2024

Charity Care for All: State Efforts to Ensure Equitable Access to Financial Assistance for Noncitizen Patients

Medha D. Makhlouf
Penn State Dickinson Law, mdm5849@psu.edu

Recommended Citation

Medha D. Makhlouf, *Charity Care for All: State Efforts to Ensure Equitable Access to Financial Assistance for Noncitizen Patients*, 23 *Houston Journal of Health Law and Policy* 55 (2024).

23(1) Hous. J. Health L. & Policy 55

Houston Journal of Health Law & Policy

CHARITY CARE FOR ALL: STATE EFFORTS TO ENSURE EQUITABLE ACCESS TO FINANCIAL ASSISTANCE FOR NONCITIZEN PATIENTS

Medha D. Makhlouf*

* Elsie de R. and Samuel P. Orlando Distinguished Professor, Professor of Law, and Director of the Medical-Legal Partnership Clinic, Penn State Dickinson Law.

I am grateful to Jessica Mantel for inviting me to participate in this Journal's 11th annual symposium, and for feedback received from other participants in the symposium. I also received helpful comments from participants in the Migration and Diversity Initiative Paper Workshop at Penn State and from my clinic students. I thank the Journal staff, especially Lizzy Do, for their suggestions to improve the Article.

ABSTRACT

Non-profit hospitals have long been required to provide certain benefits to the community in which they reside in order to maintain tax-exempt status. The nature of these community benefits has evolved since the mid-twentieth century, but "charity care"—free or discounted care for patients who are unable to pay for it—is the quintessential hospital community benefit. Although the Patient Protection and Affordable Care Act of 2010 (ACA) extended eligibility for subsidized health coverage to many more people living in the United States, some noncitizens—including those without a valid immigration status—were excluded. As a result, this group is disproportionately likely to need financial assistance to afford health care because they lack insurance. However, some hospitals exclude noncitizens from eligibility for charity care because of their immigration status.

This Article explores the development of prohibitions against discrimination on the basis of immigration status in hospital charity care programs in certain states and the relative inaction by the majority of the states and the federal government. When non-profit hospitals exclude patients from charity care on the basis of immigration status, they contribute to health care inequity among noncitizens—the population in the United States least likely to have access to health care. These actions contravene the longstanding tradition of non-profit, tax-exempt hospitals providing benefits to the community of people living in the geographic areas from which the hospitals draw their patients. Congress, state legislatures, and hospitals themselves are in a position to prohibit discrimination in charity care programs; failure to act further entrenches the exclusion of noncitizens from the threadbare health care "safety net" and perpetuates inequity in access to health care for noncitizens.

INTRODUCTION

Non-profit hospitals receive a great financial benefit from their communities in the form of federal and state tax exemptions and, in theory, are expected to make a roughly equivalent contribution to the community's health. "Charity care" [1]—discounts on or waivers of medical costs for patients who cannot afford to pay their hospital bills because they are uninsured or underinsured[2]—accounts for a majority of hospital community benefit provision.[3] Over time and changes in the law, charity care and other uncompensated care have remained the major category of hospital community benefits.[4] Given that non-profit

---

[1] When hospitals report on their provision of community benefits, they must designate charity care (financial assistance) separately from other uncompensated care like Medicaid shortfalls or bad debt, i.e., when patients fail to pay but do not apply or qualify for charity care. *See* I.R.S., INSTRUCTIONS FOR SCHEDULE H (FORM 990) 2 (2022); *see also* Ge Bai et al., *Charity Care Provision by US Nonprofit Hospitals*, 180 JAMA INTERNAL MED. 606, 606 (2020) ("[C]harity care differs fundamentally from uncompensated care or bad debt because there is no expectation that patients will pay for the services."). Hospitals typically include in the category of uncompensated care services rendered to patients with Medicaid or Medicare, because these publicly funded programs reimburse hospitals at rates lower than private insurance. *See* Mary Crossley et al., *Tax-Exempt Hospitals and Community Health Under the Affordable Care Act: Identifying and Addressing Unmet Legal Needs as Social Determinants of Health*, 131 PUB. HEALTH REPS. 195, 196 (2016); John D. Colombo, *The Role of Access in Charitable Tax Exemption*, 82 WASH. U. L.Q. 343, 368-69 (2004) ("Since the early 1980s both private insurers and the government under Medicare and Medicaid have squeezed reimbursement rates for services to virtually eliminate the possibility that hospitals and other health care providers could use profits generated by reimbursements to these covered patients to subsidize services to the uninsured."). Under certain circumstances, a hospital can include bad debt in its provision of community benefits. *See* I.R.S., INSTRUCTIONS FOR SCHEDULE H (FORM 990) 5 (2022) (requesting that hospitals report their combined bad debt expense and "provide a rationale for what portion of bad debt, if any, the organization believes is community benefit").

[2] "Underinsured" refers to the condition of having "high health insurance plan deductibles, limited insurance coverage, or high out-of-pocket expenses relative to their income." ANDREA BOPP STARK & JENIFER BOSCO, NAT'L CONSUMER L. CTR., AN OUNCE OF PREVENTION: A REVIEW OF HOSPITAL FINANCIAL ASSISTANCE POLICIES IN THE STATES 7 (2021). Charity care provided to underinsured patients discounts or waives their deductibles and/or coinsurance payments. Ge Bai et al., *supra* note 1.

[3] Hospitals report that the value of charity care provision and uncompensated care from Medicaid shortfalls combined exceeds 80 percent of the value of community benefits they provide. Simone R. Singh et al., *State-Level Community Benefit Regulation and Nonprofit Hospitals' Provision of Community Benefits*, 43 J. HEALTH POL., POL'Y & L. 229, 231-32 (2018).

[4] *See* Austin J. Hilt, *Evolving Roles of Health Care Organizations in Community Development*, 21 AMA J. ETHICS 201, 201-202 (2019); Hannah R. Sullivan, *Hospital Obligations to Address Social Determinants of Health*, 21 AMA J. ETHICS 248, 250 (Mar. 2019) (citing Rosenbaum et al.); Crossley et al., *supra* note 1.

hospitals claim that they provide community benefits valued at $62.4 billion per year, charity care should be considered a critically important source of health care for the uninsured.[5]

The Patient Protection and Affordable Care Act of 2010 (ACA) expanded subsidized health insurance to many more people living in the United States, which would presumably decrease the number of uninsured people and, relatedly, the need for hospitals to provide charity care. In line with this expectation, policymakers expected that hospital provision of community benefits relating to community health initiatives addressing social determinants of health would increase.[6] At the same time, the ACA imposed new obligations on hospitals regarding the establishment and publicization of charity care policies and introduced a new requirement for hospitals to conduct periodic Community Health Needs Assessments (CHNA) to guide their provision of community benefits.[7] Although the ACA decreased the number of uninsured people overall, it exacerbated an existing disparity in insured status between U.S. citizens and noncitizens because it both (1) maintained existing restrictions on noncitizen eligibility for Medicaid and (2) barred noncitizens with precarious or no legal status from purchasing insurance on the new health insurance exchanges.[8] Noncitizens are now "significantly more likely than citizens to be uninsured," with 25% of lawfully present noncitizens and 46% of undocumented noncitizens uninsured compared to 8% of U.S. citizens.[9] Despite this fact,

---

[5] *See* Erik Bakken & David Kindig, *Does Nonprofit Hospital Community Benefit Vary by State?*, 21(1) J. PUB. HEALTH MGMT. PRAC. 1, 5 (2015); Crossley et al., *supra* note 1, at 196.

[6] Singh et al., *supra* note 3, at 232. At that time, less than eight percent of hospital provision of community benefits were for community health improvement activities or "community-building efforts that improve health." Crossley et al., *supra* note 1, at 196.

[7] Singh et al., *supra* note 3, at 231.

[8] The reasons for the exclusion of many noncitizens from these benefits in the ACA were political. Although initial drafts of the bill contemplated expanding eligibility for subsidies to undocumented noncitizens, this idea was quickly abandoned as a political concession. *See* Bonnie Jerome-D'Emilia & Patricia D. Suplee, *The ACA and the Undocumented*, 112 AM. J. NURSING 21, 21, 26 (2012) ("The primary goal of the ACA is to extend the benefits of insurance to the largest (politically acceptable) population at this time, and as such its passage was momentous.").

[9] *Health Coverage and Care of Immigrants*, KAISER FAM. FOUND. (Dec. 20, 2022), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

some hospitals exclude certain noncitizens from eligibility for charity care.[10]

When non-profit hospitals exclude patients from charity care on the basis of immigration status, they contribute to health care inequity among noncitizens—the population in the United States least likely to have access to health coverage.[11] Most noncitizens are not eligible for subsidized health insurance on the same terms as U.S. citizens; they are excluded in the complex web of laws governing noncitizen eligibility for public benefits.[12] Many scholars have warned of "the danger of a health care system that leaves some members of society out," especially but not exclusively in the context of a global pandemic that poses health risks to all.[13]

In addition, medical debt is debilitating to the financial security and emotional and physical health of low-income patients and may be uniquely debilitating for noncitizen patients.[14] Media coverage of hospitals' billing practices have revealed their aggressive tactics, including "repeated calls, notices, lawsuits, liens on [] property, and/or wage garnishments."[15] On average, wage garnishments in such suits net

---

[10] *See id.*; *see* BOPP STARK & BOSCO, *supra* note 2, at 8.

[11] *See* BOPP STARK & BOSCO, *supra* note 2, at 11 (noting that "[f]air and equitable implementation of the law is necessary . . . so that assistance reaches eligible patients including low-income immigrants and people of color.").

[12] *See* Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235, 241-247 (2019); BOPP STARK & BOSCO, *supra* note 2, at 8 (including "documented immigrants" among those who are likely to be underinsured and uninsured because of exclusions from eligibility for Medicaid or other subsidized insurance). A handful of states have expanded access to subsidized health insurance for low-income noncitizens using state funds only. The programs in those states vary in terms of coverage and costs, but states generally strive to fill the gaps in access to care by providing all state residents with Medicaid-like insurance. Medha D. Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants,* 95 N.Y.U. L. REV. 1680, 1722-1726 (2020).

[13] Rachel Fabi & Lilia Cervantes, *Undocumented Immigrants and COVID-19: A Call for Federally Funded Health Care*, 2 JAMA HEALTH F. e212252 (2021); *see also* Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, *supra* note 12, at 1731-52 (explaining how excluding noncitizens from subsidized health coverage contravenes the two key goals of the last national health reform, equity and cost-effectiveness); Makhlouf, *Health Justice for Immigrants, supra* note 12, at 295-301 (arguing that the ethical norms underlying access to health care support the inclusion of noncitizens in subsidized health coverage).

[14] *See* Lisa Sun-Hee Park, *Medical Deportations and Racial Narratives of the Burdensome Migrant*, 66 AM. BEHAV. SCIENTIST 1627, 1637-38 (2022) (describing the "well-worn moral narrative" internalized by migrants that having medical debt is a sign of their irresponsibility or ignorance).

[15] BOPP STARK & BOSCO, *supra* note 2, at 9.

$2,500, a great burden for workers earning minimum or low wages who often have no savings or wiggle room in their budgets.[16] In addition, noncitizens typically seek to avoid surveillance by government institutions, fearing that scrutiny may have negative immigration consequences.[17] Lawsuits for unpaid medical debt are a concern because they risk revealing a noncitizen's lack of or precarious status, thus threatening their ability to remain in the United States.

Excluding patients from charity care based on their immigration status contravenes the longstanding tradition of non-profit, tax-exempt hospitals providing free or discounted care to needy people living in the geographic areas from which the hospitals draw their patients. Tax agencies' failure to sanction such hospitals implicitly undermines the conception of "community" in the Community Health Needs Assessment introduced in the ACA because it endorses an arbitrarily limited conception of community, precisely excluding noncitizen members of the community who may be most affected by barriers to accessing health care.

Only a handful of states expressly prohibit hospitals from discriminating against noncitizens in charity care programs and the federal government has not sought to do so.[18] Due to extreme political polarization in Congress, it is unlikely that federal legislation could be enacted to prohibit non-profit hospitals from discriminating against patients on the basis of immigration status in their charity care programs, which could be made a condition of maintaining federal tax exemption. However, state legislatures could enact similar prohibitions on discrimination for all hospitals as a condition of maintaining their licenses. Strategically, it would be wise to include such a reform within a broader package of reforms making charity care more accessible to low-income patients. A recent report revealed that the lack of regulation of charity care in most states leaves most non-profit hospitals "free to create bare-bones policies that provide little assistance, leaving

---

[16] *Id.* (noting that a study found that patients having wages garnished by Virginia hospitals commonly worked at Walmart, Lowe's, and Amazon).

[17] Sheryl James, *Undocumented Immigrants' privacy at risk online, on phones*, UNIV. MICH. SCH. INFO. (Apr. 6, 2018), https://www.si.umich.edu/about-umsi/news/undocumented-immigrants-privacy-risk-online-phones.

[18] BOPP STARK & BOSCO, *supra* note 2, at 11.

many low-income patients with no aid at all."[19] Reporting on billing practices at hospitals in Virginia and Tennessee revealed that twenty-five to fifty percent of medical debt was held by patients who were eligible for charity care but unaware that it was available.[20]

Several studies have examined the relationship between state-level regulation of hospital community benefits and hospitals' design and implementation of community benefit activities,[21] but none have focused on state-level prohibitions on discrimination against noncitizens in charity care. While this Article does not perform this assessment, it reasonably assumes that hospitals currently discriminating against noncitizens in charity care programs—of which there are a significant number, as reported in the media and by advocacy groups—would eliminate discriminatory eligibility criteria in response to a state law barring them.[22] The impact would be expanded access to charity care for noncitizens in that state. Even if it is not required by state or federal law, non-profit hospitals should consider meeting the needs of noncitizen communities in their service areas by ensuring that immigration status is not a criterion of eligibility for their charity care programs.

Part I begins with a historical overview of charity care provided by hospitals. It describes the evolution of non-profit hospitals' duty to provide benefits to their communities under federal law before describing state regulation of hospital community benefits. Part II provides background on the problem of the exclusion of patients from hospital charity care policies based on immigration status. It describes the gap in federal law and policy relating to discrimination against noncitizens in hospital charity care and analyzes the development of

---

[19] *Id.* at 9-10.

