass.¹⁹⁴ The same legal reasoning that protected undocumented children's right to public education under *Plyler* should extend to healthcare—an equally essential service.

The Equal Protection Clause guarantees that no state shall “deny to any person within its jurisdiction the equal protection of the laws.”¹⁹⁵ In *Plyler*, the Court held that undocumented children are “persons” within the meaning of the Fourteenth Amendment and are thus entitled to its protections.¹⁹⁶ The same principle applies in the healthcare context. Denying Medicaid coverage to undocumented children and pregnant individuals creates an unjustifiable classification that fails to further any substantial state interest.

Although the Court did not deem undocumented children a “suspect class” nor recognize education as a fundamental right, but it applied intermediate scrutiny, reasoning that undocumented children should not be penalized for their parents' actions.¹⁹⁷ The Court's logic—protecting children from bearing the consequences of their parents' immigration status¹⁹⁸—applies even more forcefully to healthcare. Unlike education, which has long-term societal benefits, healthcare is an immediate and life-sustaining necessity. Denying healthcare to undocumented children and pregnant individuals effectively imposes a preventable burden that leads to worsened outcomes, exacerbating the very inequalities *Plyler* sought to mitigate.

The *Plyler* decision recognized that denying education to undocumented children would leave them in a cycle of poverty and social disadvantage, ultimately harming the nation's economy and “fabric of society.”¹⁹⁹ Similarly, denying healthcare creates a structurally disadvantaged class of individuals who will suffer from preventable medical conditions and illness. The Court's concern in *Plyler* about the formation of a permanent underclass resonates in the

192. See *infra* Part IV.B.2–3.

193. *Plyler v. Doe*, 457 U.S. 202, 230 (1982).

194. *Id.* at 219.

195. U.S. CONST. amend. XIV, § 1.

196. *Plyler*, 457 U.S. at 210–12.

197. *Id.* at 217–18.

198. *Id.* at 219–20.

199. *Id.* at 221–22.

healthcare context: a lack of access to essential medical care ensures that undocumented children and those born to undocumented individuals will suffer from poor health throughout their lives, further marginalizing them and impeding their ability to contribute productively to society.

Furthermore, *Plyler* rejected the argument that Texas could withhold education based on fiscal constraints.²⁰⁰ The Court reasoned that undocumented immigrants, while not lawful residents, contribute to state economies, and that their exclusion did not serve a substantial state interest.²⁰¹ The same logic should apply to healthcare. Undocumented immigrants contribute significantly to the United States economy—both directly through labor and taxation and indirectly by sustaining industries that rely on immigrant labor. The exclusion of undocumented children and pregnant individuals from Medicaid is therefore not justified by cost concerns; rather, it creates inefficiencies by increasing reliance on emergency services, which are far more expensive and economically burdensome in the long term.

Plyler also emphasized that states cannot enact policies that conflict with federal immigration law or attempt to impose their own restrictions on undocumented individuals in a manner that undermines broader national interests.²⁰² Healthcare access is a matter of public welfare that extends beyond state borders, and systematically excluding undocumented populations undermines federal efforts to promote public health, prevent the spread of disease, can reduce healthcare disparities. By denying Medicaid access, states create adverse public health consequences that ultimately burden federal healthcare systems, running counter to national public health goals.

Under the *Plyler* framework, state policies that impose burdens on immigration status must be justified by a substantial state interest.²⁰³ In denying Medicaid coverage to undocumented children and pregnant individuals, the government's primary justification often rests on budgetary concerns or deterrence of immigration.²⁰⁴ However, as *Plyler* made clear, financial burdens alone do not justify the denial of fundamental services, especially when the long-term costs of exclusion outweigh the immediate savings.²⁰⁵ Similarly, deterrence-based arguments—that expanding Medicaid would incentivize undocumented immigration—fail under *Plyler* reasoning. Just as there was no evidence that granting education to undocumented children increased unlawful immigration, there is no compelling data to suggest that providing prenatal and pediatric healthcare would create a significant incentive for migration.²⁰⁶ Crucially, children—like those in *Plyler*—have no agency in their immigration status and do not migrate in pursuit of Medicaid benefits. Rather than an

200. *Id.* at 228.

