

MISCARRIAGE OF MEDICINE

The Growth of Catholic Hospitals and the Threat to Reproductive Health Care

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the Threat to Reproductive Health Care

Written by:

Lois Uttley and Sheila Reynertson of the MergerWatch Project,
and Lorraine Kenny and Louise Melling of the American Civil Liberties Union

Data Analysis by:

Patricia HasBrouck of Empire Health Advisors



American Civil Liberties Union
125 Broad Street
New York, NY 10004
www.aclu.org



MergerWatch
475 Riverside Drive, Suite 1600
New York, NY 10115
www.mergerwatch.org

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INTRODUCTION

All across the country, an ever-increasing number of acute-care hospitals are Catholic-sponsored or are affiliated with a Catholic health system, with one in nine beds now in one of these facilities. Many of the largest health care systems in the country are Catholic-sponsored and they are expanding rapidly, in part by acquiring non-Catholic hospitals. In some states, such as Washington, one quarter or more of the hospitals are Catholic-sponsored or -affiliated, and entire geographic regions have no other choice for hospital care.

Catholic hospitals have organized into large systems that behave like businesses – aggressively expanding to capture greater market share – but rely on public funding and use religious doctrine to compromise women’s health care.

Religious restrictions govern care at Catholic-sponsored facilities. At these hospitals, health professionals are prohibited from providing vital health services or honoring patients’ health care decisions when they conflict with Catholic teaching. Often at these facilities health professionals may not even provide their patients with counseling and referrals for services prohibited on religious grounds. As a result, when it comes to reproductive health care, hospitals operating under these religious rules can provide care that falls short of expected standards of care. Historically secular hospitals or hospitals founded by other religious faiths are often required to adopt some or all of the Catholic restrictions when they affiliate with or are acquired by Catholic hospitals.

This report looks at the increasing number of acute-care hospitals that are Catholic-sponsored or -affiliated and the expansion of Catholic-sponsored health systems in the United States between 2001 and 2011.¹ Indeed, 10 of the 25 largest health systems are Catholic-sponsored, with combined gross patient revenue of \$213.7 billion. The report discusses the threat this growth poses to patient access to reproductive health

services, including information and referrals. It further shows the degree to which these institutions rely on tax dollars, even as they limit medical care based on religious doctrine. At the same time, data also indicate that, despite their claims of service to the poor, Catholic-sponsored and -affiliated facilities actually provide only an average amount of charity care and report a lower percentage of gross patient revenue from Medicaid than any other type of hospital.²

In short, this report reveals how Catholic hospitals have left far behind their humble beginnings as facilities established by orders of nuns and brothers to serve the faithful and the poor. They have organized into large systems that behave like businesses — aggressively expanding to capture greater market share — but rely on public funding and use religious doctrine to compromise women’s health care. We make recommendations about how to ensure Catholic restrictions do not interfere with patients’ rights and protect access to comprehensive reproductive health care.

WHY WE CARE:

Catholic Restrictions and the Risk to Patient Health

Health care at Catholic-sponsored and -affiliated facilities is religiously restricted, even as the hospitals open their doors to people of all faiths and accept billions of taxpayer dollars.

When it comes to reproductive health care, religious doctrine can override medical standards of care or patient wishes at Catholic-sponsored facilities. These hospitals are governed by the Ethical and Religious Directives for Catholic Health Care Services (the *Directives*),³ which are issued by the U.S. Conference of Catholic Bishops and enforced by local bishops.⁴ The Catholic *Directives* prohibit a range of reproductive health services, including contraception, sterilization, many infertility treatments, and abortion, even when a woman's health or life is threatened by a pregnancy. For example, the *Directives* state plainly:⁵

- “Catholic health institutions may not promote or condone contraceptive practices.”⁶
- “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted.”⁷
- “Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution.”⁸
- “The free and informed health care decision of the person ... is to be followed so long as it does not contradict Catholic principles.”⁹

- “Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.”¹⁰
- “Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.”¹¹

Hospital staff and physicians with admitting privileges must comply with the *Directives*:

- “Catholic health care services must ... require adherence to [the *Directives*] within the institution as a condition for medical privileges and employment.”¹²
- “Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives.”¹³

When non-Catholic hospitals affiliate with Catholic-sponsored hospitals or health systems, they are usually asked to adopt all or some of these religious restrictions.¹⁴ All business partnerships involving Catholic and non-Catholic hospitals are subject to approval by the local bishop.¹⁵

In the end, health care at Catholic-sponsored and -affiliated facilities is religiously restricted, even as the hospitals open their doors to people of all faiths and accept billions of taxpayer dollars. The continued growth of these facilities, with their adherence to the *Directives*, threatens women's access to crucial, even lifesaving, reproductive health care.

In recent years, women seeking care at such hospitals have encountered a variety of obstacles, including the following:

- Denials of medically appropriate care for miscarriages, when ending a doomed pregnancy promptly would prevent the woman from becoming infected and risking her future fertility. Two such instances are detailed in the case studies section of this report, and additional examples were documented in an article published in the *American Journal of Public Health*;¹⁶
- Refusals to allow tubal ligations at the time of a cesarean-section delivery, even when a woman's physician has warned that any future pregnancies could risk her health or life;¹⁷
- Refusals to treat ectopic pregnancies promptly or with the requisite standard of care.¹⁸

As more hospitals are governed by Catholic doctrine, we expect to see more women denied appropriate care.

KEY FINDINGS:

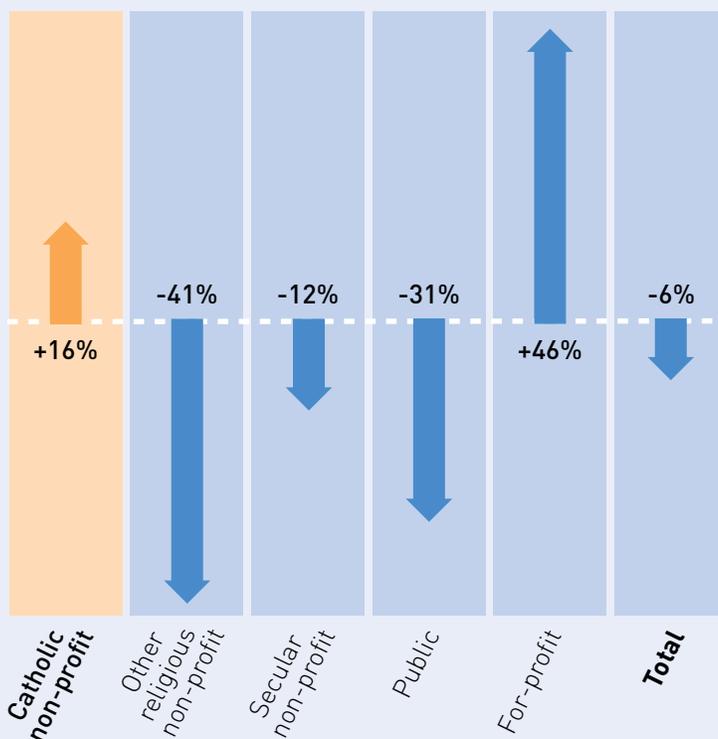
The Expanding Role of Catholic-Sponsored and -Affiliated Hospitals in the Market

In this report, we look at changes in the number and configuration of acute-care hospitals in the United States between 2001 and 2011, the latest year for which complete data were available for this analysis. We focus on acute-care hospitals because they typically operate emergency departments and maternity units, which is where Catholic health restrictions can most directly affect reproductive health care. We present data on hospital funding for 2011 only. The methodology used for the statistical analysis is described in more detail at the end of the report.

KEY FINDINGS INCLUDE THE FOLLOWING:

- Between 2001 and 2011, the number of Catholic-sponsored or -affiliated acute-care hospitals increased by 16 percent. All other types of non-profit hospitals declined in numbers, as did the number of publicly owned hospitals. Only for-profit hospitals grew faster than Catholic facilities. (See Figure 1 and Table 1.)

Figure 1 Percentage change in number of acute-care hospitals by hospital type, 2001 to 2011



- By 2011, 10 percent of all acute-care hospitals were Catholic-sponsored or -affiliated.¹⁹ The percentage was much higher in some states. In Washington State, for example, 28 percent of the acute-care hospitals were Catholic-sponsored or -affiliated in 2011, a percentage that has been climbing even higher over the last two years. Examples of other states with higher-than-average percentages of Catholic-sponsored or -affiliated hospitals in 2011 include Wisconsin with 29 percent, Iowa with 28 percent, and Missouri with 20 percent.