[20] *Id.* at 10.

[21] *See* Singh et al., *supra* note 3, at 229 (describing studies of the impact of various community benefit regulations on hospital engagement in "community-oriented activities" and hospital provision of community benefits).

[22] Enforcement of the law would, of course, affect compliance. Although scholars and policy-makers have called for stricter enforcement of community benefit requirements, enforcement has generally remained lax. *See, e.g.*, Geri Rosen Cramer et al., *Hospitals and Community Benefit Requirements: Perspectives of Community Benefit Administrators in Massachusetts*, 6 J. HOSP. MGMT. & HEALTH POL'Y 1, 13 (2022) ("Without a meaningful deterrent to improper behavior, hospitals may not live up to social and regulatory expectations. . . . To date, very few non-profit hospitals have been fined or had their tax-exempt status revoked.").

prohibitions against such discrimination at the state level. It also summarizes the negative impact of medical debt on patients' financial, emotional, and physical health when they cannot obtain financial assistance. These negative impacts burden noncitizens disproportionately because of the compounding effect of other exclusionary health care laws and policies. Part III concludes by highlighting successful advocacy strategies at the state and institutional levels that have expanded access to charity care for noncitizens.

I. HOSPITAL CHARITY CARE AND COMMUNITY BENEFITS

This Part traces the evolution of federal tax exemption for charitable hospitals, focusing on charity care as an important component of how hospitals demonstrate community benefit. It explains the basis for hospitals' tax-exempt status from their origin as almshouses for the poor—undoubtedly charitably organizations—to their modern incarnation as big businesses with legal obligations to provide benefits to their communities. Throughout this evolution, most hospitals have provided some charity care—discounted or free treatment—to needy members of the community. The final Section outlines federalism concerns that may arise when states also regulate hospitals' community benefit activities and briefly describes how states have done so.

Providing charity care to patients who are unable to afford the cost of medical treatment is one way in which hospitals may demonstrate how they benefit their communities. In theory, the community benefit standard for hospitals to maintain tax-exempt status is designed to encourage hospitals to contribute to community health and wellbeing in novel ways that may not involve clinical care at all.[23] Hospitals can demonstrate community benefit through a wide range of activities, including through "community building activities," such as physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, workforce development, and any other information the hospital wishes to provide.[24] The community benefit

[23] *See* Michael Rozier et al., *How Should Nonprofit Hospitals' Community Benefit Be More Responsive to Health Disparities?*, 21 AMA J. ETHICS 273, 277 (2019).

[24] I.R.S., Schedule H (Form 990), *supra* note 1, at 4 (2022).

standard implicitly recognizes hospitals as "anchor institutions" that have wide-ranging impacts on the health and wellbeing of their communities, including by supporting the local economy as employers and by contracting with local businesses.[25] In practice, however, charity care has dominated hospitals' provision of community benefits.[26] The dominance of charity care may come as no surprise given its historical antecedents in the law of hospital community benefits and the fact that charity care programs do not require hospitals to engage in activities outside of their normal scope of providing clinical care.[27] It may also be easier for hospitals to calculate the value of charity care provided than the value of programs aimed at addressing community health more broadly.[28] In addition, although it was expected that the need for charity care would decrease to a minimal level following the creation of Medicaid and Medicare—and later, the ACA's Medicaid expansion and new subsidies to purchase health insurance[29]—patients still struggle to afford their hospital bills due to legal exclusions from programs, administrative barriers to obtaining or maintaining coverage, and the high cost of health care.

A. Hospitals as Charitable Organizations: The Basis for Tax-Exempt Status

The legal basis for non-profit hospitals' duty to provide benefits to their communities, such as charity care, derives from the hospitals' tax-exempt status.[30] The federal and state governments are each

[25] Hilt, *supra* note 4, at 202. The University of California San Francisco Anchor Institution Initiative defines anchor institutions as "place-based, mission-driven entities such as hospitals, universities, and government agencies that leverage their economic power alongside their human and intellectual resources to improve the long-term health and social welfare of their communities." UCSF ANCHOR INSTITUTION INITIATIVE, https://anchor.ucsf.edu/ (last visited July 13, 2022).

[26] Crossley et al., *supra* note 1, at 195-96 (noting that the value of community health improvement activities or "community-building efforts that improve health" that hospitals reported in 2011 constituted less than eight percent of the reported value of all community benefits provided).

[27] *See* Rozier et al., *supra* note 23, at 274.

[28] *Id.*

[29] *See* Michael D. Rozier, *Nonprofit Hospital Community Benefit in the U.S.: A Scoping Review From 2010 to 2019*, 8 FRONTIERS PUB. HEALTH 1, 2 (2020).

[30] Robin Hacke & Alyia Gaskins, *How Can Clinicians Catalyze Investments to Improve Community Health?*, 21 AMA J. Ethics 262, 263 (2019).

responsible for making tax policy at the national and state levels, respectively, and they may have different standards for non-profit organizations to obtain tax-exempt status. This status can include exemptions from income and property taxes and eligibility to receive tax-deductible charitable contributions. On a national scale, the value of the federal income tax exemption alone is enormous, dwarfing federal public spending on preventative and public health programs. Given that non-profit hospitals claim to provide community benefits valued at upwards of $62.4 billion per year—including community health improvement activities that may or may not involve patient care, such as community education and health screenings—they should be considered a critically important source of funding for preventive and public health activities.[31] Charity care alone could be characterized as a geographically variable, multi-billion-dollar publicly funded health care safety net for the poor.[32]

In the literature discussing the rationales for tax exemption for charities, there are a variety of views, with no general consensus emerging.[33] A major line of thought theorizes tax exemption as "a subsidy for charitable activity," but, once again, arguments abound as to why charitable activity should be subsidized in this way.[34] Other scholars describe economic rationales for subsidizing charity that focus on its role in supplying goods and services that are undersupplied due to market and governmental failures.[35] Courts have recognized this rationale by describing the value of tax exemption as "a quid quo pro that charitable hospitals receive for alleviating a substantial government burden through the care they provide."[36] From this perspective, the community benefit requirement is the standard by which hospitals

---

[31] *See* Bakken, *supra* note 5 at 5; Crossley et al., *supra* note 1, at 196.

[32] *See* Ruth Mason, *Federalism and the Taxing Power*, 99 CAL. L. REV. 975, 987-88 (2011) (explaining why "tax expenditures are economically equivalent to direct government spending").

[33] Miranda Perry Fleischer, *Theorizing the Charitable Tax Subsidies: The Role of Distributive Justice*, 87 WASH. U. L. REV. 505, 514 (2010).

[34] *Id.* at 514-19.

[35] *Id.* at 518-19; *see* Colombo, *supra* note 1, at 346, 366.

[36] Sullivan, *supra* note 4, at 248 (citing Utah County by County Bd of Equalization v. Intermountain Health Care, 709 P2d 265, 268 (Utah 1985) and IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188 (10th Cir. 2003)). *But see* Fleischer, *supra* note 33, at 529 ("To say that charities should be subsidized because they relieve the government of burdens it would otherwise bear is largely meaningless without some sense of what government *should be* doing.").

demonstrate they are helping to address needs that are not being met by either the private market or the government. For example, hospital financial assistance or charity care programs play an important role in the provision of health care to people without the resources to pay for it.[37]

There is an active debate among scholars and industry spokespeople over whether tax-exempt hospitals provide community benefits commensurate to the value of their discharged tax obligations.[38] The value of the tax exemption for the nearly eighty percent of hospitals that have tax-exempt status is enormous, estimated at $24.6 billion in 2011, with approximately half of the value attributed to federal income tax exemptions.[39] On average, tax-exempt hospitals—which include government and non-profit hospitals that are obligated to provide charity care—report that they provide community benefits equal in value to approximately eight percent of their operating budgets.[40] A recent study found that the value of charity care provided nationwide in 2018 was $6.9 billion by government hospitals, $16.0 billion by non-profit hospitals, and $4.1 billion by for-profit hospitals.[41]

The federal tax code and the accompanying Treasury regulations provide the standard for organizations, including hospitals, to obtain tax-exempt status. Section 501(c)(3) of the tax code states that organizations "organized and operated exclusively for religious, charitable, scientific, … or educational purposes" may be exempt from federal

---

[37] *See* Susannah Camic Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 35 (2014).

[38] *See, e.g.*, Qingqing Sun & Thomas Luke Spreen, *State Regulation and Hospital Community Benefit Spending in Medicaid Expansion States*, 47 J. HEALTH POL., POL'Y & L. 473, 473 (2022) (forthcoming) (describing studies "suggest[ing] most nonprofit hospitals do not provide community benefits commensurate with the financial value of their tax exemption"); Bradley Herring et al., *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, 55 INQUIRY: J. HEALTH CARE 1 (2018) (finding, "on average, the amount of incremental community benefits [provided by nonprofit hospitals relative to for-profit hospitals] is comparable to the value of the [nonprofit hospital] tax exemption").

[39] *Fast Facts on US Hospitals*, AM. HOSP. ASS'N, https://www.aha.org/statistics/fast-facts-us-hospitals (last visited Apr. 24, 2023); Sara Rosenbaum et al., *The Value of the Nonprofit Hospital Tax Exemption was $24.6 Billion in 2011*, 34 HEALTH AFF. 1225 (2015).

[40] Sullivan, *supra* note 4, at 250.

[41] Ge Bai et al., *Analysis Suggests Government and Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment*, 40 HEALTH AFF. 629, 631 (2021).

income tax and receive tax-deductible contributions.[42] Treasury regulations clarify the meaning of "charitable," which includes "relief of the poor and distressed or of the underprivileged."[43] They also provide that exempt organizations must "serve[] a public rather than a private interest."[44] Although the provision of health care is not specifically listed as an exempt purpose in the statute, hospitals have always been exempt from federal income tax as charitable organizations due to their early history as institutions serving the sick and poor exclusively.[45] Several prominent American hospitals descend from almshouses, which were established as early as the seventeenth century in the American colonies as the first publicly funded institutions to house and care for the sick and poor.[46] The earliest hospitals were specifically established to care for sick, poor, and isolated people—those who may be categorized as "medically vulnerable" today.[47] This included an overwhelming number of recent immigrants with few resources, which has long been considered a problem from the perspective of hospital administrators.[48] Although hospitals have evolved since then to serve sick and injured people of all classes, they remain eligible for tax exemption as charitable organizations.

In 1953, in response to the changing social class of patients served by hospitals, the IRS provided the first guidance on the criteria that hospitals were required to meet in order to obtain tax-exempt status.[49] One of them was that hospitals must be "operated to the extent of [their] financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."[50] Through this guidance, the IRS stated its expectation that tax-

---

[42] 26 U.S.C. § 501(c).

[43] 26 C.F.R. § 1.501(c)(3)-1(d)(2) (2017).

[44] 26 C.F.R. §1.501(c)(3)-1(d)(1)(ii) (2017).

[45] Camic Tahk, *supra* note 37, at 38-39.

[46] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 149-51 (2017).

[47] *Id*.

[48] *See* CHARLES E. ROSENBERG, THE CARE OF STRANGERS, THE RISE OF AMERICA'S HOSPITAL SYSTEM 41-42, 102 (1987). In later years, when immigrant populations became more established, they established hospitals to serve their own ethnic and religious communities. *Id.* at 111.

[49] Camic Tahk, *supra* note 37, at 39 (citing Rev. Rul. 56-185, 1956-1 C.B. 202).

[50] Rev. Rul. 56-185, 1956-1 C.B. 202. The other three criteria are that the hospital "must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the

exempt hospitals would continue to provide care to patients who were unable to pay the full cost of services, and to use revenue generated from paying patients to offset such free or reduced-cost care.[51]

B. The Evolution of the Federal Community Benefit Standard

The IRS modified its approach in 1969, when it issued new administrative guidance creating a community benefit requirement for hospitals that looks very similar to the standard to qualify for tax-exempt status that exists today.[52] This change in policy was occasioned by a prediction that hospital provision of charity care would decline significantly due to the establishment of Medicare and Medicaid in 1965, which provide publicly funded insurance to certain elderly, disabled, and poor people.[53] Revenue Ruling 69-545 shifted the focus of the IRS's analysis from hospitals' provision of charity care to a more generalized inquiry about beneficial services that hospitals provide to their communities.[54] Notably, charity care was no longer explicitly required in order for hospitals to obtain tax exemption.[55]

Under this new approach, which lacked quantitative benchmarks or specific criteria outlining eligibility for tax-exempt status, hospitals had great flexibility to categorize services as community benefits and

---

care of the sick," "must not restrict the use of its facilities to a particular group of physicians and surgeons . . . to the exclusion of all other qualified doctors," and "[i]ts net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual." Rev. Rul. 56-185, 1956-1 C.B. 202.

[51] Camic Tahk, *supra* note 37, at 39.

[52] Rev. Rul. 69-545, 1969-2 C.B. 117.

[53] Mary Crossley, *Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities*, 55 HOWARD L. J. 687, 690 (2012).

[54] *Id.* at 690-91. After acknowledging that "the promotion of health" is considered a worthy charitable purpose, the IRS listed examples of factors that would indicate that a hospital is providing sufficient community benefits to justify tax-exempt status as a charitable organization serving a public interest. The factors include that the hospital has a board "composed of independent civic leaders," "maintains an open medical staff," and "operates an active and generally accessible emergency room." Rev. Rul. 69-545, 1969-2 C.B. 117.