201. *Id.*

202. *Id.* at 224–26.

203. *Id.* at 224–25.

204. *Id.* at 227–28.

205. *Id.* at 228.

206. Artiga & Pham, *supra* note 58.

incentive, healthcare access ensures that those already present and those soon to be born can develop into healthy, productive members of society. The Supreme Court already dismissed similar claims in *Plyler*, recognizing that denying public services does not deter immigration, just as providing them does not increase it.²⁰⁷ The vast majority of people who migrate to the United States do so for economic opportunities, family reunification, or safety from violence—not because of Medicaid eligibility.²⁰⁸ The idea that a pregnant individual in another country would uproot their life, risk their safety, and cross a border solely for the *possibility* of healthcare coverage assumes a level of foresight, planning, and risk-taking that is simply not borne out by immigration data.

If healthcare access was truly a driving factor for immigration, we would see significant undocumented migration to states that have already expanded Medicaid to undocumented populations, such as California and Illinois, yet there is little to no evidence to support that claim.²⁰⁹ Immigration patterns are shaped by far broader economic and political factors than the availability of medical care.²¹⁰ The claim that Medicaid expansion would create a flood of undocumented migration is nothing more than a scare tactic designed to avoid engaging with the real benefits of expansion.

The reasoning behind *Plyler* is not confined to education—it is a broader reaffirmation that the Equal Protection Clause does not permit states to arbitrarily exclude undocumented children from essential public services when doing so would impose significant harm. The same fundamental principles of justice and fairness that underpinned the *Plyler* decision demand that Medicaid be expanded to include undocumented children and pregnant individuals. Just as education ensures that children can become productive members of society, healthcare ensures their very survival and well-being. This requires that pregnant individuals also receive healthcare, since the children they carry also had no say in their status and deserve the chance to become productive and healthy members of society.²¹¹

By applying *Plyler*'s precedent, policymakers have a clear legal basis for Medicaid expansion: undocumented children and pregnant individuals are entitled to equal protection under the law, and states cannot justify their exclusion from vital healthcare programs without a substantial state interest.²¹² Given that the economic, public health, and ethical justifications

207. *Plyler*, 457 U.S. at 228.

208. *Id.* (recognizing that employment opportunities, not the availability of public benefits, are the dominant incentive for immigration); see *supra* Part II.B.

209. Vasil Yassenov et al., *States' Medicaid Expansion Counters the "Welfare Magnet" Argument*, IMMIGR. POL'Y LAB, <https://immigrationlab.org/project/states-medicaid-expansion-counters-welfare-magnet-argument/> [<https://perma.cc/9YDR-9EEA>].

210. See *supra* Part II.B.

211. Furthermore, under conservative rhetoric, life begins at conception. If life begins at conception, then despite the current administration's attempt at dismantling birthright citizenship, these unborn children will one day be United States citizens and should receive all benefits of their status.

212. See *supra* Part IV.B.1.

overwhelmingly support inclusion, there is no legitimate basis for continuing the deny Medicaid coverage to such a vulnerable population.

Expanding Medicaid is not just a compassionate policy—it is a constitutional imperative under the Equal Protection Clause. The United States has long struggled with healthcare inequities, and refusing care to those most in need only exacerbates systemic disparities. As *Plyler* recognized, our country's commitment to fairness and opportunity must extend to all individuals, regardless of their immigration status. Medicaid expansion for undocumented children and pregnant individuals is not only legally sound, but essential to upholding the principles of justice, human dignity, and public welfare that *Plyler* sought to protect.

2. Internationally Recognized Human Right

The United States prides itself on being a global leader in human rights and innovation, yet it lags behind not only peer nations, but some of its own states in providing healthcare access to undocumented children and pregnant individuals. By continuing to exclude these vulnerable populations from Medicaid, the United States isolates itself from the well-established global understanding that healthcare is a fundamental right and a necessity for a stable society. If nations with fewer economic resources can recognize the moral and practical necessity of providing healthcare to all residents, regardless of immigration status, the United States has no legitimate justification—or excuse—for failing to do the same.