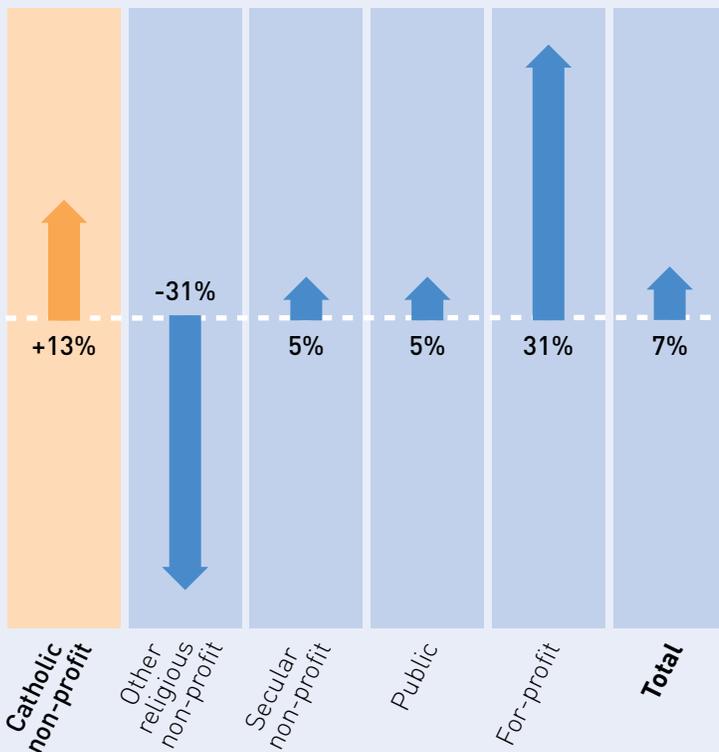
- About one in nine beds was in a Catholic-sponsored or -affiliated hospital in 2011. The number of beds in this category of hospitals increased by 13 percent, from 67,904 to 76,517, over the decade. The number of beds in other religious non-profit hospitals dropped sharply, by 31 percent, while secular non-profit beds grew by a modest 5 percent. Public hospital bed capacity also grew by 5 percent, even though the number of public hospitals decreased. The for-profit sector showed the greatest rate of growth, with 31 percent more beds. (See Figure 2 and Table 2.)

Table 1 Number and percentage of total acute-care hospitals by hospital type, 2001 and 2011

Hospital Type	2001 Hospitals	2001 % of Hospitals	2011 Hospitals	2011 % of Hospitals	Change in Number of Hospitals from 2001 to 2011
Catholic non-profit	329	8.2%	381	10.1%	+16%
Other religious non-profit	248	6.2%	147	3.9%	-41%
Secular non-profit	1,937	48.2%	1,713	45.2%	-12%
Public	843	21.0%	581	15.3%	-31%
For-profit	660	16.4%	964	25.5%	+46%
Total	4,017	100.0%	3,786	100.0%	-6%

- In 2011, 10 of the 25 largest health systems in the nation were Catholic-sponsored.²⁰ Two of those systems (Ascension Health and Catholic Health Initiatives) were the two largest non-profit health systems in the nation and among the five largest systems of any kind. (See Table 3 on page 8.)

Figure 2 Percentage change in number of beds by hospital type, 2001 to 2011



- In 2011, the 10 largest Catholic-sponsored health systems together controlled 330 acute-care hospitals with 63,579 beds — about one third of all the hospitals and beds in the 25 largest systems. (See Table 3 on page 8.) If these 10 Catholic systems were viewed as one, they would constitute the largest health system in the country.²¹

- In 2011, Catholic-sponsored or -affiliated hospitals billed the federal government approximately \$115 billion (referred to as gross government revenues) and reported receiving \$27.1 billion in net government revenues.

- Increasingly, Catholic-sponsored or -affiliated facilities are the sole or primary providers of health care for a given region. Our study found 30 Catholic hospitals that were designated by the federal government as “sole community providers” in 2011. (See Appendix B.) These facilities receive higher levels of reimbursements from the federal government for providing care to a region.²²

Table 2 Number and percentage of beds by hospital type, 2001 and 2011

Hospital Type	2001 Beds	2001 % of Total Beds	2011 Beds	2011 % of Total Beds	Change in Number of Beds from 2001 to 2011
Catholic non-profit	67,904	11.1%	76,517	11.6%	+13%
Other religious non-profit	48,770	7.9 %	33,638	5.1%	-31%
Secular non-profit	316,419	51.5%	331,878	50.9%	+5%
Public	87,077	14.2%	91,789	14.0%	+5%
For-profit	94,131	15.3%	123,260	18.8%	+31%
Total	614,301	100%	657,082	100%	+7%

- In 2011 Catholic-sponsored or -affiliated hospitals provided far less charity care proportionately than public hospitals and no more than other religiously affiliated hospitals. (See Table 4 on page 12.)
- Catholic-sponsored or -affiliated hospitals provided the lowest proportional level of service to Medicaid patients of any type of hospital, as measured by the percentage of gross patient revenues that came from Medicaid in 2011. (See Table 5 on page 13.)

AN IN-DEPTH LOOK:

The Dominance and Power of Catholic-Sponsored Health Systems

One of the most significant findings of our analysis was the growth in size of Catholic-sponsored health systems. Indeed, 10 of the 25 top health systems in the United States are Catholic. (See Table 3 on page 8.) In other words, these Catholic health systems are increasingly big business, with great power in local, regional, and national markets. They are also increasingly poised to influence health care policy.

How did this happen? In the mid-1990s, hospitals (including Catholic-sponsored hospitals), which until then had been largely stand-alone facilities, began to merge for economic

Ascension is what *Modern Healthcare* called “a financial and commercial powerhouse.”

reasons. Merging enabled facilities to control a greater share of the local market and thereby strengthen their ability to negotiate prices with insurers.²⁵ It also allowed hospitals to borrow money to upgrade facilities, to save money through joint purchasing, to share administrative and billing services, and to gain financial shelter during challenging years. This trend has continued, and now these health systems are merging with each other to form ever-bigger entities.

The histories of three of the largest Catholic-sponsored health systems are described below to illustrate the dramatic growth in their size, economic power, and potential influence on health policies. They all belong to the Catholic Health Association of the United States, a trade association for Catholic hospitals. The president of the

association, Sister Carol Keehan, has been described by *Modern Healthcare*, a leading industry magazine, as one of the 10 most influential people in health care in the United States.²⁶

ASCENSION HEALTH

In 2011, Ascension Health was the third largest health system in the country and the largest non-profit health system. Between 2001 and 2011, Ascension’s roster of acute-care hospitals grew from 36 to 69, boosting the number of beds from 8,345 to 13,706. The system’s Medicare gross revenues nearly quintupled during that decade, going from \$2.8 billion in 2001 to \$14 billion in 2011.

Ascension continues to grow. In just the past two years, the health care giant has picked up three additional Catholic-sponsored health systems with a combined \$5.4 billion in annual revenue.²⁷ Today, Ascension has a presence in every region of the country with 93 acute-care hospitals in 23 states²⁸ — including the 69 acute-care hospitals reviewed for this report — and more than 122,000 employees.²⁹

Ascension has also diversified its portfolio over the past decade to include for-profit ventures. It has a successful health care venture fund that now has assets of \$550 million,³⁰ and it has formed a joint venture with a private equity firm focused on Catholic hospital acquisitions.³¹ It is what *Modern Healthcare* called — even in 2007 — “a financial and commercial powerhouse.”³²

Table 3 Ten largest Catholic-sponsored hospital systems in 2011 and rank among top 25 systems nationally

System	Acute-care Hospitals	Beds	Rank
Ascension Health	69	13,706	3
Catholic Health Initiatives	64	10,879	5
Catholic Health East ²³	34	7,510	8
Catholic Healthcare West/Dignity Health ²⁴	36	7,321	10
Trinity Health	31	6,352	11
Catholic Healthcare Partners	25	4,648	16
Christus Health	25	4,111	17
Sisters of Mercy Health System	15	3,459	21
SSM Health Care	18	3,054	22
Bon Secours Health System	13	2,539	24

Ascension’s savvy business orientation is paired with a clear mission to uphold religious doctrine in health care. Ascension President and CEO Anthony Tersigni, who has been listed nine times in *Modern Healthcare’s* top 100 most influential people in health care,³³ has stated, “We’re always looking to strengthen Catholic health care in the United States.”³⁴ Ascension’s Web site states: “Our Catholic philosophy permeates our national health ministries.”³⁵

Ascension’s size and economic clout enhances its ability to influence national health care policy in line with its Catholic mission. For example, Ascension advocated that religiously affiliated health care institutions be exempted from having to comply with the Affordable Care Act’s rule that employers include coverage for contraception in their health plans.³⁶ While hospitals and health systems like Ascension did not get the precise relief they sought, the U.S. Department of Health and Human Services granted them an accommodation, requiring a third-party, not the employer, to arrange and pay for the contraception coverage for their employees.³⁷

CATHOLIC HEALTH INITIATIVES

In 2011, Catholic Health Initiatives (CHI) was the country’s fifth largest health system and second largest non-profit health system. Between 2001 and 2011, the number of CHI hospitals grew from 50 to 64 and its Medicare gross patient revenues ballooned from \$2.7 billion to \$12.2 billion.