[55] Camic Tahk, *supra* note 37, at 39-40. In 1983, the IRS explained that "hospitals need not provide emergency care to qualify for tax-exempt status." *Id.* at 40 (citing Rev. Rul. 83-157, 1983-2 C.B. 94). However, as the IRS clarified in 2002, tax-exempt hospitals that do not operate emergency rooms should either have a charity care policy or provide some charity care. *Id.* (citing Lawrence M. Brauer et al., Internal Revenue Serv., *Exempt Organizations Continuing Professional Education (CPE) Technical Instruction Program For Fiscal Year 2002, Topic D: Update on Health Care* 173 (2002)).

to decide how much of their budget to devote to those services.[56] In the following decades, the standard was criticized as lacking substance and incapable of ensuring that hospitals were providing community benefits comparable to the value of their tax exemptions.[57] Media reports spotlighting the harsh billing and collection policies of non-profit hospitals brought increasing attention to the issue.[58] These practices, among others, made "charitable" hospitals virtually indistinguishable from for-profit hospitals, and it became clear that the existing regulations did not incentivize tax-exempt hospitals to adopt practices that were aligned with a charitable mission.[59] Some states began denying hospitals exemption from state property taxes if they found that the value of community benefits provided—typically, charity care—was insufficient under state law, and these decisions were upheld.[60] Amid the controversy, in 2008, the IRS began requiring hospitals to provide more detailed information about how they are meeting their community benefit requirement by creating a new tax form, Schedule H, for the Form 990.[61] Reform proposals that would create substantive standards for community benefits were introduced during negotiations over the Patient Protection and Affordable Care Act of 2010 (ACA) but did not succeed.[62]

C. New Requirements under the ACA

Although the ACA did not change the community benefit standard, it did create new procedural standards designed to hold public and tax-exempt non-profit hospitals accountable to their communities,

---

[56] *See* Crossley et al., *supra* note 1, at 195; Crossley, *supra* note 53, at 690-91.

[57] Crossley et al., *supra* note 1, at 195.

[58] *Id*.

[59] Colombo, *supra* note 1, at 369.

[60] Fleischer, *supra* note 33, at 555, n. 266 (citing *Provena Covenant Med. Ctr. V. Dep't of Revenue*, 894 N.E.2d 452 (Ill. App. Ct. 2008) (basing its ruling in large part on the finding that the hospital devoted only 0.7 percent of its revenue to charity care and that the value of its tax exemption exceeded the cost of its charitable activities)).

[61] Camic Tahk, *supra* note 37, at 48 (noting that "before 2008, no comprehensive data was available about how and to what extent tax-exempt hospitals were meeting the community benefit standard or what financial policies they might have in place.").

[62] *Id.* at 43-44.

to improve patients' accessibility to charity care, and to guard against unsavory billing and collection practices.[63]

1. Community Health Needs Assessments

One of these innovations was a requirement for tax-exempt hospitals to perform triennial Community Health Needs Assessments (CHNAs) and produce an implementation strategy to guide community benefit provision.[64] Although several states had similar, longstanding requirements for hospitals to obtain exemptions from state taxes, this was the first time that such a requirement was imposed on the federal level.[65] The CHNA embeds community engagement into a hospital's decision-making process because it requires hospitals to solicit input directly from community members and those who represent their interests.[66] The IRS's interpretation of "community" is broad and permits hospitals a great deal of flexibility in defining their community. However, the regulations prohibit hospitals from "cherry-picking" their communities to exclude groups that are most at risk of having unmet health needs, including "[m]embers of medically underserved…populations in the community served by the hospital facility," defined as "populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers."[67] The CHNA requirement operates in parallel to the community benefit requirement, which was not altered by the ACA.[68]

In 2014, the IRS issued regulations clarifying the requirements for charitable hospitals to obtain tax-exempt status, including the CHNA

---

[63] *Id*. at 47-48.

[64] 26 U.S.C. § 501(r).

[65] Crossley, *supra* note 53, at 694.

[66] *See* Crossley et al., *supra* note 1, at 195; Camic Tahk, *supra* note 37, at 44, 49.

[67] 26 C.F.R. § 1.501(r)-3(b)(5)(i)(B). *See also* Mary Crossley, *Health and Taxes: Hospitals, Community Health and the IRS*, 16 Yale J. Health Pol'y, L. & Ethics 51, 67-68 (2016) ("[H]ospitals enjoy significant flexibility in defining their communities, but cannot exclude the very populations most likely to have significant health needs.").

[68] Crossley, *supra* note 67, at 73-74 ("[R]egulations fail to indicate to what extent a hospital's satisfaction of the [CHNA] requirement[] may also serve to satisfy the preexisting [community benefit] requirement.").

requirement.[69] The regulations specifically state that the CHNA must involve "input from a governmental health department and from medically underserved, low-income, and minority communities," pushing hospitals to engage with public health authorities and historically excluded groups that are most affected by health disparities.[70] However, the regulations left hospitals great flexibility to conduct CHNAs and respond to the identified community needs. This is likely due to the influence of lobbying by the hospital industry, which advocated against "detailed or prescriptive requirements that create unnecessary burden and limit [hospitals'] appropriate flexibility."[71] As a result, federal guidelines on the community benefit requirement are vague and lightly enforced.[72] In theory, hospitals that do not comply with the CHNA or financial assistance requirements may be subject to a $50,000 tax and revocation of tax-exempt status.[73] However, patients do not have a private right of action against hospitals that violate these requirements; it is up to the IRS to enforce these requirements.[74] Enforcement of the CHNA regulations does not appear to be a priority of the IRS: A recent study found that only 60 percent of hospitals that reported completing a CHNA had posted it to their websites in compliance with the law, and that up to 40 percent of hospitals' CHNAs were missing basic required information such as "[a] description of

---

[69] Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78,954 (Dec. 31, 2014).

[70] Crossley et al., *supra* note 1, at 196.

[71] Crossley, *supra* note 67, at 81 (quoting AMERICAN HOSPITAL ASSOCIATION, COMMENT LETTER ON PROPOSED RULE REGARDING COMMUNITY HEALTH NEEDS ASSESSMENTS FOR CHARITABLE HOSPITALS 2 (June 27, 2013)) (internal quotation marks removed).

[72] *See* Sullivan, *supra* note 4, at 250 ("[T]he [2014] regulations do not identify particular mechanisms for addressing community needs, nor do they mandate any specific infrastructure for intervention."); *id*. (noting that "only 2 hospitals have lost tax-exempt status in consequence" of not meeting the community benefit requirements); Alex Myers et al., *Should Hospital Emergency Departments Be Used as Revenue Streams Despite Needs to Curb Overutilization?*, 21 AMA J. Ethics 207, 210 (2019) (stating that "only a handful of hospitals" have lost tax-exempt status for this reason) (internal citation omitted).

[73] *See* 26 U.S.C. § 4959; *Consequence for Non-Compliance with Section 501(r)*, INTERNAL REVENUE SERVICE, https://www.irs.gov/charities-non-profits/consequence-of-non-compliance-with-section-501r (last updated July 15, 2022).

[74] BOPP STARK & BOSCO, *supra* note 2, at 8.

resources potentially available to address the significant health needs identified through the CHNA."[75]

2. Regulation of Billing Practices and Financial Assistance Programs

Other ACA innovations tied to the maintenance of federal tax exemption sought to eliminate financial barriers to care in hospitals. First, hospitals must establish written charity care policies with clear eligibility criteria, explanations of how discounts are calculated, instructions on how to apply for charity care, and descriptions of how the policies are "widely publicized[d]" in the community.[76] As a result, many non-profit hospitals created a publicly available charity care policy for the first time with a relatively transparent application process. In addition, charity care policies must be provided to patients in their preferred languages and on paper, if requested.[77] Second, the ACA prohibited certain billing practices that patient advocates had long deemed predatory: charging uninsured patients more than they would have been billed had they had health insurance and engaging in "extraordinary collection actions" without first determining that the patient didn't qualify for charity care.[78]

D. The Patchwork of State Laws Governing Hospital Community Benefits

Federalism concerns may arise in the regulation of tax exemptions for charitable hospitals and, therefore, in the laws governing charity care. State governments are constrained in their policymaking by certain provisions of the Constitution and by federal legislation, but generally have great autonomy to set tax policy that matches local values and political preferences.[79] Overall, scholars have observed that states

---

[75] Leo Lopez III et al., *U.S. Nonprofit Hospitals' Community Health Needs Assessments and Implementation Strategies in the Era of the Patient Protection and Affordable Care Act*, 4 JAMA NETWORK OPEN e2122237 (2021) (finding that 25 percent of CHNAs reviewed did not include this information).

[76] 26 U.S.C. § 501(r)(4)(A).

[77] 26 C.F.R. § 1.501(r)-4(b)(5); *see also* David E. Velasquez, *Charity Care Needs To Be Better Than This*, 40 HEALTH AFF. 672, 674 (2021) (describing the challenges patients face when charity care applications are not accessible in these ways).

[78] 26 U.S.C. § 501(r)(5)-(6).

[79] *See* David E. Wildasin, *Pre-Emption: Federal Statutory Intervention in State Taxation*, LX NAT'L

tend to follow federal tax policy as a matter of administrative convenience, even in cases when the federal policy does not match local preferences.[80] Therefore, the federalism impact of federal tax policy may be to influence states to enact policies that they otherwise would not have chosen.

Such concerns may be heightened when the federal government uses tax incentives—such as the tax exemption for charitable hospitals—to influence the behavior of private institutions in a way that conflicts with local values and preferences. The federal standard for tax exemption directs the provision of hospital community benefits that are valued in the billions of dollars.[81] Unlike some conditional grants to the states, federal tax incentives do not direct states to enact specific policies; however, they can still "crowd out state regulation" by holding hospitals to a federal standard that leaves little room for states to influence the provision of community benefits by hospitals.[82] It is, therefore, not surprising that many states deem hospitals that comply with the IRS standard for federal tax exemption to be eligible for exemption from state and local taxes.[83] When the federal government reaches past states to direct behavior by private entities in furtherance of federal policy, states have little power to resist those policies—which matters if those policies do not reflect local values and preferences.[84]

TAX J. 649, 650-53 (2007).

[80] Mason, *supra* note 32, at 1019-21.

[81] The value of the tax exemption for charitable hospitals was estimated to be $24.6 billion in 2011. Sara Rosenbaum et al., *The Value of the Nonprofit Hospital Tax Exemption was $24.6 Billion in 2011*, 34 HEALTH AFF. 1225 (2015). *See* Mason, *supra* note 32, at 988 ("[S]ince the federal government more through tax expenditures than through federal grants to the states, arguably we should be even more concerned about the federalism impact of tax expenditures than [conditional] grants.").

[82] Mason, *supra* note 32, at 994.

[83] Singh et al., *supra note* 3, at 232.

[84] *See* Mason, *supra* note 32, at 1011 (pointing out that, unlike in the case of conditional grants when states can refuse the grant to avoid becoming subject to non-preferred conditions, in the case of federal tax incentives, states "have no right of refusal, because states cannot exempt their residents from federal tax provisions."). *See, e.g.*, James J. Fishman, *Stealth Preemption: The IRS's Nonprofit Corporate Governance Initiative*, 29 VA. TAX REVIEW 545, 586 (2009) (describing how such action by federal agencies "hinders and undermines states' roles as laboratories of innovation introducing new social, economic and legal experiments."); Fishman at 557 ("[T]he power to exempt from tax presents the opportunity to intimidate, harass and bully.").

On the other hand, when state preferences agree with the policy goals behind federal tax incentives, the impact is "federalism-preserving" because it bolsters states' ability to direct hospitals' behavior in line with their values and preferences.[85] Taking the example of the hospital community benefit standard, states can—and some have—set an even higher or more specific standard for state tax exemption than what is required by federal policy in order to influence hospitals' provision of community benefits.[86] Given two standards, hospitals will likely default to meeting the higher state standard unless they can afford to forgo the state tax exemption. It is these states—those that venture beyond federal policy in terms of protecting access to care for uninsured people—that are the focus of this Article.

As of 2021, thirty-three states and Washington, D.C. regulate the provision of community benefits by non-profit hospitals seeking exemptions from state taxes.[87] However, relatively few states have provided more specific guidance on community benefits requirements generally or charity care specifically.[88] Some states do not regulate charity care at all.[89] The most common types of community benefit regulation involve requirements to (1) submit reports on community benefit activities to state regulators, (2) conduct CHNAs, (3) meet minimum standards for the value of community benefits provision, and (4) set minimum income eligibility standards in charity care programs.[90] Notably, regulations requiring hospitals to provide access to charity care programs to all eligible patients, regardless of immigration status, are not among the most common types of state community benefit regulations.

Although many state regulations overlap with federal requirements,[91] some states have more stringent requirements. For example, some states require *all* hospitals—for-profit, non-profit, and public—

---

[85] Mason, *supra* note 32, at 1011.

[86] *See* Singh et al., *supra* note 3, at 232.

[87] Sun & Spreen, *supra* note 38, at 474.

[88] BOPP STARK & BOSCO, *supra* note 2, at 14-15.

[89] BOPP STARK & BOSCO, *supra* note 2, at 37.

[90] Singh et al., *supra* note 3 at 231.

[91] Sun & Spreen, *supra* note 38, at 483.

to provide charity care.[92] While there is no federal regulation requiring hospitals to provide community benefits equivalent to or exceeding a minimum value,[93] at least five states require tax-exempt hospitals to provide community benefits equal or greater in value than their tax savings or a certain percentage of net revenues.[94] Other states delineate approved community benefit activities or have more detailed community engagement requirements during the needs assessment processes.[95] Of the four most common categories of state community benefit regulations, CHNA requirements and minimum income eligibility standards for charity care may present the best opportunities to encourage hospitals to consider addressing the health care access needs of noncitizen members of their communities.

State CHNA requirements, as with the federal requirement established in the ACA, are intended to guide hospitals' provision of community benefits, informing hospitals about where to redirect or increase resources in order to address the community needs identified.[96] In theory, if a hospital were to identify noncitizen access to affordable health care as a community need, it would shift or increase resources to expand access to health care for that community. However, without an additional requirement to allocate resources fairly among the identified community needs, CHNA requirements may not affect hospitals' provision of community benefits.[97]

Minimum income eligibility standards for charity care require hospitals to provide financial assistance to patients who are most likely to be burdened with medical debt—those with low or no income who are uninsured or underinsured. Ten states have laws requiring hospitals to provide charity care to patients meeting specific eligibility

---

[92] BOPP STARK & BOSCO, *supra* note 2, at 11.

[93] *See* Sun & Spreen, *supra* note 38, at 481; Rozier et al., *supra* note 23, at 273-74 (citing G. Nelson et al., Hilltop Inst., Community Benefit State Law Profiles (Jan. 2015), https://www.hilltopinstitute.org/wp-content/uploads/publications/CommunityBenefitStateLawProfiles-January2015.pdf). Five states require tax-exempt hospitals to commit funding to community benefit programs equal or greater in value than their tax savings or a certain percentage of net revenues).