Beyond economic and practical considerations, the United States is also failing to meet its obligations under international human rights standards. The ICESCR, which the United States has signed, affirms that healthcare is a fundamental human right.²¹³ While the United States has not ratified the treaty, its signature signals an acknowledgment that healthcare access should not be arbitrarily restricted based on immigration status. Article 12 of the ICESCR explicitly calls for access to maternal and child healthcare as part of the right to health.²¹⁴ Article 10 recognizes that children and pregnant individuals require special protections and denying them healthcare contradicts these principles.²¹⁵ By refusing to extend Medicaid to undocumented children and pregnant individuals, the United States is violating not only the spirit of the ICESCR but also its own professed commitment to human rights and public health. If the United States expects to maintain credibility in advocating for human rights and decency on a global level, it cannot continue policies that deny essential services to the most vulnerable residents within its own borders. Failing to provide healthcare access to undocumented children and pregnant individuals is not just an economic and public health failure—it is a moral and international

213. See *supra* Part III.B.3 (discussing the ICESCR and its treatment of healthcare as a fundamental right).

214. See *supra* Part III.B.3 (discussing ICESCR Article 12).

215. See *supra* Part III.B.3 (discussing ICESCR Article 10).

embarrassment.

In many developed nations, the debate over whether undocumented individuals should receive healthcare has long been settled in favor of inclusion. Countries like France and Thailand have recognized that denying healthcare to vulnerable populations is not only ethically indefensible, but also economically and socially counterproductive.²¹⁶ These countries have adopted policies ensuring that all individuals, regardless of immigration status, receive healthcare because they understand the broader consequences of exclusion: increased healthcare costs, worsened public health outcomes, and the erosion of social cohesion. The United States, by contrast, continues to tie healthcare access to immigration status, a policy choice that actively works against its own interests. By denying healthcare to undocumented children and pregnant individuals, the United States is not saving money—it is guaranteeing higher long-term costs through preventable emergency room visits, increased parent and infant mortality, and an overall sicker population that will still require medical attention, but in the least efficient and most expensive way possible. If nations with fewer resources can afford to provide healthcare to undocumented children and pregnant individuals, why does one of the wealthiest nations in the world insist it cannot? The answer is not about feasibility—it is about political will and a refusal to acknowledge that exclusionary policies create more harm than they prevent.

Opponents of Medicaid expansion argue that providing healthcare to undocumented individuals places an undue financial burden on the system; however, comparative models show that the opposite is true. Thailand's MHIS and France's AME program illustrate that integrating undocumented populations into healthcare systems is not an economic drain, but rather, a cost-saving measure.²¹⁷ Thailand, despite being a developing nation, has recognized that early intervention and preventive care are far cheaper than emergency treatments, which has driven Thailand's expansion of health coverage to migrants regardless of status.²¹⁸ France has also avoided the inefficiencies of exclusionary healthcare policies by ensuring that undocumented individuals receive regular medical care, reducing the strain on emergency rooms and overall healthcare costs.²¹⁹

In stark contrast, the United States' model forces undocumented children and pregnant individuals into the most expensive form of care: emergency treatment. Under EMTALA, hospitals are required to treat anyone who comes through their doors, meaning the federal government is already subsidizing care

216. See *supra* Part III.B.1–2 (discussing Thailand's and France's healthcare programs for undocumented immigrants).

217. INT'L LAB. ORG., *supra* note 119; André & Azzedine, *supra* note 51.

218. König et al., *supra* note 137; Tschirhart et al., *supra* note 120.

219. Caihol et al., *supra* note 143; Marsaudon et al., *supra* note 142.

for undocumented children and pregnant individuals.²²⁰ However, it is doing so in the least efficient, most expensive way possible.²²¹ Expanding Medicaid would not create a new financial burden; it would shift existing, uncontrolled costs into a structured, preventive system that is far more effective and less expensive.

3. *Economics of State-Level Successes*

The United States does not need to speculate whether expanding Medicaid for undocumented children and pregnant individuals would be economically viable because state-level experiments have already proven its success. Several states have already done what the federal government refuse to do: recognize that providing healthcare to undocumented children and pregnant individuals is both a moral imperative and a policy necessity. California and Illinois have expanded Medicaid access for these populations, and their experiences dismantle the primary arguments against federal expansion. California's Medi-Cal expansion has led to higher rates of prenatal care, improved birth outcomes, and increased reports of good health among undocumented children—all without crippling the state's budget.²²² If California, a lone state subsidizing this program on its own, can sustain this program, why should the federal government be unable to do so? Illinois' "All Kids" and maternity coverage programs have also prevented emergency healthcare crises and reduced state costs by ensuring that pregnant individuals receive necessary prenatal care.