This giant Catholic-sponsored health system continues to grow. In May 2013, for example, CHI completed a \$2 billion acquisition of St. Luke’s Episcopal Health System in Texas,³⁸ which included six acute-care hospitals in the Houston-metro area, as well as three emergency care centers, two medical clinics, and two diagnostic and treatment centers. Catholic health care restrictions now apply in all of these historically non-Catholic facilities.³⁹

CHI is also now the majority sponsor of KentuckyOne Health, Kentucky’s largest health system, formed in 2012 by the merger of two local health systems, Jewish Hospital & St. Mary’s Healthcare and St. Joseph Health System.⁴⁰ The University of Louisville Hospital joined the system in early 2013 in an arrangement that “carved out” governance of its Center for Women and Infants, thus protecting it as a secular health care provider,⁴¹ but subjected the rest of the hospital and its 2,600 employees to Catholic restrictions on delivery of medical care.⁴²

Today, because of the addition of new hospitals since 2011, CHI has 87 acute-care hospitals in 17 states, approximately 88,000 employees, and annual operating revenues of more than \$10 billion.⁴³

Like Ascension, CHI has a powerful position in the marketplace as well as the ability to influence health policy. *Modern Healthcare* has included CHI's President and CEO Kevin Lofton 10 times on its list of the 100 most influential people in health care.⁴⁴ CHI established an online Advocacy Action Center in 2007, "designed to make the collective voice of Catholic Health Initiatives heard in the nation's capital ... [and] to participate in key advocacy efforts by communicating with legislators."⁴⁵

CATHOLIC HEALTH EAST/TRINITY HEALTH

Catholic Health East (CHE) and Trinity Health were two of the largest health systems in the nation in 2011. In 2013, they merged. As a combined system, CHE Trinity Health has 82 acute-care hospitals in 20 states, annual operating revenue of \$13.3 billion, more than \$19 billion in assets, and close to 86,000 employees, including about 4,000 physicians.⁴⁶

The beginnings of this behemoth were modest. CHE was created in 1998 when three regional Catholic health systems combined with the goal of "strengthen[ing] the role and identity of the Catholic health ministry in the eastern United States."⁴⁷ By 2011, the Pennsylvania-based system had become the eighth largest health system in the nation. Trinity Health, headquartered in Michigan, was formed in 2000 through the merger of two smaller Catholic systems. A decade later it had become the eleventh largest health system in the United States.

In an interview with *Crain's Detroit Business*, Judith Persichilli, interim president and CEO of the newly merged system, touted its financial strengths and remarked that the merger announcement had prompted other hospitals, including secular ones, to express interest in joining the system.⁴⁸ Persichilli indicated that CHE Trinity Health "would look to align with secular organizations if they 'share our vision and values.'"⁴⁹ Trinity Health officials said they hoped the merger would give them a more powerful, unified voice as a Catholic system.⁵⁰ Trinity Health President and CEO Joseph Swedish called the mega-merger "a natural progression ... so we can better serve people much more efficiently based on our Catholic tradition."⁵¹ That would mean, of course, more hospitals that are restricted in the health care they provide.

In October 2013, CHE Trinity Health named a new high-profile president and CEO, Richard J. Gilfillan, who had been the founding director of the federal Center for Medicare and Medicaid Innovation and the former chief executive at the highly successful Geisinger Health Plan.⁵² "In the midst of a transforming industry, Rick brings a national presence and comprehension to guide our ministry as we pursue new opportunities, tackle new challenges and fulfill our mission," the chair of CHE Trinity Health's board of directors said, in announcing the appointment.⁵³

OUR TAX DOLLARS AT WORK:

Public Funding of Catholic-Sponsored and -Affiliated Hospitals

Even as Catholic hospitals impose religious restrictions on the services they provide — limiting information, referrals, and care — they receive billions of taxpayer dollars each year.

Looking at revenues from Medicare and Medicaid reimbursements, this study found that in 2011:

- Catholic-sponsored and -affiliated hospitals billed Medicare \$81 billion and Medicaid \$34 billion, for a combined total of \$115 billion in “gross patient revenues”; and
- Catholic-sponsored and -affiliated hospitals reported receiving \$27 billion in combined Medicare and Medicaid net revenue.⁵⁴

These public sources accounted for 45.7 percent of total revenues for Catholic-sponsored or -affiliated hospitals, on par with the percentages for other types of hospitals, such as other religious non-profit hospitals (46.4 percent), for-profit hospitals (44.6 percent), secular non-profit hospitals (45.2 percent), and public hospitals (44.6 percent). While these numbers are significant, they understate the public dollars hospitals are receiving, because they do not include hospital reimbursements from Medicare and Medicaid managed care plans. These dollars are now being reported as private insurance dollars, not public money. This underreporting will likely become even more substantial as more people become enrolled in Medicare or Medicaid managed care plans.⁵⁵

Federal dollars typically come with conditions set forth by the federal government. For example, to receive Medicaid and Medicare dollars, hospitals must satisfy certain Conditions of Participation, including requirements to ensure that the patient be “informed of his or her health status, ... involved in care planning and treatment, and ... able to request or refuse treatment.”⁵⁶ In addition, the facilities must “[m]eet the emergency needs of patients in accordance with acceptable standards of practice.”⁵⁷ Hospitals that receive Medicare reimbursements must also comply with the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires facilities with emergency departments to provide treatment to patients with a medical emergency “as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely.”⁵⁸

Complaints and other reports indicate a need for investigations to ensure these conditions are satisfied. Recent complaints lodged with the Centers for Medicare & Medicaid Services (CMS), which enforce the Conditions of Participation, include the following:

- One asking CMS to address a situation in Colorado, where a Catholic-sponsored hospital (part of the CHI system) admonished a physician for advising a pregnant patient about all her treatment options, including the possibility that ending her pregnancy might be necessary to save her life.⁵⁹

- Another asking CMS to investigate Mercy Health Partners in Michigan (part of Trinity Health) after the hospital did not respond appropriately when presented with a patient experiencing premature rupture of membranes. (See Case Study on page 15.)⁶⁰
- A third asking CMS to investigate the provision of emergency care in Catholic facilities, after a bishop admonished a nun who, as a hospital administrator, concurred in a decision to allow a lifesaving abortion at a then-Catholic-sponsored hospital in Arizona. Later, after the hospital refused to agree to stop providing lifesaving abortions in the future, the diocese revoked the hospital's affiliation with the church.⁶¹
- A fourth recounting studies showing mismanagement of miscarriage and ectopic pregnancies at Catholic hospitals.⁶²

The Conditions of Participation should be enforced to ensure, at minimum, emergency reproductive health care and access to information about all of a patient's treatment options at all hospitals, including at Catholic-sponsored and -affiliated hospitals.⁶³

DEBUNKING THE MYTH:

Catholic-Sponsored and -Affiliated Hospitals and Service to the Poor

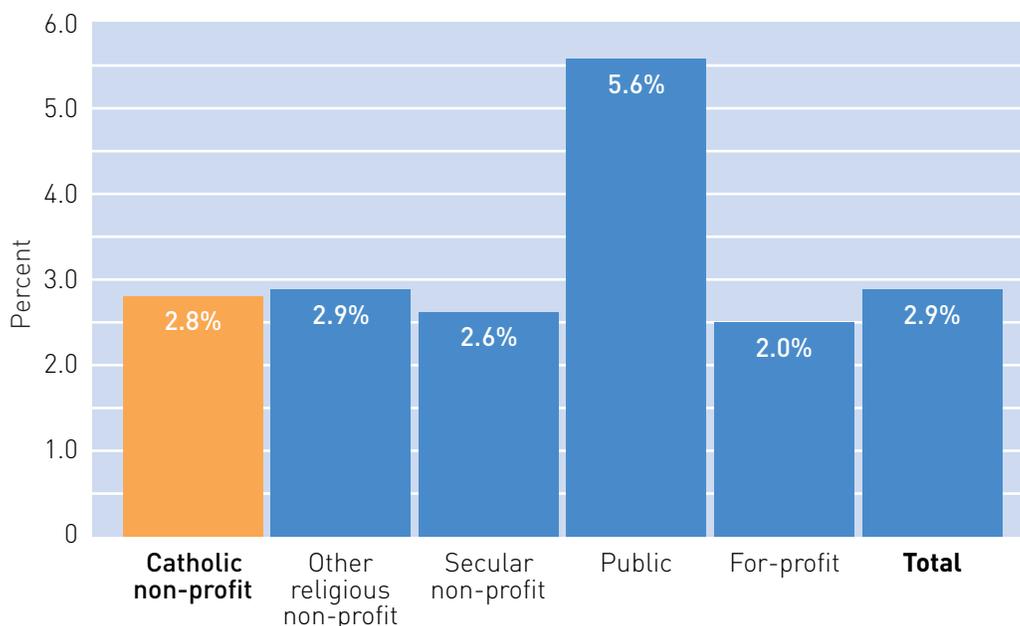
Our analysis shows that, when compared to other types of hospitals, Catholic-sponsored and -affiliated hospitals do not provide a disproportionately large share of charity care or care for Medicaid patients.

Catholic hospitals often counter criticisms of their reproductive health restrictions by emphasizing their mission of serving the poor and providing charity care.⁶⁴ This invites the question: Do Catholic-sponsored and -affiliated hospitals actually do more than their fair share of serving the poor, through charity care and service to Medicaid patients, such that the good they provide might offset the harm imposed by limiting access to services?

Our analysis shows that, when compared to other types of hospitals, Catholic-sponsored and -affiliated hospitals do not provide a disproportionately large share of charity care or care for Medicaid patients. In fact, they provide disproportionately less charity care than do public hospitals and other religious non-profit hospitals, and less care for Medicaid patients than any other type of hospital.

Hospitals report to CMS the dollar value of “charity care”⁶⁵ — health care they provide to patients who are unable to pay. This figure in isolation fails to tell the complete story, however. It must be viewed in context. Across all hospitals nationwide, the value of charity care provided amounts to 2.9 percent of total patient revenue. So we would expect the charity care that an average hospital provides to amount to 2.9 percent of its patient revenue. According to claims made by some Catholic hospitals, we would expect this percentage

Figure 3 Charity care as a percentage of total patient revenue, 2011



to be higher among Catholic-sponsored and -affiliated hospitals. This is not the case, though. As Figure 3 and Table 4 illustrate, public hospitals provide by far the highest level of charity care relative to total patient revenue. Catholic hospitals and other non-profit hospitals provide roughly the average amount of charity care. (See Figure 3 and Table 4.)

Table 4 Charity care charges by hospital type, 2011

Hospital Type	Charity Care Charges (in billions)	Total Gross Patient Revenue (in billions)	Charity Care as a Percentage of Total Gross Patient Revenue
Catholic non-profit	\$7.0	\$251.0	2.8%
Other religious non-profit	\$3.4	\$117.1	2.9%
Secular non-profit	\$29.5	\$1,122.2	2.6%
Public	\$16.5	\$295.0	5.6%
For-profit	\$7.9	\$402.2	2.0%
Total	\$64.3	\$2,187.4	2.9%

Another common measure of service to the poor is the amount of care a hospital provides to low-income patients covered by Medicaid. Gross patient revenues reported for 2011 show that Catholic-sponsored or -affiliated hospitals had the lowest percentage of gross patient revenues coming from Medicaid, as compared with all other hospital types. (See Table 5.) Even for-profit hospitals had a greater share of gross patient revenues from Medicaid, and public hospitals had the highest percentage.

Table 5 Medicaid gross revenue by hospital type, 2011

Hospital Type	Gross Medicaid Revenue (in billions)	Total Gross Patient Revenue (in billions)	Medicaid as a Percentage of Total Gross Patient Revenue
Catholic non-profit	\$33.7	\$251.0	13.4%
Other religious non-profit	\$17.3	\$117.1	14.8%
Secular non-profit	\$160.9	\$1,122.2	14.3%
Public	\$54.1	\$295.0	18.4%
For-profit	\$59.0	\$402.2	14.7%
Total	\$325.1	\$2,187.4	14.9%

CASE STUDIES:

The Impact of Catholic Health Care Restrictions

As discussed above, Catholic-sponsored and -affiliated hospitals prohibit some health services, limit others, and often constrain the ability of staff even to counsel a patient about prohibited care or provide referrals to alternative providers.⁶⁶ These restrictions have real consequences for the diverse populations the hospitals serve, especially in geographic regions where a Catholic-sponsored or -affiliated facility is the sole community provider. Following are two case studies that illustrate how these restrictions have affected patients, physicians, and staff at Catholic-sponsored or -affiliated facilities. These stories are illustrative, but not unique.

“We were told that we wouldn’t have a problem with dealing with miscarriages ... and it turned out not to be true.”

Dr. Bruce Silva
Sierra Vista, AZ

SIERRA VISTA, ARIZONA

In early 2010, historically secular Sierra Vista Regional Health Center in southeastern Arizona began a trial two-year affiliation with the Catholic Carondelet Health Network, a member of the Ascension Health system.⁶⁷ As a condition of the affiliation, Sierra Vista, the sole community provider of acute care in a rural three-county region, was required to follow the *Directives*.

In 2010, a woman who had been 15-weeks pregnant with twins arrived at the Sierra Vista emergency department after miscarrying one of the twins at home. The remaining fetus had a heartbeat. The doctor who examined her recommended that the pregnancy be terminated, given the low chances of a

successful pregnancy and the risks of attempting to continue the pregnancy, including severe hemorrhaging and infection. The physician recalled, “The patient and her husband were, of course, upset by the situation, but decided to proceed with the treatment.”⁶⁸

The physician and staff then began routine preparations to complete the miscarriage. A hospital administrator intervened and ordered the physician to transfer the patient to avoid violating the *Directive* against abortion. The patient was sent by ambulance to another hospital 80 miles away where she received the care she needed.⁶⁹

“It was a very gut-wrenching thing to put the staff through [and to] put the patient through, obviously,” recalled the attending physician.⁷⁰ Another obstetrician felt misled by the hospital administration. “We were told that we wouldn’t have a problem with dealing with miscarriages ... and it turned out not to be true.”⁷¹

Shortly after this incident, the board of Sierra Vista Regional Medical Center voted to discontinue its affiliation with Carondelet Health Network.⁷² The hospital subsequently joined a for-profit health system that has no religious affiliation and is therefore no longer constrained by the *Directives*.

While Catholic health care restrictions should no longer threaten patient health at this Arizona hospital, the issue is far from resolved for other acute-care facilities around the country.

MUSKEGON, MICHIGAN

In 2010, a pregnant mother of three suffered unnecessarily and her health was jeopardized because Mercy Health Partners, a member of Trinity Health, put the *Directives* above her health needs.

Tamesha Means arrived at Mercy Health Partners after her water broke and she began having contractions. She was 18-weeks pregnant. The hospital diagnosed her with preterm premature rupture of membranes (PPROM) and sent her home to wait, telling her there was nothing it could do. It did not tell her that, given the stage of her pregnancy and her condition, the fetus she was carrying had almost no chance of survival and that prolonging the pregnancy could put her health and possibly even her life at risk. Nor did the hospital tell her that the safest treatment option was to induce labor and terminate the pregnancy.

By failing to inform her about her options, the likelihood that her baby would not survive, or the risks of delaying treatment, Mercy Health Partners unnecessarily put Ms. Means' health at grave risk.