[94] Sun & Spreen *supra* note 38, at 481.

[95] *See* Sullivan, *supra* note 4, at 251-52 (describing requirements in California, Vermont, Texas, and Washington State).

[96] Singh et al., *supra* note 3, at 233-34.

[97] *Id.*

criteria, with all setting minimum income eligibility standards.[98] Notably, these laws apply to all hospitals licensed in the state—not just tax-exempt hospitals.[99] Other states have focused efforts on regulation of charity care in non-profit hospitals or publicly funded hospitals only.[100] Fundamentally, policymakers in these states recognize that a lack of resources to pay for health care should be the most important criterion for determining eligibility for charity care. A state that focuses on hospital charity care's role in alleviating poverty and poor health caused by medical debt may be more inclined to prohibit hospitals from declining to assist patients based on non-income-related criteria, such as immigration status. In other words, state policymakers may consider other criteria on which minimum standards for charity care should be imposed, such as nondiscrimination on the basis of immigration status.

Studies or data on the extent to which state community benefit regulations are enforced are not available.[101] In Illinois, where a recent legislative reform guaranteed state residents access to hospital charity care regardless of immigration status, the advocates behind the campaign have been disappointed with the Attorney General's enforcement of the new law.[102] However, there is a role for "communities, advocates, local elected officials, and the media" to play in pushing state attorneys general to enforce these laws and protect patients.[103] In Washington State, such efforts led the state attorney general to sue a non-profit hospital that was not complying with laws requiring hospitals to offer charity care applications to all low-income patients and to "ask[] how much the patient could pay that day" (rather than demanding payment of the full amount due).[104]

In addition to regulating charity care programs through tax exemption laws, states may set standards for such programs—as well as medical billing and collections practices generally— through other

[98] BOPP STARK & BOSCO, *supra* note 2, at 4.

[99] *Id,* at 11.

[100] *Id.* at 4.

[101] Singh et al., *supra* note 3, at 257.

[102] JENNY CHIANG, TAKING ACTION IN ILLINOIS TO ADDRESS MEDICAL DEBT DISPARITIES IN IMMIGRANT COMMUNITIES 3 (2022).

[103] BOPP STARK & BOSCO, *supra* note 2, at 10.

[104] *Id.*

mechanisms, including hospital licensing laws, certificate of need programs, and reimbursements from state-funded programs aimed at improving access to affordable care.[105] Through such mechanisms, some states have required all hospitals—not just non-profit, tax-exempt hospitals—in the state to establish financial assistance policies and even impose minimum income eligibility criteria for charity care.[106] Circumstances within each state may dictate the best mechanism for guaranteeing equitable access to patient financial assistance.[107]

It is worth noting that several jurisdictions have expanded Medicaid-like coverage to a subset of noncitizens who are excluded from Medicaid because of their immigration status, including undocumented immigrants, which will theoretically reduce reliance on charity care.[108] One reason for doing so is based on an understanding of the ways in which the health of populations is interconnected—a lesson well-learned during the COVID-19 pandemic.[109] Another rationale is that expanding access to Medicaid or health insurance premium subsidies for currently excluded noncitizens would shift or save costs for the state.[110] Health insurance enables people to seek out cost-effective and timely care, possibly reducing preventable emergency room visits and hospital admissions.[111] Expanding access to health insurance may also positively affect worker productivity, allowing more noncitizens to remain in the workforce.[112] Finally, there are humanitarian and ethical reasons for states and health care systems to support the health of

---

[105] *Id.*

[106] *Id.* at 4.

[107] *Id.* at 10.

[108] NAT'L IMMIGR. L. CTR., MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES (Jan. 2023), https://www.nilc.org/wp-content/uploads/2022/12/med-services-for-immigrants-in-states-2023-1-1.pdf; *Health Coverage and Care of Immigrants*, *supra* note 9.

[109] *See, e.g.*, Michael Ollove, *More States Offer Health Coverage to Immigrant Children*, STATELINE (Dec. 6, 2022, 12:00 AM), https://stateline.org/2022/12/06/more-states-offer-health-coverage-to-immigrant-children/.

[110] *See, e.g.*, PREETHI RAO ET AL., RAND, EXPANDING INSURANCE COVERAGE TO UNDOCUMENTED IMMIGRANTS IN CONNECTICUT 27 (2022) (noting possible cost savings to the health care system, such as reduced spending on Emergency Medicaid, recoupment of federal funds via a Section 1115 waiver, and recoupment of federal Advance Premium Tax Credit funds via a Section 1332 waiver).

[111] *See, e.g.*, Jerome-D'Emilia & Suplee, *supra* note 8, at 21, 26 (2012).

[112] Fabi & Cervantes, *supra* note 13, at 2-3 (2021).

noncitizens in their communities.[113] An oft-cited concern by state policymakers is that more inclusive Medicaid policies would encourage in-migration by noncitizens living in other states; however, recent studies examining the effect of these policies have found that there is no "welfare magnet" effect.[114]

Among the jurisdictions that have expanded access to subsidized coverage for excluded noncitizens are California, Connecticut, the District of Columbia, Illinois, Maine, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington.[115] Other states have plans in the coming years to expand such coverage to all residents regardless of status. Colorado, for example, will provide coverage to children under 19 no later than January 1, 2025.[116] Some states' programs provide benefits identical to Medicaid coverage while others provide limited benefits;[117] still others require recipients to pay a premium, typically discounted.[118] A trend among states has been to begin by expanding access to state-funded health insurance to children, regardless of immigration status, before expanding access to other age categories. This is based on the understanding that lack of access to health insurance in childhood "may set back the health and development of [] children, leading to potentially reduced quality of life or lower life expectancy, costly medical conditions, and lower productivity during adulthood."[119]

The incremental expansions of access to subsidized health coverage for excluded noncitizens at the state level reflect a growing awareness of the importance of access to health coverage for all and the inadequacy of charity care programs to fill the gaps in access to care.

---

[113] *See* Makhlouf, *Health Justice for Immigrants*, *supra* note 12, at 284.

[114] Vasil Yasenov et al., *Public Health Insurance Expansion for Immigrant Children and Interstate Migration of Low-Income Immigrants*, JAMA PEDIATRICS 23 (2019).

[115] NAT'L IMMIGR. L. CTR., *supra* note 108; *see* Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, *supra* note 12, at 1722-26 (providing details about these programs, including differences in program design).

[116] NAT'L IMMIGR. L. CTR., *supra* note 108, at 1-2 (also noting that California will expand coverage to additional groups of noncitizens in the coming years).

[117] Montgomery and Prince George's Counties in Maryland, Minnesota, and Washington provide limited coverage to certain residents regardless of immigration status. *Id*. at 4, 7.

[118] *Id.* at 4, 7 (noting such programs in Massachusetts and Washington).

[119] VALERIE LACARTE, MIGRATION POL'Y INST., IMMIGRANT CHILDREN'S MEDICAID AND CHIP ACCESS AND PARTICIPATION: A DATA PROFILE 2 (2022).

These legal reforms also present a better solution to the problem of ensuring access to care from the hospitals' perspective because, unlike charity care, they allow hospitals to see a revenue.[120] Health insurance also enables people to maintain continuity of care, unlike charity care which requires separate applications for each medical episode and is typically approved on a temporary, treatment-by-treatment basis.[121] Charity care may not be the best solution for ensuring access to care for all, but until there is universal coverage for low-income people living in the United States, the need for it will remain.

II. EXCLUSION OF NONCITIZENS FROM CHARITY CARE

This Part places the current-day occurrence of noncitizens' exclusion from charity care in the context of other policies affecting noncitizens' access to health care. Section A explains why charity care plays an important role in noncitizen access to health care. Section B describes reasons why hospitals may choose to exclude noncitizens from charity care. Section C describes the evidence that some hospitals expressly exclude patients from charity care because of their immigration status; more commonly, however, hospitals erect administrative or other barriers to charity care that disproportionately limit access for noncitizens. Section D analyzes the legal basis for hospitals' discrimination against noncitizens in charity care.

A. The Importance of Charity Care Access in the Context of Ineligibility for Subsidized Health Insurance

A discussion of the exclusion of noncitizens from hospital charity care must be placed in the context of the exclusion of noncitizens from health care more generally. Noncitizens without legal status are excluded entirely from Medicaid, the Children's Health Insurance Program, and ACA subsidies to purchase private insurance—publicly funded programs meant to subsidize the cost of health insurance for

---

[120] A recent study examining the effects of expanding access to Medicaid and individual health insurance market subsidies to undocumented and legally present recent immigrants in Connecticut estimated cost savings to hospitals on uncompensated care spending of $50 to $59 million. RAO ET AL., *supra* note 110, at 27 (2022).

[121] *See* Jerome-D'Emilia & Suplee, *supra* note 8, at 23.

low- and middle-income households.[122] Noncitizens—especially those without a valid immigration status—are less likely to be offered health insurance by their employers.[123] Uninsured noncitizens, like uninsured U.S. citizens, typically cannot afford to pay for health care services out of pocket, and therefore go without the care they need.[124] The difference for noncitizens is that, because of their immigration status, they are more often excluded from the programs and subsidies that enable U.S. citizens to access health insurance. Exclusions from hospital charity care eliminate the "payor of last resort" for low-income, uninsured people to obtain necessary health care.[125]

There is a common misconception that anyone who comes to a hospital emergency room is entitled to treatment. Under the Emergency Medical Treatment and Labor Act of 1986, a person who arrives at a hospital emergency room must be examined to determine if they have an emergency medical condition (EMC), regardless of their ability to pay.[126] If they do not have an EMC, the person is not entitled to further services under EMTALA unless they can pay for them. If the person does have an EMC, the hospital must provide treatment to stabilize the person's condition or transfer the person to another hospital where they can be treated appropriately.[127] Once the person's condition has been stabilized, they can be discharged without any guarantee

---

[122] *Key Facts on Health Coverage and Care of Immigrants*, KAISER FAM. FOUND. (Sept. 17, 2023), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/#:~:text=Undocumented%20immigrants%20are%20not%20eligible,coverage%20through%20the%20ACA%20Marketplaces.

[123] Thomas C Buchmueller, et al., *Immigrants and Employer-Sponsored Health Insurance*, 42:1 HEALTH SERV. RES. 286, 286 (Feb. 2007).

[124] *See, e.g.*, Jerome-D'Emilia & Suplee, *supra* note 8, at 26.

[125] *Id.* at 23.

[126] "Emergency medical condition" (EMC) refers to (A) a medical condition manifesting itself by acute symptoms sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in – (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions – (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child. 42 U.S.C. § 1395dd(e)(1)(A)-(B).

[127] *See Understanding EMTALA*, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, https://www.acep.org/life-as-a-physician/ethics—legal/emtala/emtala-fact-sheet/.

of follow-up care or ongoing treatment for a chronic condition that may have caused the EMC.[128] By guaranteeing that people can be screened and treated for EMCs, regardless of their ability to pay, EMTALA plays a small but important role in providing access to health care for uninsured noncitizens.

Hospitals can be reimbursed for providing treatment for EMCs for uninsured people by assisting them with applying for retroactive coverage through Medicaid. If the person treated does not qualify for Medicaid because of their immigration status, the hospital may be reimbursed through a mechanism called Emergency Medicaid.[129] If the person treated declines to apply for Emergency Medicaid—perhaps out of fear of being identified as a noncitizen with no status or precarious status—or is unable to complete the application for any reason, they will be billed for the services received.[130] Although EMC is defined by federal statute, state interpretations of the term vary widely.[131] In some states, the definition of EMC is limited to the kind of condition that is appropriately treated in a hospital emergency room such as broken bones, heart attacks, and emergency dialysis. Other states have a more generous definition of EMC that includes scheduled dialysis, treatment for cancer, prenatal care for people with high-risk

---

[128] Lilia Cervantes et al., *Economic Impact of a Change in Medicaid Coverage Policy for Dialysis Care of Undocumented Immigrants*, 34 JASN 1132, 1132-33 (2023) (describing how some states have considered kidney failure to be an EMC only after a patient has become critically ill, permitting hospitals to discharge kidney failure patients who have received emergency hemodialysis without scheduling outpatient hemodialysis, arranging for home dialysis, or coordinating dialysis-related medications and surgeries).

[129] *Non-citizens*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, https://www.macpac.gov/subtopic/noncitizens/.

[130] *See, e.g.*, CONG. RES. SERV., IMMIGRANTS' ACCESS TO HEALTH CARE 19 (Dec. 21, 2022) ("EMTALA does permit hospitals to bill patients for services; as such, it is not necessarily a source of free care."); Mitchell H. Katz & Eric K. Wei, *EMTALA—A Noble Policy That Needs Improvement*, 179 JAMA INTERNAL MED. 693, 694 (2019) (noting that "no funding is associated with EMTALA" and "[m]any uninsured persons will be unable to pay their full bill). There are other mechanisms through which hospitals are partially reimbursed for providing uncompensated care when patients are unable to pay—as is often the case when an uninsured person is billed for services provided in the emergency room. These include Disproportionate Share Hospital Payments under Medicaid and other and supplemental funding for healthcare provided to undocumented noncitizens. *See* Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, *supra* note 12, at 1769.

[131] *See id.* at 1703-04 (2020) (providing details on Emergency Medicaid and states' abilities to define emergency medical conditions).

pregnancies, and, more recently, any treatment related to COVID-19.[132] This means that there is significant geographic variability in uninsured noncitizens' access to health care to treat serious medical conditions. The Centers for Medicare & Medicaid Services have not disagreed with states' interpretations of EMC as it relates to reimbursement under Emergency Medicaid.[133]

Uninsured noncitizens' other options for accessing affordable health care are limited. Federally Qualified Health Centers (FQHCs) play an important role in providing primary health care services to people, regardless of their immigration status or their ability to pay, for fees that are much lower than the cost of care.[134] FQHCs are subsidized by the federal government.[135] However, most FQHCs struggle to serve their patients in a timely manner due to limited resources and overwhelming needs in the community. For example, the wait times for an appointment for mental health services at FQHCs in Harrisburg, PA, can be as long as two months. In addition, FQHCs do not provide secondary care; if a primary care doctor believes that an uninsured, noncitizen patient needs to see a specialist such as a cardiologist, the patient must figure out how to cover the cost on their own.[136]

There has been some movement on the federal level to provide coverage of pregnancy-related services to people, regardless of immigration status. As mentioned above, EMA is routinely approved for reimbursement of labor and delivery services. Congress has also provided options to states to expand coverage of prenatal care to certain noncitizens who are excluded from Medicaid.[137] Most recently,

---

[132] *See* Jin K. Park et al., *State Flexibility in Emergency Medicaid to Care for Uninsured Noncitizens*, 4 JAMA HEALTH FORUM e231997 (2023).