These programs serve as clear evidence that investing in preventive healthcare for undocumented populations yields significant public health and economic benefits. If state-level expansions do not cause the financial devastation that critics predict, then the federal government's refusal to act is not based on economic concerns, but on an unwillingness to extend the same logic on a national scale. Medicaid expansion for undocumented children and pregnant individuals is not an untested or radical proposal. It is a proven model that some of the country's most economically powerful states have already implemented with success.²²³

The global and state-level evidence is clear: providing healthcare to undocumented children and pregnant individuals is not a matter of feasibility but of political will. Other nations, including those with fewer resources than

220. See *Understanding EMTALA*, AM. COLL. EMERGENCY PHYSICIANS [<https://perma.cc/H5NQ-QZN6>] (last visited Mar. 8, 2025) (If not subsidized by government payouts, then providers are not receiving any compensation for their services, further increasing healthcare costs for everyone else).

221. See *supra* Part II.C.1.

222. See *supra* Part III.B.4 (discussing California's and Illinois's Medicaid expansions and their health outcomes).

223. See *California's Economy (2026)*, PUB. POL'Y INST. OF CAL., <https://www.pplic.org/publication/californias-economy/> [<https://perma.cc/EES5-DDA2>] (last visited June 1, 2026) (reporting California's 2025 GDP of \$4.3 trillion, roughly 14% of national GDP, ranking among the world's largest economies).

the United States, have recognized that healthcare access must extend to all residents, regardless of immigration status. State-level programs in California and Illinois have proven that Medicaid expansion for undocumented populations leads to better health outcomes and is economically feasible. Furthermore, exclusionary policies violate international human rights standards and place the United States at odds with global themes of healthcare as a basic right. The United States can no longer afford to perpetuate a policy that increases healthcare costs, worsens public health outcomes, and undermines its own principles.

The decision to exclude undocumented children and pregnant individuals from Medicaid is not merely an oversight—it is a deliberate policy failure that prioritizes ideology over evidence and political expediency over public health. The current system forces hospitals, taxpayers, and communities to absorb the financial and human costs of preventable medical crises while denying healthcare to those who need it most. This approach is not only irrational, but self-defeating. If the goal of a healthcare system is to protect the health of a population while controlling costs, then restricting access to essential care for undocumented children and pregnant individuals accomplishes the exact opposite. The refusal to expand Medicaid ignores the reality that denying care today creates exponentially higher costs tomorrow—costs borne not by undocumented individuals alone, but by every person who shares their schools, workplaces, and communities.

Some states may challenge a federal mandate to expand Medicaid, citing concerns about federal overreach and state sovereignty. Legal challenges could arise on the grounds of federalism, with states arguing that they should retain control over Medicaid eligibility. However, such challenges would face significant legal hurdles. The federal government has broad authority under the Spending Clause of the Constitution to impose conditions on federal funding programs, such as Medicaid. Additionally, while the Supreme Court's decision in *Sebelius* allows states to opt out of Medicaid expansion under the Affordable Care Act,²²⁴ this ruling does not preclude the possibility of federal incentives or a narrower expansion targeting undocumented pregnant individuals and children.

While the Supreme Court's ruling in *Sebelius* declared expansion could not be compulsory, as that would amount to coercion, it did not strip the federal government of its power to encourage expansion through funding mechanisms. The ruling did not establish a constitutional prohibition on federal Medicaid expansions; rather, it determined that the federal government could not penalize states by withholding existing Medicaid funding if they refused expansion.²²⁵ This distinction is crucial. The federal government retains the power to offer incentives, set new conditions for funds, and create specific Medicaid categories that states can voluntarily adopt.

224. Nat'l Fed'n of Indep. Bus. v. *Sebelius*, 567 U.S. 519 (2012).

225. *Id.* at 589.