The following morning, Ms. Means returned to the hospital with painful contractions, bleeding, and an elevated temperature. The hospital monitored her contractions and gave her two Tylenol. After Ms. Means' temperature went down, the hospital again sent her home.

Later that night, Ms. Means returned to the hospital in extreme distress. Hospital staff again told her there was nothing they could do. While staff began preparing the paperwork to send her home yet again, Ms. Means began to deliver. The hospital then began tending to her miscarriage. She gave birth to a very premature son, who died within hours. Ms. Means' medical records show acute chorioamnionitis and acute funistis, infections that Ms. Means developed after her water broke.

By failing to inform her about her options, the likelihood that her baby would not survive, or the risks of delaying treatment, Mercy Health Partners unnecessarily put Ms. Means' health at grave risk and ultimately, failed to follow medical standards for PPRM with signs of infection. The ACLU has asked CMS to investigate Mercy Health Partners and filed a lawsuit on behalf of Ms. Means.⁷³

A CAUTIONARY TALE:

Marketplace Dominance by Catholic-Sponsored Systems in Washington State

In 2011, 28 percent of the acute-care hospitals in Washington State were sponsored by or affiliated with Catholic health systems; this is almost three times the national percentage of acute-care hospitals run by Catholic sponsors. That share may soon reach 44 percent as a number of transactions involving secular and Catholic health systems reach completion.⁷⁴ These partnerships threaten access to comprehensive reproductive health care across Washington. The threat is most severe in the northwest corner of the state, where three small publicly owned hospitals could soon become the last remaining facilities in that five-county region of the state that are not Catholic-sponsored or-affiliated.

In some states, such as Washington, one quarter or more of the hospitals are Catholic-sponsored or -affiliated, and entire geographic regions have no other choice for hospital care.

Recent transactions between secular and Catholic health systems in Washington involve three of the largest health systems there:

- PeaceHealth, a nine-hospital Catholic-sponsored health system based in Clark County, has been most active in creating partnerships with non-Catholic facilities. Since 2010, PeaceHealth has taken over operation of a publicly owned acute-care hospital⁷⁵ and an independent system, including two hospitals, multiple outpatient facilities, a physician group and a health plan for Medicaid enrollees.⁷⁶ PeaceHealth is now negotiating affiliation agreements with two other public hospitals that provide acute-care services, putting at risk reproductive health care services currently provided at these hospitals.⁷⁷
- In 2013, Franciscan Health System, based in Tacoma and part of the giant Catholic Health Initiatives system, completed two affiliation agreements with large, secular hospitals in Washington State. One is with Highline Medical Center,⁷⁸ which includes a 154-bed acute-care hospital, a 115-bed specialty center, and more than 20 clinics. It serves a low-income population in the West Seattle/

Burien community. Despite promises that Highline facilities would remain secular, doctors at all its facilities are now required to follow the *Directives*.⁷⁹ Harrison Medical Center, a regional health provider and the only full-service hospital on Kitsap Peninsula, is now affiliated with Franciscan as well.⁸⁰ The affiliation agreement prohibits Harrison from performing elective abortions or providing aid-in-dying services, which are legal in Washington.⁸¹ The next closest acute-care facility is an hour-long ferry ride away in Seattle.

- Providence Health & Services, a Catholic system based in Renton and one of the largest health systems in the Northwest, is now affiliated with historically secular Swedish Medical Center, a seven-hospital system with presence in Seattle and the surrounding suburbs.⁸² As a condition of the partnership, Swedish has discontinued providing elective abortions at all its facilities.⁸³

Most of these recent deals received little public attention and escaped state oversight because they were designed as affiliation agreements, not full-asset mergers or acquisitions.

Over time, these affiliation agreements could result in the imposition of more or all of the *Directives*, either because the extent of the business partnership expands or the local bishop chooses to enforce the *Directives* more strictly.

Health care advocates in Washington are pursuing multiple avenues to address the recent rash of completed and proposed Catholic-secular hospital partnerships. For example, an allied group of local activists and organizations⁸⁴ asked the governor to place a moratorium on all hospital transactions until a state-wide health assessment could be completed.⁸⁵ The governor declined to take that course of action⁸⁶ but asked the state Department of Health (DOH) to issue proposed rules that would subject more proposed hospital transactions to state regulatory review.⁸⁷

The state attorney general also issued an opinion affirming that public hospital districts that offer maternity services must provide equivalent benefits, services, or referrals for birth control and abortion as required by Washington State's Reproductive Privacy Act.⁸⁸ This ruling, however, provides protection only at publicly owned health care facilities.

CONCLUSION AND RECOMMENDATIONS:

Protecting Patients' Rights and Access to Comprehensive Reproductive Health Services

As this report documents, the number of Catholic-sponsored and -affiliated hospitals is growing at a greater rate than that of any other type of hospital, except for-profit facilities. Catholic-sponsored health systems are now 10 of the 25 largest systems in the nation. When it comes to the provision of health care in acute-care hospitals, medical standards and community needs, not religious directives, should be the guide.

When it comes to the provision of health care in acute-care hospitals, medical standards and community needs, not religious directives, should be the guide.

Below are immediate steps that federal and state governments, as well as advocates and health professionals and patients, can take to improve access to critical reproductive health care and information. These steps are important to improving care. They will not, however, remedy all the problems identified in this report. They cannot do so, given that federal and state policies currently sanction hospitals' refusals to provide appropriate care in some contexts.⁸⁹ Looking forward, those laws must be repealed. We need not wait until that time, however, to act.

1. Ensure robust governmental oversight of proposed hospital mergers, affiliations, and acquisitions in order to identify and address any potential loss of reproductive health care and other vital health services.

States that regulate hospital transactions must scrutinize proposed transactions to assess whether they will result in a loss of health care services vital to the community, including reproductive health care.

If a proposed hospital partnership would require a facility to discontinue any reproductive health services, state regulators should require an assessment of the likely impact on the community and a plan of affirmative steps to ensure patients' access to these services. If the new entity fails to fulfill promised steps, regulators should take action, including assessing penalties or rescinding authorization for the consolidation.

Of course, regulators can take action only if they have the authority under state laws to scrutinize proposed transactions, to make demands on behalf of the community when care is curtailed, and to take action when conditions imposed on the transaction are not fulfilled. Thus, at the most basic level, advocates and state officials must ensure that the legal authority exists for meaningful review of mergers and other hospital affiliations.

2. Enforce federal law to ensure that patients are given full information about their treatment options.

As noted in the report, patients at Catholic-sponsored or -affiliated hospitals are not always given information about treatment if it is inconsistent with Catholic teaching. The Conditions of Participation, however, require hospitals, as a condition of receiving Medicare and Medicaid

funding, to ensure that the patient has the right to participate in “the development and implementation of his or her plan of care,”⁹⁰ which includes being involved in care planning and treatment.

There is no way for a patient to be involved in the development of a plan of care if the patient lacks information as to the options for care. Both legal and ethical principles of informed consent require doctors to tell patients about all reasonable treatment options, “including those [the doctor] does not provide or favor, so long as they are supported by respectable medical opinion.”⁹¹

CMS should fully enforce these patient protections. It should issue a statement clarifying the obligations of all hospitals, regardless of religious affiliation, to provide information about care options, consistent with the Conditions of Participation. CMS should also investigate complaints of alleged violations, initiate investigations, and take all necessary corrective action where violations are found, including “resolving any deeper, systemic problems.”⁹²

3. Enforce federal law requiring treatment of medical emergencies.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires any hospital that receives Medicare funds and operates an emergency department to stabilize an individual determined to have an emergency medical condition, and prohibits a covered hospital from transferring an individual with an emergency medical condition who has not been stabilized. If stabilizing the patient means terminating a pregnancy, as it will in certain situations, the hospital must do so. The Conditions of Participation similarly require that hospitals meet “the emergency needs of patients in accordance with acceptable standards of practice.”⁹³

CMS should fully enforce these provisions of law. It should issue a statement clarifying the obligation of all hospitals, regardless of religious affiliation, to provide the critical care that EMTALA and the Conditions of Participation demand. CMS should investigate complaints of alleged violations promptly, initiate investigations, and take all necessary corrective action where violations are found.

4. Establish higher standards for facilities designated as “sole community hospitals,” with attendant financial rewards, to meet the health needs of patients in their catchment areas.