[133] *See id*. (noting that "CMS has clarified that the federal statute provides substantial leeway for states to define qualifying conditions [for Emergency Medicaid]")

[134] CONG. RES. SERV., *supra* note 130; Samantha Artiga & Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, KAISER FAM. FOUND. (July 15, 2019), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/.

[135] CONG. RES. SERV., *supra* note 130, at 20; Artiga & Diaz *supra* note 134.

[136] Artiga & Diaz *supra* note 134.

[137] *See* Legal Immigrant Children's Health Improvement Act of 2007, S. 764, 110th Cong. § 2 (2007); *See* State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children, 67 Fed. Reg. 61,956, 61,974 (Oct. 2, 2002) (codified at 42 C.F.R. § 457,10) (revising the definition of "child" to mean a person from conception through

Congress gave states an option to expand Medicaid coverage for twelve months of postpartum coverage and a majority of states have chosen to do so.[138] These trends demonstrate a growing awareness of the importance of pregnancy-related care to all people in the United States, regardless of immigration status.

In response to the COVID-19 pandemic, several federal emergency declarations created policies that expand access to health care for noncitizens.[139] States were authorized to expand the definition of EMC to include all COVID-related testing and treatment.[140] In addition, noncitizens benefitted from access to COVID-19 vaccines that were available regardless of immigration status.[141] Notably, noncitizens who were otherwise excluded from Medicaid benefitted from a requirement that states ensured continuous Medicaid coverage for recipients, including Emergency Medicaid recipients.[142] This policy expired shortly before the end of the COVID-19 Public Health Emergency.[143] In summary, many gaps in noncitizen access to care remain and, in theory, charity care programs can help to fill these gaps in noncitizen access to care.

---

age 19 for purposes of CHIP coverage).

[138] *Medicaid Postpartum Coverage Extension Tracker*, KAISER FAM. FOUND., (Dec. 8, 2022), https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

[139] *See* Rachel Dolan & Madeline Guth, *How Have States Used Medicaid Emergency Authorities During COVID-19 and What Can We Learn*, KAISER FAM. FOUND. (Aug. 26, 2021), https://www.kff.org/medicaid/issue-brief/how-have-states-used-medicaid-emergency-authorities-during-covid-19-and-what-can-we-learn/#:~:text=States%20used%20Medicaid%20emergency%20authorities%20to%20make%20changes%20across%20a,Medicaid%20and%2For%20CHIP%20coverage.

[140] *Id*.

[141] *Immigrant Access to COVID-19 Vaccines: Key Issues to Consider*, KAISER FAM. FOUND. (Jan. 13, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/immigrant-access-to-covid-19-vaccines-key-issues-to-consider/#:~:text=The%20federal%20government%20has%20provided,associated%20with%20obtaining%20the%20vaccine.

[142] *See* Jill R. Horwitz & Lindsay F. Wiley, *Not Ready for the End Game – Why Ending Federal Covid-19 Emergency Declarations Will Harm Access to Care*, 386;16 NEW ENG. J. MED. e40, e40(3) (2022).

[143] Jennifer Tolbert & Meghana Ammula, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision*, KAISER FAM. FOUND. (June 9, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/.

B. Evidence and Effects of Exclusion

Hospitals typically limit the scope of their charity care programs for financial reasons.[144] Since most hospitals are not required to provide a threshold level of charity care in order to maintain tax-exempt status, their administrators may conclude that it is worthwhile to recoup any amount of payment for services from patients rather than forgiving the debt outright.[145] Policies excluding patients from charity care based on financial or other characteristics may be more likely to be identified and contested by patients and their advocates. Noncitizen patients, by contrast, may be less organized or motivated to object to charity care policies that exclude them, especially if they are undocumented or hold a precarious status. Legal services organizations may not encounter noncitizen patients as often due to funding restrictions that prevent them from representing certain classes of noncitizens, which makes it easier for exclusionary charity care policies to go undetected by advocates for low-income people in the community.[146] In extreme cases, hospitals are so resistant to providing charity care to admitted noncitizens that they would rather contract with a private medical transport company—often at great cost—to return the patient to their country of origin, a process known as "medical deportation"

---

[144] *See, e.g.*, Zachary Levinson et al., *Hospital Charity Care: How It Works and Why it Matters*, KAISER FAM. FOUND. (Nov. 3, 2022), https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/ ("Some reports suggest that the financial outlook for hospitals has deteriorated in recent months, which may make it harder for hospitals to maintain current levels of charity care."); *see* Jessica Silver-Greenberg & Katie Thomas, *They Were Entitled to Free Care. Hospitals Hounded Them to Pay*, N.Y. TIMES, https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html (Dec. 15, 2022) (describing how executives at a large nonprofit hospital chain instituted a policy to extract payments from patients who would have qualified for charity care because they were "frustrated" about how charity care provision was affecting the corporation's finances). However, this argument is weak for certain hospital chains such as Providence, which "is sitting on $10 billion that is invests, Wall Street-style, alongside top private equity firms" and "earned $1.2 billion in profits through investments" in 2021. *Id*. (noting that "Providence received roughly $1.2 billion in federal, state and local tax breaks" and that the corporation's chief executive "earned $10 million in 2020").

[145] *See* Silver-Greenberg & Thomas, *supra* note 144 (describing how Rev Up "provided Providence's employees with a detailed playbook for wringing money out of patients—even those who were supposed to receive free care because of their low incomes").

[146] *See LSC Restrictions and Other Funding Sources*, LEGAL SERV. CORP. (Mar. 9, 2023), https://www.lsc.gov/about-lsc/laws-regulations-and-guidance/lsc-restrictions-and-other-funding-sources.

or "medical repatriation."[147] For all these reasons, hospitals may find that they are unlikely to encounter resistance to a policy that excludes patients from charity care based on immigration status.

Some hospitals exclude noncitizens from charity care based on erroneous beliefs that federal law requires the exclusion of certain categories of noncitizens from state and locally funded public benefits programs.[148] Because these hospitals receive reimbursements for uncompensated care from state and local bodies, they believe that the restrictions on eligibility for public benefits contained in the Personal Responsibility and Work Reconciliation Act (PRWORA) of 1996 applies to them. However, the PRWORA restrictions on immigrant eligibility for federal public benefits are inapplicable, as hospital charity care programs—even if subsidized by federal funds dedicated to reimbursing uncompensated care—are not considered "federal public benefits" as the term is defined in PRWORA.[149] What is clear is that for

---

[147] *See* Park, *supra* note 14, at 1630-31, 1639; FREE MIGRATION PROJECT, FATAL FLIGHTS: MEDICAL DEPORTATION IN THE U.S. 12 (2021) ("Just one medical deportation flight can cost at least $50,000"); SETON HALL LAW SCHOOL & NY LAWYERS FOR PUBLIC INTEREST, DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS: A STUDY ON THE PRACTICE OF MEDICAL REPATRIATION 18 (2012) (describing a case study in which a Maryland hospital repatriated a noncitizen with a serious neck injury to Guatemala without considering providing charity care to support his ongoing treatment).

[148] *See* Lisa Cacari Stone et al., *The Potential Conflict Between Policy and Ethics in Caring for Undocumented Immigrants at Academic Health Centers*, 89 ACAD. MED. 536, 537 (2014) (describing how the academic health center at the University of New Mexico changed its charity care policy in response to the 1996 welfare law, restricting access to "qualified immigrants," a legal term of art); *H.B. 112: Prohibit Discrimination in Local Health Benefits*, NM TOGETHER FOR HEALTHCARE, https://nmtogether4health.org/wp-content/uploads/2021/03/Factsheet-HB112-Health-Benefits-Non-Citizens-2021-03-06-updated.pdf (last visited Mar. 1, 2023). Hospitals in other states, such as Colorado, have justified the exclusion of noncitizens from charity care based on confusion over whether charity care should be considered a "public benefit" that falls within a state law's restriction on undocumented immigrants' eligibility for state-funded public benefits. *See* Kristin Jones, *Charity Health Care Hard to Come by for Undocumented Immigrants*, ROCKY MOUNTAIN PBS, https://www.rmpbs.org/blogs/news/charity-health-care-hard-to-come-by-for-undocumented-immigrants/ (Apr, 13, 2020) (describing Colorado University Hospital's policy excluding undocumented immigrants from charity care).

[149] 8 U.S.C. § 1611(c)(2) (defining federal public benefit); 8 U.S.C. § 1611(b)(1)(D) (defining exceptions); Final Specification of Community Programs Necessary for Protection of Life or Safety Under Welfare Reform Legislation, 66 Fed. Reg. 3613 (Jan. 16, 2001) (interpreting statute to exclude certain programs offered by government-funded nonprofit organizations to protect life or safety); Specification of Community Programs Necessary for Protection of Life or Safety Under welfare Reform Legislation, 61 Fed. Reg. 45985, at 45985 (Aug. 30, 1996) (same).

non-profit hospitals with tax-exempt status, providing benefits to their community *is* a legal obligation, and there is nothing preventing noncitizens—even people who are undocumented—from being considered members of the community.

Reports of hospital charity care policies that contain express restrictions on the basis of citizenship or immigration status can be found in the news media,[150] academic articles,[151] and reports by advocacy organizations.[152] Most hospitals also post their charity care policies on their websites and, without searching too long, it is possible to find several policies containing express restrictions. Many hospitals limit eligibility for charity care to U.S. citizens and Lawful Permanent Residents. This includes institutions as diverse as Allegheny Health Network in western Pennsylvania,[153] Broward Health in south Florida,[154] and Union Hospital in Elkton, Maryland.[155] Other institutions, such as Cobre Valley Regional Medical Center in Arizona, are even more restrictive, limiting charity care eligibility to U.S. citizens.[156] Phelps Health in Rolla, Missouri, deems U.S. citizens or those married to U.S. citizens eligible.[157] Some hospitals have vague criteria that are likely to create confusion, such as Grant Memorial Hospital in Petersburg, West Virginia, which states that applicants "must provide proof of United

---

[150] *See, e.g.*, Anna Wilde Mathews et al., *Big Hospitals Provide Skimpy Charity Care—Despite Billions in Tax Breaks*, WALL ST. J. (July 25, 2022), https://www.wsj.com/articles/nonprofit-hospitals-vs-for-profit-charity-care-spending-11657936777; Kristin Jones, *Charity Health Care Hard to Come by for Undocumented Immigrants*, ROCKY MOUNTAIN PBS (Apr. 16, 2015), https://www.rmpbs.org/blogs/news/charity-health-care-hard-to-come-by-for-undocumented-immigrants/.

[151] *See, e.g.*, Lisa Cacari Stone et al., *The Potential Conflict Between Policy and Ethics in Caring for Undocumented Immigrants at Academic Health Centers*, 89 ACAD. MED. 536 (2014); David A. Acosta & Sergio Aguilar-Gaxiola, *Academic Health Centers and Care of Undocumented Immigrants in the United States: Servant Leaders or Uncourageous Followers?*, 89 ACAD. MED. 540 (2014).

[152] *See, e.g.*, CMTY. CATALYST, STATE INITIATIVES TO EXPAND COVERAGE AND ACCESS TO CARE FOR UNDOCUMENTED IMMIGRANTS (2021).

[153] ALLEGHENY HEALTH NETWORK, FINANCIAL ASSISTANCE POLICY 4 (2021).

[154] BROWARD HEALTH, FINANCIAL ASSISTANCE PROGRAM POLICY 4 (2020).

[155] UNION HOSP., FINANCIAL ASSISTANCE POLICY AND PROCEDURE 3 (last revised Jan. 2022).

[156] COBRE VALLEY REG'L MED. CTR., PATIENT FINANCIAL ASSISTANCE Policy 2 (last revised Feb. 2021).

[157] PHELPS HEALTH, FINANCIAL ASSISTANCE 1 (last revised Jan. 2021).

States citizenship or legal immigration."[158] University of North Carolina Health states that "International Patients" are excluded from charity care, defining the term to mean "one who is a citizen of a foreign country and has entered the United States by virtue of a Visa of any type, effective or expired."[159] Others, such as Penn State Health, insist that they do not consider citizenship or immigration status as a criterion of eligibility for charity care, but among the documents they request from applicants is "[p]roof of citizenship or lawful permanent residence status (green card)."[160]

Some hospitals effectively exclude noncitizens from charity care without express restrictions by instituting administrative requirements that disproportionately—but not exclusively—bar access to noncitizens. While such policies are not the main subject of this Article, they are worth discussing in some detail to demonstrate how failing to enforce existing regulations or to regulate altogether can contribute to inequitable access to health care. For example, hospitals that require charity care applicants to submit certain documents or information that undocumented people or people with precarious immigration status are unlikely to have effectively exclude those people from charity care. For example, prior to 2021, a prominent non-profit hospital in New Mexico had long required applicants to provide a Social Security Number (SSN) to qualify for charity care, barring undocumented immigrants and other noncitizens ineligible for SSNs from charity care.[161] In a state in which there is an estimated 60,000 undocumented Latinx immigrants who experience a disproportionately high poverty rate, this policy had a significant impact on immigrants' access to health care.[162] A study examined differences in documentation requirements

---

[158] GRANT MEM'L HOSP., PATIENT FINANCIAL ASSISTANCE POLICY 2 (Nov. 2021).

[159] UNC HEALTH, PATIENT FINANCIAL ASSISTANCE 8 (last revised July 2022).

[160] PENN STATE HEALTH, FINANCIAL ASSISTANCE APPLICATION 1. The policy states, somewhat confusingly, that "The patient must be a United States citizen, permanent legal resident or PA resident who can provide proof of residency (excludes Non-US Citizens living out [*sic*] the US)." PENN STATE HEALTH, FINANCIAL ASSISTANCE POLICY 4 (Jan. 2023).