Additionally, a targeted expansion focused on undocumented children and pregnant individuals is distinct from the broad ACA expansion. The *Sebelius* decision was based in part on the argument that the ACA expansion was so dramatic that it effectively rewrote the Medicaid program.²²⁶ A more narrowly tailored expansion, such as one aimed at providing prenatal and pediatric care, does not fundamentally alter Medicaid the same way, and is less likely to be viewed as coercive. The federal government could craft an incentive-based approach that avoids the coercion concerns raised in *Sebelius*, while still encouraging nationwide adoption.

Moreover, the financial argument against Medicaid expansion collapses under the weight of real-world evidence.²²⁷ While there is an upfront investment that will be required, refusing to expand based on this cost is shortsighted since the long-term benefits outweigh the initial cost, especially when considering how uncompensated care would be reduced.²²⁸ Additionally, states like California and Illinois have already expanded Medicaid to undocumented children and pregnant individuals, and the results contradict the claim that such policies would be fiscally unsustainable. These states have seen improved outcomes, proving that investment in early care leads to greater savings over time. The economic reality is clear: when Medicaid expands, costs go down, not up.

4. Public Health Basis for Expansion

A society's health is only as strong as its most vulnerable members. Excluding undocumented children and pregnant individuals from Medicaid is not a private crisis, but a public health disaster in the making. Infectious diseases do not check immigration status before spreading through a community. An undocumented child who cannot receive regular pediatric care does not simply suffer alone; their illness creates greater risks for classmates, teachers, and neighbors. A pregnant individual who is denied prenatal care does not merely put their own health at risk, but increases the risks to the child, both in the womb and outside it with lifelong complications. The consequences of excluding undocumented children and pregnant individuals from Medicaid extends far beyond their own lives, creating a domino effect of worsening health outcomes for every person.

The notion that public health can be compartmentalized—that denying healthcare to one group does not affect the broader population—is a dangerous

226. *Id.* at 583–84.

227. See Jesse Cross-Call, *Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics' Claims*, CTR. ON BUDGET AND POL'Y PRIORITIES (Oct. 9, 2018), <https://www.cbpp.org/research/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims>. (Expansion results in net savings for state budgets since states do not have to spend as much on uncompensated care and other costs).

228. See Bryce Ward, *The Impact of Medicaid Expansion on States' Budgets*, COMMONWEALTH FUND (May 5, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets>.

and deeply flawed assumption. Due to the COVID-19 pandemic, we have already seen what happens when preventable diseases go unchecked, when populations are left vulnerable, and when emergency rooms become the default healthcare provider for people who should have received basic preventive care. When millions of people are excluded from care, diseases spread faster, hospitals become overwhelmed, and communities suffer. Yet despite these lessons, the United States continues to impose arbitrary barriers to Medicaid for undocumented children and pregnant individuals, as if their suffering exists in isolation. Public health is a collective endeavor, and every barrier to care weakens the entire system.

Opponents of Medicaid expansion often claim that covering undocumented individuals would be too expensive, yet this argument ignores the simple economic fact that treating preventable conditions early is far cheaper than waiting until they become medical emergencies. The United States already pays for undocumented individuals' healthcare—but in the most inefficient and expensive way possible. Hospitals cannot legally turn away patients in emergency situations, which means that when undocumented children and pregnant individuals are denied primary care, they inevitably end up in emergency rooms, where treatment costs skyrocket. The government and hospitals absorb these costs, and rather than investing in cost-saving preventive care through Medicaid, they simply pass the burden on.

The numbers make the case even stronger. A single emergency room visit for an untreated infection, a preventable complication in pregnancy, or an unmanaged chronic disease can cost thousands of dollars—often far more than the cost of ongoing primary care would have been. Hospitals cannot afford to absorb these costs indefinitely, so an alternative must be found and implemented.

5. Workforce Stability Benefits from Expansion

Beyond healthcare costs, denying Medicaid to undocumented individuals creates an economic liability that extends beyond the hospital and into the workforce. The United States depends on undocumented labor to sustain critical industries. These workers contribute billions of dollars to the economy, yet they are systematically denied access to healthcare, which weakens the very workforce that keeps the country running. A sick worker is a less productive worker.²²⁹ A parent who must choose between going to work and caring for a sick child—because that child could not get basic medical care—is a parent that contributes less to the economy. The economic harm of this policy is not theoretical—it is already happening.