CMS should require more of hospitals before they receive the designation of being a sole community hospital and its attendant financial rewards. In particular, CMS should adopt a rule requiring hospitals, as a condition of receiving special payments as a sole community hospital, to meet health care needs as appropriate and inform patients of all treatment options.

5. Expose harms to patients resulting from enforcement of the Directives.

It is critical that providers and patients lodge complaints with CMS; pursue legal action where appropriate; speak out at forums concerning mergers; and otherwise publicize harms resulting from enforcement of the *Directives*. Exposure of the harms is important to spur policy change. This is true whether the harm takes the form of lack of information, delayed treatment of miscarriages, or denial of sterilization at the time of childbirth, among others.

6. Ensure transparency of public funding of religiously affiliated hospitals.

As more Medicare and Medicaid dollars are being channeled through managed care plans, it is harder to track public funding of hospitals. The public has a right to know the magnitude of federal spending going to hospitals that bar certain reproductive health services. CMS should monitor and report the amount of tax dollars hospitals are receiving.

7. Require hospitals to make public their policies on the provision of reproductive health care services.

State health departments should promulgate rules requiring all hospitals to post and to report their policies on the provision of reproductive health care. State health departments could then post these policies on their Web sites. Consumers would then have access to information to help inform their decisions about where to seek health care.

Currently, CMS — through its Conditions of Participation — requires hospitals to notify patients upon admission if the hospital does not honor a patient’s advance directives for end-of-life care because of religious objections. CMS should expand the Conditions of Participation to similarly require hospitals to notify patients of any restrictions on the provision of reproductive health care, where relevant.⁹⁴

8. Reform public policy so that it protects patients in need of reproductive health information and services, as well as individual practitioners willing to provide these services.

The first seven recommendations go only so far in addressing the problems outlined in this report. That is because a host of laws and measures protect institutions, such as Catholic hospitals, that refuse to provide medical information and services to which they have religious or ethical objections. Religiously affiliated hospitals receive billions of dollars in public funding, while maintaining health care restrictions that deny women needed reproductive health care.

Indeed, today, federal and state agencies risk losing federal funding if they “discriminate” against health care institutions that refuse to provide abortion services or even referrals.⁹⁵ While the full reach of these measures is unclear, what is clear is that they bolster institutional policies that can interfere with doctors’ ability to provide the care they think appropriate.

Our policies need to change. We need more protection for patients’ rights and access to needed reproductive health care. The power of the public purse should be used to ensure that facilities are providing adequate information, referrals, and critical care to women.

In other contexts, policymakers have looked to funding streams to effect change in hospitals. For example, in the 1960s, the federal government required hospitals receiving Medicare payments to integrate segregated facilities in accordance with Title VI of the Civil Rights Act of 1964.⁹⁶ More recently, in 2010, the Obama administration required hospitals receiving Medicare or Medicaid reimbursements to advise patients that they have the right to designate visitors and made clear that this right cannot be limited based on sexual orientation or gender identity, among other reasons.⁹⁷

Going forward, we need broad policy reform such that women’s health and rights are respected.

Methodology

Empire Health Advisors, an independent health care consulting firm in Saratoga Springs, NY, conducted data analysis for this study. Hospital data were acquired from Definitive Healthcare – a health care informatics company whose products include an online database of hospital descriptive, utilization, and financial information. The data are updated on a daily basis as information becomes available related to new cost report filings, hospital mergers and acquisitions, and other data modifications.

The Definitive Healthcare source for the financial and utilization data used in this study is the Medicare Cost Report that is filed annually by every hospital. The most current reports available are for hospital fiscal year 2012 (generally ending June 2012), but the majority of hospitals in the database are reporting 2011 data, with fewer than 5 percent of hospitals reporting from earlier years. That is why 2011 data is used for this report.

The hospitals included in the analysis are acute-care hospitals that provide a full range of services. Psychiatric, long-term care, rehabilitation, critical access, pediatric, federal, and developmental facilities were excluded. Throughout this report, unless otherwise noted, “hospital” refers to acute-care facilities.

There are four basic sponsorship types of community hospitals in the United States as defined by the Centers for Medicare and Medicaid Services: governmental (such as those operated by a municipality), proprietary, and two categories of voluntary non-profits: church and other. For purposes of this report and its audience, the term public is used to describe governmental hospitals, for-profit to describe proprietary, and secular non-profit to clearly distinguish them from religiously sponsored hospitals. Each hospital in the study database was assigned to one of these types based upon its self-designation on its cost report. In the case of religious hospitals, Empire Health Advisors designated hospitals as Catholic or other based upon research into each individual hospital by research staff. In a small number of cases where the self-designation appeared to be incorrect, the research team checked the sponsorship with hospital Web sites and modified the sponsorship to improve accuracy of the designation. There may be additional hospital self-designations that are incorrect that remain unverified, but the research team believes the number of such cases to be negligible.

Lead researcher, Patricia HasBrouck structured and assessed the data to understand issues such as:

- Have there been notable shifts in hospital sponsorship and, if so, why and what does it mean for the population?
- How much consolidation has been occurring in the hospital marketplace, why, and how is it affecting the health care landscape? How are hospital systems changing and what impact does that have on health care policy and on individual access to services?

In every case, these questions were considered with an eye toward reproductive health care. This report connects findings from the data with other information sources to develop a more complete picture of the current hospital industry and the dynamics of the changing systems of care.

Appendix A

Sampling of The Ethical and Religious Directives for Catholic Health Care Services⁹⁸

5. Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.
9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.
24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.
25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes – usually family members and loved ones – should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.
27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.
28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.
36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.
38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.
39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.
41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).
44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.
45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.
47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.
48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.
50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.
52. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.
53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.
58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.
59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

Appendix B

Catholic Sole Community Hospitals in the United States, 2011

Hospital	City	State	Beds	Discharges	ER Visits
Sierra Vista Regional Health Center	Sierra Vista	AZ	88	5,656	27,939
St. Elizabeth Community Hospital	Red Bluff	CA	76	3,012	35,199
Mercy Regional Medical Center	Durango	CO	82	5,439	22,269
St. Mary's Hospital and Medical Center	Grand Junction	CO	278	12,136	48,124
St. Joseph Regional Medical Center	Lewiston	ID	103	4,358	32,929
St. Anthony Regional Hospital	Carroll	IA	59	1,796	9,311
Mercy Medical Center - North Iowa	Mason City	IA	211	12,142	46,009
Via Christi Hospital Pittsburg	Pittsburg	KS	101	4,660	16,547
Salina Regional Health Center	Salina	KS	177	6,971	30,823
St. Catherine Hospital	Garden City	KS	90	2,896	12,692
St. Claire Regional Medical Center	Morehead	KY	91	4,341	33,688
Northern Maine Medical Center	Fort Kent	ME	43	1,257	11,027
Mercy Hospital - Cadillac	Cadillac	MI	82	3,756	31,806
St. Joseph Hospital	Tawas	MI	49	1,907	26,306
OSF St. Francis Hospital	Escanaba	MI	48	2,038	27,785
Essentia Health St. Joseph's Medical Center (FKA St. Joseph's Medical Center)	Brainerd	MN	140	5,825	46,411
Essentia Health St. Mary's Hospital - Detroit Lakes (FKA St. Mary's Regional Health Center)	Detroit Lakes	MN	41	2,511	14,612
Saint James Healthcare	Butte	MT	86	3,863	19,269
Good Samaritan Hospital	Kearney	NE	196	8,664	18,117
Genesis Bethesda Hospital	Zanesville	OH	283	16,789	78,282
Mercy Medical Center	Roseburg	OR	125	7,461	46,674
Avera St. Luke's Hospital	Aberdeen	SD	107	5,773	21,238
Christus Spohn Hospital Beeville	Beeville	TX	49	1,916	19,139
Christus Spohn Hospital Kleberg	Kingsville	TX	77	3,879	19,088
Covenant Hospital Plainview	Plainview	TX	49	2,092	14,001
Christus Spohn Hospital Alice	Alice	TX	104	3,436	29,915
Providence Centralia Hospital	Centralia	WA	74	5,592	38,653
PeaceHealth St. Joseph Hospital	Bellingham	WA	207	26,709	58,050
Saint Mary's Hospital	Rhineland	WI	62	1,599	25,681
Saint Joseph's Hospital	Marshfield	WI	470	18,737	31,330
TOTAL			3,560	181,555	892,914