[161] Janet Page-Reeves et al., *Policy Implications of Structural Violence and Syndemic Dynamics: A Lens for Addressing Latinx Immigrant Diabetes Health Disparities*, 22 CURRENT DIABETES REP. 137, 143 (2022).

[162] *Id*. This discriminatory hospital policy was the impetus for a campaign to enact a state law that prohibited hospitals that receive public funds from discriminating against noncitizens in charity care. *See* Section III.A.1.a, *infra*.

in health clinics designed to provide care to noncitizens who were ineligible for Medicaid in two different states, Florida and New Jersey.[163] The Florida clinic turned away half of the noncitizens seeking care because they could not meet the burdensome documentation requirements relating to employment and income.[164] The New Jersey clinic permitted patients to attest to these matters, enabling it to serve a much higher proportion of people seeking care.[165]

Hospitals' failure to comply with language access requirements is another effective bar to charity care for some noncitizens. In 2021, David Velasquez wrote of his challenging experience as a medical student helping his father to apply for charity care from a California hospital after a hospitalization for a heart attack.[166] Not only was the charity care application form only available in English (in violation of IRS requirements), but it was also only available online, which made it virtually inaccessible to the patient, a limited English speaker without access to or knowledge of how to use a computer.[167] When charity care policies are unavailable in patients' native languages or are only accessible online, as described in David Velasquez's narrative, these decisions likely disproportionately affect "older patients and people of color, who are less likely to own and use a computer or have access to broadband internet because of systemic barriers."[168] Another administrative barrier to charity care at the unnamed hospital was a fourteen-day deadline from receipt of the hospital bill to submit an application, which Velasquez only managed to overcome, on behalf of his father, by "pleading with the hospital."[169] On the day they submitted the application in person, he writes, "It felt like we were going into battle."[170] The barriers Velasquez describes may not target uninsured or underinsured noncitizens, but they are likely to disproportionately affect them.

---

[163] Mallory Myers, Health Care for Hispanic Immigrants: Improving the Accessibility and Quality of Preventive Services 27 (May 2016) (unpublished manuscript) (on file with author).

[164] *Id*.

[165] *Id*.

[166] David E. Velasquez, *Charity Care Needs To Be Better than This*, 40 HEALTH AFF. 672 (2021).

[167] *Id*. at 672-74.

[168] *Id*. at 674.

[169] *Id*. at 673.

[170] *Id*.

Numerous such examples abound.[171] Aside from recent coverage of the problems with hospital charity care in *The New York Times* and *The Wall Street Journal*, the Medical-Legal Partnership Clinic at Penn State Dickinson Law, which I direct, has encountered issues obtaining charity care for clients due to the fact that they speak limited English and are unfamiliar with the U.S. health care system. One client, an asylum seeker, was hospitalized for more than a month after suffering from a medical emergency. In her initial encounters with hospital staff responsible for finances and billing, an interpreter was not used. The ensuing miscommunication resulted in a note being created in her billing file characterizing the client as "difficult." The hospital's application for Emergency Medicaid was inaccurate and incomplete, and it was denied. The Clinic became involved at that point, but hospital records containing inaccurate information due to the failure to use an interpreter doomed the application, and the Clinic was unable to overcome the presumption that our client was ineligible. After that, the Clinic began applying for charity care from the hospital but was told that our client was not eligible because her application for Emergency Medicaid had been denied. This policy is concerning because it excludes patients who are most in need of financial assistance: those who are unable to pay back their hospital bills due to a lack of health insurance. It is yet another example of a charity care policy that is disproportionately likely to harm noncitizens.

Finally, when hospitals fail to address patients' concerns about immigration surveillance in health care, noncitizen patients and patients with close ties to noncitizens may decline to apply for charity care programs because they fear negative immigration consequences for themselves or their family members.[172] These feared negative immigration consequences include the denial of immigration benefits or, for undocumented immigrants, arrest by immigration enforcement officers.[173] Although some of these fears are based on misinformation, there are valid reasons for certain noncitizens to be concerned about

---

[171] *See, e.g.*, CHIANG, *supra* note 102 (reporting that many hospitals in Illinois do not offer brochures about charity care programs in languages other than English).

[172] *See* Medha D. Makhlouf, *Health Care Sanctuaries*, 20 YALE J. HEALTH POL'Y, L. & ETHICS 1, 9-17 (2021).

[173] *Id*. at 12-14.

immigration surveillance in health care.[174] For example, "public charge" is a provision of immigration law that requires certain applicants for certain immigration benefits to disclose their use of certain public benefits.[175] Through a regulatory change, the Trump Administration temporarily expanded the types of benefits—including Medicaid—that would be considered in the public charge analysis.[176] These changes created a "chilling effect" in noncitizens' enrollment in the public benefits to which they were entitled.[177] It is a reasonable assumption that this effect would extend to noncitizen participation in financial assistance of any kind, including charity care.[178] As another example, during a campaign for legislative reform of hospital financial assistance laws in Illinois, noncitizen residents reported that staff at certain hospitals had threatened to deport them or report them to Immigration and Customs Enforcement (ICE).[179] When policymakers do not adequately address concerns about immigration surveillance in health care, hospitals can adopt policies to assure noncitizens that they are doing all they can to protect them from negative immigration consequences.[180] Without such assurances—including when applying for charity care—some noncitizens may hesitate to incur the perceived risk of providing personal information to the hospital.

When uninsured, low-income patients are excluded from charity care—whether directly or indirectly—the negative financial, emotional, and physical effects of dealing with a health issue intensify. The

---

[174] *Id*. at 18-20.

[175] Inadmissibility on Public Charge Grounds; Implementation of Vacatur, 86 Fed. Reg. 14221 (Mar. 15, 2021) (to be codified at 8 C.F.R. pts. 103, 106, 212, 213, 214, 245, 248).

[176] Inadmissibility on Public Charge Grounds, 84 Fed. Reg. at 41292, 41295 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 245, 248).

[177] *One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019*, URB. INST. (June 18, 2020), https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019.

[178] *See* Shanzeh Daudi, *Choosing Between Healthcare and a Green Card; The Cost of Public Charge*, 70 EMORY L.J. 201, 225-226 (2020) (discussing fear that receiving or using any public benefits would harm noncitizens' ability to stay in the U.S.); *see* Sarah Brayne, *Surveillance and System Avoidance: Criminal Justice Contact and Institutional Attachment*, 79 AM. SOCIO. REV. 367, 368 (2014).

[179] Chiang, *supra* note 3.

[180] Makhlouf, *supra* note 172.

uninsured have less access to care and are therefore less likely to receive preventative treatment for major and chronic health conditions.[181] When uninsured noncitizens do seek care, they are often faced with unaffordable medical bills.[182] Medical bills can threaten financial well-being and result in negative consequences, such as difficulty in paying for necessities, dipping into savings, borrowing money, and even having bills sent to collections.[183] Unpaid medical debt affects one's credit score, making it "harder and more expensive to buy or rent a car or home or to borrow money."[184] In order to pay off medical bills, some patients might forgo necessary purchases, such as groceries or prescriptions, or postpone paying off utility bills, potentially endangering their health and wellbeing.[185] The lack of access to quality care and the inability to pay for these medical bills can create stress and negatively affect mental well-being.[186]

Access to charity care not only has impacts at the individual level, but also affects the overall health system as well. Given the large number of noncitizens with no or precarious legal status living in the United States, exclusion from the health care safety net can also negatively affect population health and the health system.[187]

C. Legal Basis for Exclusion

Despite the economic, efficiency, and health costs of expressly excluding noncitizens from charity care, nothing in federal law prohibits hospitals from doing so. While the federal government has required non-profit hospitals to have financial assistance policies in order to maintain tax-exempt status, it has not mandated any particular

---

[181] *Key Facts About the Uninsured Population*, KAISER FAM. FOUND., (Dec. 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=Uninsured%20adults%20are%20also%20more,collections%20resulting%20in%20medical%20debt.

[182] *Id*.

[183] *Id*.

[184] Silver-Greenberg & Thomas, *supra* note 145 (describing how a patient whose medical debt was sent to a debt collection company after the birth of her twins dealt with a 200-point drop in her credit score, even though she should have been determined eligible for charity care).

[185] *See id*.

[186] *Id*.

[187] Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, *supra* note 12, at 1773.

criteria.[188] This lack of regulation extends to criteria relating to citizenship or immigration status. Therefore, any lawsuit challenging hospital charity care policies that discriminate on the basis of immigration status are unlikely to succeed.

One regulation pertaining to the conduct of CHNAs prohibits hospitals from "cherry-picking" their communities to exclude groups that are most at risk of having unmet health needs, which could include immigrant groups in some communities, but it does not provide a strong basis for compelling hospitals to include noncitizens in charity care programs. The regulation states that such groups include "[m]embers of medically underserved…populations in the community served by the hospital facility," defined as "populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers."[189] For example, if a hospital were to leave out representatives of a significant immigrant group residing in the community from its CHNA, it would likely violate the regulation. Although the requirement appears to reflect policymakers' understanding that CHNAs should help hospitals provide benefits—including charity care—to the community in an equitable manner, it would be a stretch to argue that it requires hospitals to serve all medically underserved populations in all its community benefit programs.

More broadly, federal civil rights law does not protect noncitizens from discrimination on the basis of immigration status in obtaining health care. Section 601 of Title VI of the Civil Rights Act of 1964 prohibits entities that receive Federal financial assistance from discriminating "on the ground of race, color, or national origin."[190] Virtually every non-profit hospital is considered to receive Federal financial assistance if it accepts Medicaid or Medicare Part A (hospital

---

[188] Emery Winter, *Yes, most hospitals are required to offer financial assistance*, VERIFY, (Jul. 22, 2021, 2:35 PM), https://www.verifythis.com/article/news/verify/health-verify/most-hospitals-required-to-offer-free-care-financial-assistance-for-low-income-patients/536-58a81b20-b1ef-40c0-b81c-fe45162c9303 ("But there are no eligibility requirements the ACA outlines aside from that. Each state can set its own definitions of what's medically necessary, and there is no income limit the federal government sets.")

[189] 26 C.F.R. § 1.501(r)-3(b)(5)(i)(B); *see also* Crossley, *supra* note 67, at 67-68 ("[H]ospitals enjoy significant flexibility in defining their communities, but cannot exclude the very populations most likely to have significant health needs.").

[190] 42 U.S.C. 2000d.

insurance).[191] Section 1557 of the ACA extended protection on these grounds and others to "any health program or activity…which receives funding from HHS," including doctors' offices that accept Medicaid. However, no court or agency has interpreted "national origin" to mean "immigration status."[192] Instead, in the health care context, protections against discrimination on the basis of national origin have largely come to mean discrimination based on limited English proficiency.[193] While language access requirements in hospitals certainly benefit many noncitizens, they do not protect them from being excluded from charity care programs because of their immigration status. In the employment sphere, there is some case law relating to "citizenship discrimination" under Title VII's prohibition against discrimination on the basis of national origin, but guidance from the U.S. Equal Employment Opportunity Commission states that such claims may succeed only if it is "pretext" for national origin discrimination.[194] If the law otherwise requires employees to be U.S. citizens or to hold a valid immigration status or work authorization, employers may decline to hire a person because of their immigration status.[195] Likewise, while some noncitizens may succeed in discrimination claims against hospitals based on perceptions of their identity, it is their national origin or ancestry that must be the crux of the claim—not their immigration status.[196] The lack of a clear statute or regulation

---

[191] *See* Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78,954, 78,977 (Dec. 31, 2013).

[192] The most recent Notice of Proposed Rulemaking by HHS relating to Section 1557 of the ACA does not indicate that discrimination on the basis of immigration status violates the prohibition on discrimination on the ground of national origin. *See* Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47,832-33 (Aug. 4, 2022).

[193] *See, e.g.*, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311 (Aug. 8, 2003) (describing the evolution of language access requirements under Title VI).

[194] EEOC Enforcement Guidance on National Origin Discrimination, U.S. EQUAL EMPL. OPPORTUNITY COMM'N (Nov. 18, 2016), https://www.eeoc.gov/laws/guidance/eeoc-enforcement-guidance-national-origin-discrimination#_Toc451518837.

[195] *Id*.

[196] As an example of discrimination on the basis of national origin in federally assisted programs, the U.S. Department of Justice provides the following: "At a hospital in an area with a large Latino population, employees in outpatient clinic routinely make fun of, comment on the accents of, and sometimes delay services to Latino patients. Latino patients are told to bring

prohibiting hospitals from discriminating on the basis of immigration status in their community benefits programs means it is unlikely that civil rights law provides a remedy.

The exception is in states that have laws protecting noncitizens from discrimination in charity care. The mechanisms used by these states vary, and Part III highlights case studies from four states that have recently enacted prohibitions against discrimination in hospital charity care.

III. REFORMING CHARITY CARE TO ENSURE ACCESS FOR NONCITIZENS

Charity care reform is one of the few issues within health law and policy that has gained some bipartisan traction in recent years.[197] Political attention to the inadequacy of charity care appears to be cyclical, emerging every decade or so.[198] Proposals to improve the provision of charity care at the federal level are numerous and varied, reflecting the complexity of the problems of health care affordability and medical debt.[199] They include proposals to set a minimum income threshold for charity care eligibility; to require hospitals to provide community benefits equivalent to or exceeding a minimum amount; to create a "floor-and-trade" system enabling hospitals in wealthier communities to subsidize charity care provided by another hospital in order to meet a minimum required by law; heightening oversight and enforcement of existing charity care laws; and reforming the tax exemption so that it reflects the value of community benefits provided by particular hospitals.[200] Yet the hospital lobby has successfully prevented major reforms from being enacted at the federal level.[201] Across the country, the

---

their own interpreter before they can see a doctor." U.S. DEPT. OF JUSTICE CIVIL RIGHTS DIVISION, FEDERAL PROTECTIONS AGAINST NATIONAL ORIGIN DISCRIMINATION 12 (Aug. 2010).

197 *See* Velasquez, *supra* note 77, at 674 (mentioning to Republican Senator Chuck Grassley's advocacy on the subject).

198 Levinson et al., *supra* note 145.

199 Levinson et al., *supra* note 145.

200 *Id*.