A healthcare system that actively undermines the well-being of a critical

229. This author feels it necessary to note that no individual should have their value based on their economic worth, but due to the current political landscape and the unerring dedication to capitalism in the United States, it is an argument that must be used.

labor force is a system that undercuts its own economic stability. Expanding Medicaid is not just a public health imperative; it is an investment in the country's workforce. Healthier workers ultimately benefit businesses, tax revenues, and economic growth. The refusal to provide healthcare to undocumented children and pregnant individuals is not saving money—it is costing the United States billions of dollars in lost productivity and preventable absenteeism. The economic choice is not between providing or not providing healthcare; it is between paying for preventive care now or paying more for lost labor and emergency treatments later.

The only thing standing in the way of Medicaid expansion is political inertia and an unwillingness to acknowledge that healthcare is not a privilege reserved for those with the right papers, but a necessity for any functioning society. The question is no longer whether Medicaid expansion should happen, but how much longer the country is willing to pay the price for failing to act. Every day of inaction is another day of unnecessary suffering, higher costs, and preventable deaths. The time to expand Medicaid is not tomorrow, not in some distant future when politics align—it is now. To do anything less is to choose inefficiency, economic waste, and human neglect over the benefits of inclusion.

V. CONCLUSION

The recognition of personhood under the Constitution demands that undocumented individuals, particularly vulnerable groups like children and pregnant individuals, be treated with dignity and fairness. Excluding them from healthcare access contradicts this principle and disregards the foundational values of equality and opportunity of American society. Ensuring access to healthcare is not just a matter of individual wellbeing; it reflects a commitment to societal cohesion, economic stability, and the prevention of systemic inequities.

The exclusion of undocumented populations from essential healthcare services creates ripple effects that extend beyond individual harm. Preventable diseases, untreated conditions, and complications from inadequate prenatal care result in greater reliance on emergency services, higher long-term healthcare costs, and intergenerational impacts on health and economic mobility. These outcomes are not only morally troubling but also fiscally shortsighted. A system that prioritizes emergency care over prevention imposes unnecessary costs on taxpayers and weakens the collective health of society.

While the legal and ethical arguments for reform are clear, the broader benefits of inclusivity are equally compelling. International examples demonstrate that providing broad healthcare access benefits everyone, not just the privileged. Similarly, state-level initiatives show that expanding coverage to undocumented individuals is both feasible and beneficial, offering models for broader policy adoption. These examples underscore the practicality of reform and the tangible rewards of investing in equitable healthcare policies.

Now is the time to move beyond reactive and exclusory healthcare policies

and embrace a more inclusive system that addresses both public health needs and economic efficiency. By expanding Medicaid, the United States can achieve long-term savings, reduce the strain on emergency healthcare systems, and improve the health of entire communities. Efforts by the current administration to dismantle Medicaid threatens not only undocumented individuals, but millions of low-income Americans who rely on it for essential care. Instead of eliminating or further restricting Medicaid, policymakers must strengthen and expand it to ensure that it continues to fulfill its role as a crucial safety net.

The moral and ethical imperatives are equally clear: healthcare is a basic human right. As the United States grapples with persistent healthcare inequities, policymakers must act with both compassion and pragmatism. Denying healthcare to individuals—especially to children and pregnant individuals—because of their immigration status undermines the nation’s commitment to equity and justice. Expanding Medicaid to these populations is about more than money and government; it’s about recognizing the inherent dignity and humanity of every person within our borders.

Policymakers must prioritize federal reforms, such as amending the PRWORA and expanding the ACA to undocumented populations. Simultaneously, state governments must continue leading the way, drawing inspiration from successful initiatives in California and Illinois to create Medicaid expansions tailored to the needs of these vulnerable groups. These efforts underscore the broader values of fairness and public responsibility, emphasizing that healthcare is a necessity for all individuals living within the United States. Expanding Medicaid to undocumented children and pregnant individuals is a critical step toward building a healthier, more equitable society for all. Now is the time to act, ensuring that the most vulnerable among us have access to the care they need and deserve.