Appendix C

25 Largest Health Care Systems in the United States, 2011

2011 Rank (by number of beds)	System	Hospital Type	2011 Hospital Beds	2011 Number of Hospitals
1	HCA - The Healthcare Company	For-profit	33,439	161
2	Community Health Systems	For-profit	15,318	123
3	Ascension Health	Catholic non-profit	13,706	69
4	Tenet Healthcare Corporation	For-profit	11,617	47
5	Catholic Health Initiatives	Catholic non-profit	10,879	64
6	Health Management Associates	For-profit	9,293	69
7	Kaiser Foundation Hospitals	Secular non-profit	8,455	33
8	Catholic Health East	Catholic non-profit	7,510	34
9	New York Presbyterian Healthcare System	Secular non-profit	7,412	31
10	Dignity Health (FKA Catholic Healthcare West)	Catholic non-profit	7,321	36
11	Trinity Health	Catholic non-profit	6,352	31
12	Adventist Health System Sunbelt	Religious non-profit	5,921	33
13	Lifepoint Hospitals	For-profit	5,615	54
14	Carolinas Healthcare System	Secular non-profit	5,122	31
15	Universal Health Services	For-profit	4,756	26
16	Catholic Healthcare Partners	Catholic non-profit	4,648	25
17	Christus Health	Catholic non-profit	4,111	25
18	Sutter Health	Secular non-profit	4,041	27
19	Banner Health System	Secular non-profit	3,917	16
20	Prime Healthcare Services	For-profit	3,503	24
21	Sisters of Mercy Health System	Catholic non-profit	3,459	15
22	SSM Health Care	Catholic non-profit	3,054	18
23	Bon Secours Health System	Catholic non-profit	2,539	13
24	Adventist Health	Religious non-profit	2,073	15
25	Allina Health System	Secular non-profit	2,056	10

Bibliography of Key News Articles

- Reed Abelson. *Catholic Hospitals Expand, Religious Strings Attached*. The New York Times, Feb. 21, 2012.
- Jonathan Cohn. *Unholy Alliance*. The New Republic, Feb. 22, 2012.
- Editorial. *Women's Health Care at Risk*. The New York Times, Feb. 29, 2012.
- Susan Berke Fogel & Lourdes A. Rivera. *Religious Beliefs and Healthcare Necessities: Can They Coexist?* American Bar Association – Human Rights Magazine, Spring 2003.
- Molly M. Ginty. *Treatment Denied*. Ms. Magazine, Spring 2011.
- Kirk Johnson. *Hospital Mergers Reset Abortion-Access Battle*. The New York Times, May 12, 2013.
- Sarah Kliff. *Catholic Hospitals are Growing. What Will That Mean for Reproductive Health?* The Washington Post, Dec. 2, 2013.
- Nina Martin. *Catholic Hospitals Grow, and With Them Questions of Care*. Pro Publica, Oct. 17, 2013.
- Stephanie Mencimer. *Do Bishops Run Your Hospital?* Mother Jones, Nov./Dec. 2013.
- Carol M. Ostrom. *Hospitals' Proposed Affiliation with Catholic Systems Opposed*. The Seattle Times, Apr. 27, 2013.
- Carol M. Ostrom. *Inslee Orders State to Update Hospital-Merger Rules*. The Seattle Times, July 8, 2013
- Jordan Rau, *In Quest to Grow, Catholic Hospital System Pares Religious Ties*. Kaiser Health News, Jan. 23, 2012.
- Ashok Selvam. *Business Conversion*. Modern Healthcare Magazine, Jan. 28, 2013.
- Lucky Severson. *Catholic-Secular Hospital Mergers*. PBS: Religion and Ethics Newsweekly, Mar. 25, 2011.
- Rob Stein. *Reproductive Care Restrictions at Catholic Hospitals Spark Conflict, Scrutiny*. The Washington Post, Jan 20. 2011.
- Rob Stein. *Abortion Fight at Catholic Hospital Pushes ACLU to Seek Federal Help*. The Washington Post, Dec. 22, 2010.
- Laura Ungar. *Merger Mania: Louisville Hospitals Part of the U.S. Surge*. The Courier-Journal, Nov. 7, 2011.

Bibliography of Papers and Reports

- Am. Civil Liberties Union. *Religious Refusals and Reproductive Rights* (2002).
- Beldon, Russonello Strategists. *American Attitudes on Religious Exemptions: In Theory and Practice*, A national opinion survey for the American Civil Liberties Union and Catholics for Choice (2012).
- Comm. on Health Care for Underserved Women, Am. Coll. of Obstetricians & Gynecologists Comm. Op. No. 530, *Access to Postpartum Sterilization* (2012).
- Comm. on Ethics, Am. Coll. of Obstetricians & Gynecologists, Comm. Op. No. 385, *Limits of Conscientious Refusals in Reproductive Medicine* (2007).
- Marge Berer. *Termination of Pregnancy as Emergency Obstetric Care: The Interpretation of Catholic Health Policy and Consequences for Pregnant Women*. Reproductive Health Matters (2013).
- Julie Cantor & Ken Baum. *The Limits of Conscientious Objection – May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?* 351 New Eng. J. Med. 2008 (2004).
- R. Alta Charo. *The Celestial Fire of Conscience*. 352 New Eng. J. Med. 2471 (2005).
- Elena N. Cohen & Alison Sclater. *Truth or Consequences: Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care*. Nat'l Women's Law Center (2003).

Farr A. Curlin et al. *Religion, Conscience, and Controversial Clinical Practices*. 356 *New Eng. J. Med.* 593 (2007).

Sabrina Dunlap. *When Views Collide: How Hospital Mergers Restrict Access to Reproductive Health Care*. 2 *Am. U. Health Law & Policy Brief* 30 (2008).

Lori R. Freedman et al. *When There's A Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*. 98 *Am. Journal of Pub. Health* 1774 (2008).

Lori R. Freedman & Debra B. Stulberg. *Conflicts in Care for Obstetric Complications in Catholic Hospitals*. *Am. U. Journal of Bioethics Primary Research* (2012).

Guttmacher Institute. *State Policies in Brief: Refusing to Provide Health Services*. (2009).

Ron Hamel. *Thinking Ethically About Emergency Contraception*. 91.1 *Health Progress* 62 (2010).

Ibis Reproductive Health, Catholics for a Free Choice. *Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms* (2002).

MergerWatch. *No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States* (2002).

Jill Morrison & Micole Allekotte. *Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious, or Ethical Reasons*. 9 *Ave Maria L. Rev.* 141 (2010).

Standards of Care Project, Nat'l. Health Law Program. *Health Care Refusals: Undermining Quality Care for Women* (2010).

Nat'l Women's Law Ctr. *Below the Radar: Health Care Providers' Religious Refusals Can Endanger Pregnant Women's Lives and Health* (2011).

Kevin O'Rourke. *Catholic Health Care and Sterilization*. 83 *Health Progress* 43 (2002).

Comm. on Bioethics. *Physician Refusals on the Basis of Claims of Conscience*. 124 *Pediatrics* 1689 (2009).

Ramesh Raghavan. *Question of Faith*. 297 *Journal of the Am. Medical Assoc.* 1412 (2007).

Andrea Ries Thurman & Torri Janecek. *One Year Follow-Up of Women with Unfulfilled Postpartum Sterilization Requests*. 116 *Am. Coll. of Obstetricians & Gynecologists* 1071 (2010).

Sandra E. Reznik. *Plan B: How It Works*. 91.1 *Health Progress* 59 (2010).

Elizabeth Sepper. *Taking Conscience Seriously*. 98 *VA. L. Rev.* 1501 (2012).

Debra Stulberg et al. *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*. 25 *U. Chi. Journal of Gen. Intern. Med.* 725 (2010).

Debra Stulberg et al. *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies*. 207 *Am J Obstetrics & Gynecology* 1 (2012).

Lois Uttley et al. *Merging Catholic and Non-Sectarian Hospitals: New York State Models for Addressing Ethical Challenges*. 17 *N.Y. State Bar Ass'n Health L. Journal* 38 (2012).

Robin Fretwel Wilson. *Essay: The Limits of Conscience: Moral Clashes over deeply Divisive Healthcare Procedures*. 34 *Am. J.L. & Med.* 41 (2008).

Nikki Zite et al. *Failure to Obtain Desired Postpartum Sterilization: Risk and Predictors*. 105 *Obstetrics and Gynecology* 794 (2005).