201 *See, e.g.*, Robert Pear, *Hospitals Mobilizing to Fight Proposed Charity Care Rules*, N.Y. TIMES (May 31, 2009) (describing hospitals' successful campaign to oppose a minimum charity care requirement).

eligibility criteria for charity care vary widely among the states that have not regulated alienage restrictions in hospital charity care.[202]

Advocacy groups and scholars have highlighted the problem of discrimination against noncitizens in hospital charity care programs and have called for legal reform to prohibit such discrimination.[203] However, political polarization in Congress means that it is unlikely that federal legislation prohibiting non-profit hospitals from discriminating against patients on the basis of immigration status in their charity care programs will be enacted any time soon. There are similar challenges for some states.[204] However, several state legislatures have recently recognized the health, economic, and moral rationales for nondiscrimination in charity care programs.[205] This Part highlights advocacy strategies at the state and institutional levels that have successfully expanded access to charity care for noncitizens.

A. Rationales for Reform

There are good reasons for both state legislators and hospital administrators to adopt nondiscriminatory charity care policies. This Section describes four rationales relating to finances, fairness, protecting the health of all, and addressing racial health inequities.

1. Finances

Concerns about hospitals contributing their fair share of community benefits may motivate reforms to prohibit discrimination in charity care. Charity care is a major component of most—if not all—nonprofit hospitals' community benefits provision, and studies have

---

[202] *See, e.g.*, Jenny Chang, *Taking Action in Illinois to Address Medical Debt Disparities in Migrant Communities*, COMMUNITY CATALYST (2022).

[203] *See, e.g.*, Page-Reeves et al., *supra* note 161, at 143; *State Initiatives to Expand Coverage and Access to Care for Undocumented Immigrants*, CMTY. CATALYST, (Apr. 2021), https://www.communitycatalyst.org/wp-content/uploads/2022/11/Advocacy-Guide-ImmigrantsCoverage.pdf; Danna Casserly, H*ealth Care for Immigrants: A Manual for Advocates in Pennsylvania*, PENNSYLVANIA HEALTH LAW PROJECT, (Jun. 2017), https://www.phlp.org/uploads/attachments/ckdhout757n4vy8u8bw8ak92x-immigrant-health-care-manual-for-advocates-june-2017-update.pdf.

[204] *See* Boris Shor & Nolan McCarty, *Two Decades of Polarization in American State Legislatures*, 3 J. POL. INST. & POL. ECON. 343, 344 (2022).

[205] *See* Simone R. Singh et al., *State-Level Community Benefit Regulation and Nonprofit Hospitals' Provision of Community Benefits*, 43 J. HEALTH POL., POL'Y & L. 229, 230-31 (2018).

consistently shown that the value of community benefits that these hospitals provide is less than the value of their tax exemption.[206] More regulation of hospital community benefits at the state level—including nondiscrimination mandates—may increase the amount of hospital community benefits provision overall.[207] A requirement prohibiting discrimination against noncitizens in charity care is one way to bring tax-exempt hospitals' contributions to their communities closer to the value of the tax benefits they receive.

Contrary to some hospitals' motivation to limit patients' eligibility for charity care—whether based on immigration status or other criteria—strict criteria do not necessarily benefit hospitals financially. As one study from Colorado found, uninsured patients paid just 26% of their medical bills.[208] Arguably, more humane billing practices and expanded eligibility for discounted care could enable uninsured patients to pay back a larger portion of their bills.[209]

In fact, more stringent community benefits regulation can benefit hospitals in numerous ways, including by reducing administrative burdens.[210] When charity care programs do not use citizenship or immigration status to determine eligibility, hospitals can shift resources away from processing applications and deciphering immigration statuses and toward what they do best: provide health care. Uniform charity care requirements for hospitals can reduce administrative burdens for hospitals related to developing financial assistance policies and procedures.[211]

In addition, hospitals that are shouldering a disproportionate share of uncompensated care in a region may benefit financially from stricter and more uniform criteria around charity care. A key component of the success of the legislative campaign in Illinois to clarify that the term "resident" did not refer to citizenship or immigrations status

---

[206] *Id.*

[207] *See* Singh et al., *supra* note 3, at 257.

[208] *See* ALLISON NESWOOD, CASE STUDY: EXPERIENCES BATTLING MEDICAL DEBT DRIVE REFORM OF HOSPITAL FINANCIAL ASSISTANCE LAWS IN COLORADO 11 (Dec. 2021).

[209] *Id.*

[210] *See id.* at 10-11 (describing how a Colorado law reduced the administrative burden of language access requirements by requiring a state agency to develop a standardized statement of patient rights that is translated into multiple languages).

[211] *Id.* at 11.

was the partnership between a coalition of immigrant-serving community organizations and Cook County Hospital, which sought to spread the costs of uncompensated care among local hospitals.[212]

2. Fairness

Advocates have found that emphasizing the unfairness of charity care exclusions that are based on immigration status is an effective strategy for persuading state legislators to enact a nondiscrimination provision. It is reasonable to argue that noncitizens who contribute to the tax base that funds programs that reimburse hospitals for uncompensated care should benefit from those hospitals' charity care programs. This was the rationale that ultimately persuaded policymakers in New Mexico to enact a legal prohibition on discrimination against noncitizens in hospital charity care.[213]

New Mexico has a multi-layered system of funding health care access for the poor. One feature of this system is the Indigent Hospital and County Health Care Program, in which hospitals and other health care providers may apply to County Indigent Hospital and County Health Care Boards for reimbursement of care provided to patients who meet a statewide eligibility standard of 150 percent (or higher, if funds remain at the end of the fiscal year) of the per capita personal income in the state.[214] The Indigent Hospital and County Health Care Program is funded through county property taxes.[215] This puts the onus on health care providers, rather than patients, to apply. Since care provided to noncitizen patients is reimbursable through these county-funded programs, there is an incentive for health care providers to screen noncitizen patients for eligibility on equal terms as citizen patients.

Enacted in 2021, the Health Benefits for Certain Non-Citizens Act was the culmination of a twenty-year campaign by health and immigration advocacy groups that documented inconsistent or discriminatory restrictions on noncitizen eligibility in some counties' health care

---

[212] *See* Chiang, *supra* note 102, at 6-7.

[213] Page-Reeves et al. *supra* note 159, at 143.

[214] *Free Care: A Compendium of State Laws*, CMTY. CATALYST, INC. (Sept. 2003) (citing N.M. Stat. Ann. §§ 27-5-1, et. seq. for the New Mexico Indigent Hospital and County Health Care Act).

[215] N.M. STAT. ANN. § 27-5-9 (West 2021).

access programs for the poor.[216] One of the most impactful shifts during the campaign came when the public and policymakers began to understand the denial of public benefits to taxpaying noncitizens and essential workers as unfair.[217] As a result of the law, hospitals are now prohibited from discriminating against patients on the basis of immigration status in state- or county-funded indigent care programs.[218] This includes hospital charity care programs if the hospital receives funding from the county's indigent care program[219] or the state-funded safety net care pool.[220]

Many legislators may be unaware of the ways in which noncitizens—including undocumented people—contribute to federal, state, and local tax bases. Noncitizens with employment authorization can obtain Social Security numbers (SSNs) and pay taxes on the same terms as U.S. citizens. Undocumented noncitizens and others without valid employment authorization pay income taxes as well.[221] Some

---

[216] H.B. 112, 2021 Leg., 55th Sess. (N.M. 2021); Page-Reeves et al., *supra* note 159, at 142; *see also Governor Signs Bill to Ensure Immigrants Can Access Healthcare Regardless of Status*, NM TOGETHER FOR HEALTHCARE (Apr. 7, 2021), https://nmtogether4health.org/media-press/governor-signs-bill-to-ensure-immigrants-can-access-healthcare-regardless-of-status/. Over the years, advocates were successful at achieving several other reforms that improved immigrants' and low-income peoples' access to health care, such as "improved access to language support services, a self-pay discount of 45% for uninsured/uninsurable patients, agreements to change debt collection for low-income debtors and institute payment plans, the expansion of primary care/family medicine clinics to four low-income neighborhoods, the creation of two low-cost primary care community clinics . . . and the formation of a CHW network located in community-based organizations and funded by the county."). Page-Reeves et al., *supra* note 159, at 143.

[217] Page-Reeves et al., *supra* note 159, at 143 (noting that an advocacy organization found that "approximately 60,000 undocumented New Mexicans pay roughly $68 million in annual state and local taxes.").

[218] N.M. STAT. ANN. § 27-5-5.2 (West 2021).

[219] *Id.* Hospitals are not required to provide traditional charity care to patients under state law, but they are required to submit their charity care policies and related data to the New Mexico Health Policy Commission each year. *See* N.M. STAT. ANN. §§ 24-14A-3(D), 24-14A-5 (requiring reporting on charity care); *see also* N.M. CODE R. §§ 7.1.24.1 -.17 (LexisNexis 2023) (describing reporting requirements).

[220] N.M. STAT. ANN. § 27-5-4 (2021) (defining "qualifying hospital" as "an acute care general hospital licensed by the department of health that is qualified to receive payments from the safety net care pool pursuant to an agreement with the federal centers for medicare and medicaid services"). The Safety Net Care Pool is a statewide program that distributes funds to hospitals based on a formula that takes into account the amount of uncompensated care that hospitals provide.

[221] *See* LISA CHRISTENSEN GEE ET AL., UNDOCUMENTED IMMIGRANTS' STATE AND LOCAL TAX

apply for an Individual Taxpayer Identification Number (ITIN), which enables them to file a tax return and claim income that was reported by their employers to the Internal Revenue Service (IRS).[222] Others provide a fake SSN, someone else's SSN, or a previously valid SSN to their employer.[223] In both cases, payroll taxes are withheld as for any other employee, but undocumented noncitizens are excluded from many programs that these taxes support, including Social Security benefits if they retire or become disabled.[224] Undocumented noncitizens' contributions to the federal tax base are estimated to exceed $23.6 billion, which was the amount paid in 2015 by people who filed taxes using ITINs, the vast majority of whom are likely undocumented.[225] Note that this number excludes the contributions of undocumented noncitizens who filed federal taxes using invalid SSNs. It is estimated that undocumented noncitizens pay approximately $11.74 billion in state and local taxes each year, which includes payroll taxes, sales taxes, excise taxes, and property taxes.[226] In three of the states with the largest undocumented populations, undocumented noncitizens contribute more than $1 billion in state and local taxes to each state.[227] Learning from New Mexico's example, educating the public and policymakers about the tax contributions of noncitizens and the exclusion of noncitizens from tax-funded programs may be a useful strategy to promote immigrant-inclusive charity care reform in other jurisdictions.

CONTRIBUTIONS, 6 (2017), https://itep.sfo2.digitaloceanspaces.com/ITEP-2017-Undocumented-Immigrants-State-and-Local-Contributions.pdf (estimating that between 50 and 75 percent of undocumented noncitizens pay income taxes).

222 *See* Hunter Hallman, *How do Undocumented Immigrants Pay Federal Taxes? An Explainer*, BIPARTISAN POL'Y CTR (Mar. 28, 2018), https://bipartisanpolicy.org/blog/how-do-undocumented-immigrants-pay-federal-taxes-an-explainer/.

223 *Id.*

224 *Id.*

225 AM. IMMIGR. COUNCIL, THE FACTS ABOUT THE INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER (ITIN) 2, (2022), https://www.americanimmigrationcouncil.org/sites/default/files/research/the_facts_about_the_individual_tax_identification_number_0.pdf (citing INTERAL REVENUE SERVICE, NATIONAL TAXPAYER ADVOCATE, ANNUAL REPORT TO CONGRESS: VOLUME 1 199 (2015), https://www.taxpayeradvocate.irs.gov/wp-content/uploads/2020/08/ARC15_Volume1.pdf).

226 Christensen Gee et al., *supra* note 220, at 2-3.

227 *Id.* These states are California ($3,199,394,000), Texas ($1,560,896,000), and New York ($1,102,323,000). *Id.*

3. Protecting the Health of All

During the COVID-19 pandemic, public health messaging to promote social distancing, masking, isolation and quarantine, and vaccination among the general public has emphasized how such actions protect entire communities.[228] The relationship between individual and population health is straightforward in the context of a highly infectious virus: If one person is infected and doesn't take precautions to limit the spread of the virus, they will put everyone with whom they come into contact at risk.[229] This relationship can also help to justify policies that promote access to health care for all, including access to financial assistance like charity care programs. This was another of the rationales that advocates in New Mexico cited to support a state law prohibiting discrimination against noncitizens in state and local health care programs for the poor, stating that "[e]nding discrimination in healthcare protects all New Mexicans."[230]

4. Addressing Health and Health Care Inequity

In some states, a desire to address health and health care inequities relating to income, race, and other characteristics has motivated legislation to protect noncitizens from discrimination in hospital charity care programs.[231] Access to health care is stratified based on income and race, and charity care eligibility criteria that exclude needy patients exacerbate health care inequity.[232] Without the ability to pay for health care or the assurance of assistance, people who are struggling financially may forgo care. If they do not, they are left with medical debt.[233] As described earlier in this Article, low-income people with medical debt are often forced to make difficult choices to either pay

---

[228] *See, e.g., How to Protect Yourself & Others*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html (Oct. 19, 2022) ("There are many ways your actions can help protect you, your household, and your community from severe illness from COVID-19.").

[229] *Id.*

[230] *H.B. 112: Prohibit Discrimination in Local Health Benefits supra* note 148.

[231] *See, e.g., id.*

[232] *See* Silver-Greenberg, *supra* note 145.

[233] *See Key Facts*, *supra* note 179.

down the debt or pay for rent, utilities, groceries, medicine, and other items that are essential to protect their health and wellbeing.[234]

In Maryland, since 2020, hospitals have been prohibited from "us[ing] a patient's citizenship or immigration status as an eligibility requirement for financial assistance."[235] This provision was included within the text of an equity-focused comprehensive medical debt protection law that focused on protecting the health and wellbeing of low-income families. The bill also enacted other protections against discrimination in hospital charity care programs, including discrimination on the basis of "race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic identity, genetic information, or disability."[236] An aim of the law was to ensure that low-income people, regardless of other characteristics including immigration status, were protected from devastating consequences like destitution and homelessness through "unconscionable and immoral" debt collections by hospitals.[237] Supporters of the bill also pointed to the disproportionate impact of medical debt on communities of color that "already struggle with disparities related to access to health care and social determinants of health."[238]

Likewise, an Illinois reform clarifying that the definition of "Illinois resident" in the charity care statute is intended to include people of all citizenship and immigration statuses was part of a package of reforms aimed at defining hospitals' roles in addressing health inequities. The statute requires hospitals to "describe activities that aim to address health disparities, advance health equity, and improve

---

234 *See* Silver-Greenberg, *supra* note 145.

235 H.B. 1420, 2020 Leg., 440th Sess. (Md. 2020); *see also* S.B. 875, 2020 Leg., 440th Sess. (Md.2020) (2020), MD. CODE ANN., HEALTH-GEN. § 19-214.1(i) (West 2020).

236 H.B. 1420; *see also* S.B. 875; *see also* MD. CODE ANN., HEALTH-GEN. § 19-214.1(ii).

237 *As Maryland Hospitals Continue to Sue Patients, Lawmakers Call for 'Guardrails'*, INSURANCENEWSNET: HEALTH INS. NEWSL. (Feb. 28, 2020), https://insurancenewsnet.com/oarticle/as-maryland-hospitals-continue-to-sue-patients-lawmakers-call-for-guardrails (quoting Delegate Robbyn Lewis, who introduced the bill in the Maryland House).

238 *Id.* (quoting Marceline White, executive director of the Maryland Consumer Rights Coalition); *see also* Nguyen & Rukavina, *A Path Toward Ending Medical Debt: A Look at State Efforts*, CMTY. CATALYST 15-16 (Dec. 2021), https://communitycatalyst.org/wp-content/uploads/2022/11/path-toward-ending-medical-debt.pdf (describing how advocates in New York and Maryland have called attention to the racially disparate consequences of medical debt lawsuits).

community health through their community benefit plans."[239] To raise awareness of the problem that the reform would address, advocates met with local and state politicians to describe how hospitals that claimed to provide charity care to all eligible patients regardless of immigration status violated their own policies in individual cases.[240] The advocates report that by describing specific examples of inequitable access to charity care, state legislators "found the issues very concerning and expressed their support for the advocates."[241]

A Colorado law requiring health care facilities to screen all uninsured patients—regardless of immigration status—for publicly funded health coverage and other financial assistance programs[242] was enacted with the support of Black and Latino legislators who were committed to "championing policies that aim to improve health and economic stability for communities of color."[243] Advocates sought out these legislators to "sharpen[] their analysis on how medical debt perpetuates the cycle of racial inequity…"[244] They relied on survey data indicating that "Black Coloradans were nearly twice as likely to have had trouble paying a medical bill than white Coloradans" and that "nearly one in four Coloradans (23%) from communities of color were struggling with medical debt in collections" compared with 13% of

---

[239] Nguyen & Rukavina, *supra* note 238, at 11-12.

[240] Chiang, *supra* note 102, at 8.

[241] *Id.*

[242] These include the Colorado Indigent Care Program (CICP), and Hospital Discounted Care (HDC). CICP is the state's program for distributing federal and state funds to partially reimburse health care providers for uncompensated care. *See Colorado Indigent Care Program Operations Manual*, COLO. INDIGENT CARE PROGRAM 1 (2022), https://hcpf.colorado.gov/sites/hcpf/files/2022-23%20Section%20I%20Eligibility.pdf. HDC refers to a new regulatory limit on how much hospitals can charge patients with income at or below 250 percent of the federal poverty level and who do not qualify for CICP. *See Colorado Hospital Discounted Care*, COLO. DEP'T HEALTH CARE POL'Y & FIN., https://hcpf.colorado.gov/colorado-hospital-discounted-care. Payment plans for hospital bills through HDC are limited to no more than four percent of a patient's gross monthly income. *Id.* They are also limited to 36 months of payment, after which hospitals must consider the bill paid in full. *Id.* Both CICP and HDC are available to undocumented people.

[243] Nguyen & Rukavina, *supra* note 238, at 16 (discussing HB 21-1198: Health-care Billing Requirements for Indigent Patients); *see also* Neswood, *supra* note 208 at 14 (noting that a lesson learned from the development of HB/ 21-1198 was that "[a] clear focus on equity is essential for developing effective policy").

[244] Nguyen & Rukavina, *supra* note 238, at 16.

Coloradans overall.[245] The inclusive screening requirement benefitting noncitizens was part of a larger bill that ensured broad-based accessibility to publicly funded programs designed to reduce medical debt for state residents.[246] Another immigrant-inclusive feature of the required screening is that it counts as members of the household relatives who live abroad and who are financially supported by the patient applicant.[247] This feature recognizes previously ignored ways in which medical debt can adversely affect diverse families.

B. Types of Reforms

1. State Nondiscrimination Requirements

States' experiences have shown that when it comes to ensuring noncitizens' access to charity care, an explicit nondiscrimination mandate works best. For example, Maryland law prohibits hospitals from using citizenship or immigration status as an eligibility requirement for charity care.[248] Likewise, New Mexico law clearly prohibits discrimination against noncitizens in hospital charity care.[249] These are straightforward legal reforms to ensure that low-income noncitizens are not excluded from hospital charity care because of their immigration status.

Illinois' experience illustrates the risks of not being explicit about nondiscrimination on the basis of immigration status: It had to reform the law twice in order to achieve the intended effect of ensuring that hospitals provide access to charity care for all patients who qualify financially, regardless of immigration status.[250] The first reform, passed in 2012, required hospitals to provide charity care to low-income

---

[245] Neswood, *supra* note 208, at 5.

[246] *See id.* at 7 (describing the priorities for legislative reform, which included "[e]nsuring screening processes that would connect people to public coverage or discounts").

[247] Graf, *supra* note 241, at 21 ("Households may also include family members who live outside the state or country that have at least 50% of their support provided by the patient or guardian.").

[248] H.B. 1420, 2020 Gen. Assemb., Reg. Sess. (Md. 2020); S.B. 875, 2020 Leg., Reg. Sess. (Md. 2020); Md. Code, Health – Gen. § 19-214.1 (West, Westlaw through 2022 Reg. Sess. Of Gen. Assemb.).

[249] *H.B. 112: Prohibit Discrimination in Local Health Benefits*, *supra* note 148.

[250] S.B. 1840, 102nd Gen. Assemb., Reg. Sess. (Ill. 2021).

Illinois "residents,"[251] a term that some hospitals understood to imply something about valid immigration status,[252] although the word "resident" was intentionally chosen to not refer to citizenship or immigration status. These hospitals interpreted the law to mean that they could require that applicants present specific documentation of valid immigration status.[253] Community organizations observed noncitizen patients being turned away from major non-profit hospitals and directed to seek care at the public Cook County Hospital, despite the fact that those non-profit hospitals claimed in their financial assistance policies that the assistance was available to patients regardless of immigration status.[254] The second reform law, enacted in 2021, the Illinois Hospital Uninsured Patient Discount Act, addressed any possible or purported confusion about the term "Illinois Resident" by clarifying that it means "any person who lives in Illinois and who intends to remain living in Illinois."[255]

Colorado also engaged in a multi-step reform process to ensure equitable access to charity care for noncitizens because of the failure to mandate inclusion initially. A 2012 law required hospitals to "offer" to screen patients for eligibility for publicly funded coverage and discounted care.[256] The law did not effectively ensure that all patients, such as low-income noncitizens, were made aware of financial assistance for which they were eligible. In 2021, a new law was enacted requiring hospitals to screen all uninsured patients for eligibility for publicly funded coverage and discounted care programs, regardless of a patient's immigration status.[257] The examples from Illinois and Colorado demonstrate that reforms to prevent discrimination against noncitizens in health care may be piecemeal and iterative, but it also

---

[251] CHIANG, *supra* note 102, at 4 (referring to SB3261, the Illinois Hospital Uninsured Patient Discount Act).

[252] *Id*. at 3,11.

[253] *Id*.

[254] *Id*. at 8.

[255] *Id*. at 5.

[256] ALLISON NESWOOD, COLORADO CENTER ON LAW & POLICY, EXPERIENCES BATTLING DEBT DRIVE REFORM OF HOSPITAL FINANCIAL ASSISTANCE LAWS IN COLORADO 4 (2022).

[257] *Colorado Hospitals are Now Required to Provide Discounted Care to Eligible Coloradans*, COLO. CHILD.'S CAMPAIGN (Sep. 2, 2022), https://www.coloradokids.org/colorado-hospitals-are-now-required-to-provide-discounted-care-to-eligible-coloradans/.

presents a cautionary tale for states that may have fewer opportunities to pass immigrant-inclusive legislation.

In some cases, changes in laws governing hospital community benefits do not have the intended outcomes, but this is unlikely in the case of a prohibition on discrimination on the basis of immigration status. Unintended effects have been observed for state regulations that set a minimum standard or "floor" for hospital community benefits.[258] For example, one study found that some hospitals in states that set a minimum standard for provision of community benefits reduced the value of benefits provided to match the new minimum standard.[259] It also found that some hospitals reduced their income eligibility standard for charity care to match a state-mandated minimum.[260] In such cases, it is possible that overall provision of hospital community benefits may decrease or that fewer people will have access to hospital financial assistance. In response to a state-mandated prohibition on discrimination on the basis of immigration status in charity care, it is possible that some hospitals would modify other eligibility criteria in order to reduce the number of patients served. However, such efforts would not likely single out noncitizen community members for exclusion and could be discouraged through further regulation by the state, e.g., setting minimum standards or prohibitions on discrimination relating to other patient characteristics.

A potential limitation of a nondiscrimination mandate is that it, alone, may be insufficient to improve health outcomes in immigrant communities. Scholars have observed that differences among states in public narratives about noncitizens' "deservingness" of health care had more of an impact on health outcomes than the formal policies regarding access to health care.[261] Indeed, stigma based on characterizations of "undeservingness" and negative stereotypes about immigrants can cause low self-esteem and psychological distress, which are negative health impacts.[262] In addition to legal reform, there must be

---

[258] Singh et al., *supra* note 3, at 259.

[259] *Id*. at 234.

[260] *Id*.

[261] *See* Christian Abraham Arega, *Structural Violence, Politics and Notions of Healthcare Deservingness for Undocumented Latino Immigrants in Indiana vs. Illinois*, 6 UNIV. OF NOTRE DAME DEP'T OF ANTHROPOLOGY ANTHROCENTRIC (May 2020).

[262] Page-Reeves et al., *supra* note 159, at 144.

concerted efforts to change public narratives around immigrant access to health care.[263] For example, public recognition around health care as a human right, regardless of one's immigration status, has been a successful strategy in some states.[264]

It is also important to acknowledge that charity care is an incomplete solution to the problem of unaffordable health care for poor and uninsured or underinsured people.[265] In Part II.C, I recounted the challenges faced by the Velasquez family as they applied for charity care from a California hospital. Although their application was approved, the family later learned, as is often the case, that physicians' fees and ambulance charges were not covered by charity care, leaving them with a substantial—but significantly discounted—medical debt resulting from the health crisis.[266] Reforms cannot transform charity care into a source of affordable health care for people without access to adequate health insurance.

2. Hospital-Level Policies

Across the country, hospitals have voluntarily eliminated aggressive billing practices and revised their charity care policies in the interest of patient accessibility in response to advocacy by members of their communities. A recent report highlights actions taken by several hospitals to stop suing patients with medical debt, stop pursuing wage garnishment, and increase the discount on medical bills for uninsured patients.[267] As the report notes, "[t]he hospitals' change of practices demonstrates that improvements toward comprehensive financial assistance plans are feasible."[268] Such advocacy could also persuade hospitals that currently discriminate against noncitizens in charity care to eliminate these restrictions in the interest of providing a benefit to the community.

---

[263] *Id*.

[264] *Id*. at 143-44.

[265] *See* Velasquez, *supra* note 77, at 674 ("The ultimate goal for patients traversing the health care system's complicated financial web is not enhanced charity care but affordable and comprehensive health insurance coverage.").

[266] *Id*. at 673.

[267] BOPP STARK & BOSCO, *supra* note 2, at 10.

[268] *Id*.

Beyond charity care, hospitals can engage in other community benefit activities that would address health care inequity and likely increase their revenue from low-income noncitizens, including lobbying to expand immigrant access to publicly funded health coverage; advocating for a broader interpretation of "emergency medical condition" so that more noncitizens have access to care through Emergency Medicaid; and supporting immigration reforms to legalize the status of undocumented immigrants. These actions would further the inclusion of noncitizens in health care and would likely be fiscally beneficial for hospitals.[269] Through institutional reforms, hospitals can become places of sanctuary—rather than exclusion—for noncitizens.[270]

CONCLUSION

When non-profit hospitals exclude patients from charity care on the basis of immigration status, they contribute to health care inequity among noncitizens—the population in the United States least likely to have access to health care. These actions conflict with the longstanding tradition of non-profit, tax-exempt hospitals providing benefits to the community of people living in the geographic areas from which the hospitals draw their patients. Excluding noncitizens from charity care undermines the community benefit requirement by implicitly endorsing an unjustifiably limited conception of "community."

To remedy this, policymakers at every level and hospital administrators should consider advancing policies that prohibit the exclusion of patients from hospital charity care programs on the basis of their immigration status. These actions would both preserve the integrity of the community benefit requirement and work to counteract the numerous ways in which noncitizens have been excluded from the threadbare health care "safety net." Policies that further the inclusion

---

[269] *See* Cecilia Rouse et al., *The Economic Benefits of Extending Permanent Legal Status to Unauthorized Immigrants*, THE WHITE HOUSE (Sept. 17, 2021), https://www.whitehouse.gov/cea/written-materials/2021/09/17/the-economic-benefits-of-extending-permanent-legal-status-to-unauthorized-immigrants/ (regarding immigration reform, noting that newly-legalized noncitizens may take up public benefits, such as Medicaid, for which they were ineligible before, and would also contribute in larger numbers to the tax base that supports hospital finances).

[270] *See* Makhlouf, *Health Care Sanctuaries*, *supra* note 172.

of noncitizens in health care represent concrete steps toward achieving health care equity in the United States.