Endnotes

¹ We use the phrase “Catholic-sponsored” to refer to hospitals that are owned by a Catholic entity, such as an order of Catholic sisters or brothers or a diocese. We use “Catholic-affiliated” to refer to hospitals that were historically non-Catholic but have formed a business partnership with a Catholic hospital or system. Catholic-sponsored facilities must comply with all the Ethical and Religious Directives for Catholic Health Care Services (the *Directives*) discussed in this report. Catholic-affiliated hospitals typically agree to adhere to some or all of the *Directives* as a condition of the business partnership. Lois Uttley, et al., *Merging Catholic and Non-Sectarian Hospitals: New York State Models for Addressing the Ethical Challenges*, 17 NYSBA HEALTH L.J. 38 (2012).

² This report focuses on Catholic-sponsored and -affiliated facilities because they occupy such a significant share of the market and they subject patients and physicians to extensive restrictions on health care.

³ United States Conference of Catholic Bishops, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), available at <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf> [hereinafter *Directive(s)*].

⁴ *Id.* at 8.

⁵ Appendix A includes more excerpts from the *Directives* relevant to patient care.

⁶ *Directive 52, supra* note 3.

⁷ *Directive 45, supra* note 3.

⁸ *Directive 53, supra* note 3.

⁹ *Directive 28, supra* note 3; see also *Directive 27* (“Free and informed consent requires that the person ... receive all reasonable information about the essential nature of proposed treatment and its benefits ... and any reasonable and morally legitimate alternatives ...”) (emphasis added).

¹⁰ *Directive 50, supra* note 3.

¹¹ *Directive 40, supra* note 3.

¹² *Directive 5, supra* note 3.

¹³ *Directive 9, supra* note 3.

¹⁴ Uttley, et al., *supra* note 1, at 38.

¹⁵ *Id.*

¹⁶ Lori R. Freedman, Uta Landy & Jody Steinauer, *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. OF PUB. HEALTH 1774 (2008); Lori R. Freedman & Debra B. Stulberg, *Conflicts in Care for Obstetric Complications in Catholic Hospitals*, 4 AM. J. OF BIOETHICS PRIM. RES. 1 (2013).

¹⁷ Jonathan Cohn, *Unholy Alliance*, THE NEW REPUBLIC, Feb. 22, 2012, available at www.newrepublic.com/article/politics/magazine/100960/catholic-church-hospital-health-care-contraception.

¹⁸ Sabrina Rubin Erdely, *Could Your Doctor Deny You Health Care?*, SELF, May 2007, available at <http://www.self.com/health/2007/05/denial-of-health-care?printable=true>; Letter from Judy Waxman, Vice President Health and Reproductive Rights, National Women’s Law Center, and Jill C. Morrison, Senior Counsel at National Women’s Law Center, to Marilyn Tavenner, Thomas E. Hamilton, and James Randolph Farris, M.D., Centers for Medicare & Medicaid Services (Jan. 20, 2011) (citing studies), available at http://www.nwlc.org/sites/default/files/pdfs/nwlc_cms_complaint_jan_2011.pdf [hereinafter Waxman Letter].

¹⁹ These numbers and percentages differ from those published by the Catholic Health Association of the United States (CHA) because this report focuses solely on acute-care hospitals. See Catholic Health Association of the United States,

Catholic Health Care in the United States (Jan. 2013), available at http://www.chausa.org/docs/default-source/general-files/mini_profile-pdf.pdf?sfvrsn=0. CHA's stated membership of 630 facilities, 12.6 percent of all hospitals and 14.9 percent of all hospital beds, includes rehabilitation hospitals and other types of facilities where religious restrictions on reproductive health care have little or no impact. *Id.*

²⁰ This is ranked by number of acute-care hospital beds.

²¹ HCA Healthcare Company, a for-profit hospital chain, was the largest health care system in the country in 2011, with 161 acute-care hospitals and 33,439 beds. See Appendix C for a complete list of the 25 largest health systems in the country.

²² See 42 C.F.R. § 412.92 (2013) (defining criteria for sole community hospitals, largely based on distance from other like facilities).

²³ In 2013, Catholic Health East and Trinity Health merged into a larger combined system. See *infra* page 9.

²⁴ In January 2012, Catholic Healthcare West changed its name to Dignity Health and announced that, while rooted in the Catholic tradition, it would no longer be a ministry of the Catholic Church. Its traditionally Catholic hospitals still have all the Catholic health restrictions, while a limited set of Catholic health restrictions are imposed on any non-Catholic hospital in its system. See Kathy Robertson, *Catholic Healthcare West Changes Name to Dignity Health, Ends Church Affiliation*, SACRAMENTO BUS. J., Jan. 24, 2012, available at www.bizjournals.com/sacramento/news/2012/01/24/chw-dignity-health-ends-religious-affili.html.

²⁵ For details on the financial incentives behind hospital mergers, see Eduardo Porter, *Health Care's Overlooked Cost Factor*, N.Y. TIMES, June 11, 2013, available at <http://www.nytimes.com/2013/06/12/business/examinations-of-health-costs-overlook-mergers.html?pagewanted=all>. ("[Mergers] were a great deal for hospitals. The fees they charged to insurers soared.")

²⁶ *100 Most Influential People in Healthcare – 2013, 10. Sister Carol Keehan, Catholic Health Association*, MODERN HEALTHCARE, Aug. 24, 2013, available at <http://www.modernhealthcare.com/gallery/20130824/PHOTO/824009999/PH&Params=Itemnr=10&Template=galleryzoom>.

²⁷ Angela Mueller, *Ascension Health on Steroids: Marian Deal Grows Nation's Largest Catholic System to \$20 Billion*, ST. LOUIS BUS. J., Sept. 28, 2012, available at <http://www.bizjournals.com/stlouis/print-edition/2012/09/28/ascension-health-on-steroids.html>.

²⁸ Beth Kutscher, *Ascension Completes Marian Health Acquisition*, MODERN HEALTHCARE, Apr. 1, 2013, available at <http://www.modernhealthcare.com/article/20130401/NEWS/304019967>.

²⁹ Ascension Health, ASCENSION HEALTH ALLIANCE ANNUAL REPORT (2012), available at <http://www.ascensionhealth.org/annualreport/aha.html>.

³⁰ Amir Kurtovic, *Ascension Health Ventures Closes on \$225 Million Venture Fund*, ST. LOUIS BUS. J., Jan. 7, 2013, available at <http://www.bizjournals.com/stlouis/blog/BizNext/2013/01/ascension-health-ventures-closes-on.html>.

³¹ See Mueller, *supra* note 27.

³² Melanie Evans, *Ascending in Healthcare*, MODERN HEALTHCARE, May 14, 2007, available at <http://www.modernhealthcare.com/article/20070514/NEWS/70511014>.

³³ *100 Most Influential People in Healthcare – 2013, 61. Anthony Tersigni, Ascension Health Alliance*, MODERN HEALTHCARE, Aug. 24, 2013, available at <http://www.modernhealthcare.com/gallery/20130824/PHOTO/824009999/PH&Params=Itemnr=61&Template=galleryzoom>.

³⁴ See Mueller, *supra* note 27.

³⁵ Ascension Health, <http://www.ascensionhealth.org/> (last visited Dec. 2, 2013).

- ³⁶ Letter from Antony R. Tersigni, President and Chief Executive Officer, Ascension Health Alliance to Centers for Medicare & Medicaid Services (Apr. 5, 2013), available at http://www.act2020.org/cmsassets/files/Ascension_Health_Comment_Letter.pdf.
- ³⁷ Ascension and others asked for an exemption which, if granted, would have meant the employer would have no obligation under the rule and the employees would have no coverage. Under the accommodation, objecting hospitals and other non-profits that hold themselves out as religious need not provide coverage but must instead only certify their objections to providing contraception coverage to their insurer, and the insurer or another third party must then provide payments for contraceptives. 26 C.F.R. § 54.9815-2713A(a) (2013); 29 C.F.R. § 2590.715-2713 (2013); 45 C.F.R. § 147.130 (2013). Any number of religiously affiliated non-profit entities is objecting to even this requirement. American Civil Liberties Union, *Challenges to the Federal Contraceptive Coverage Rule*, available at <https://www.aclu.org/reproductive-freedom/challenges-federal-contraceptive-coverage-rule> (last visited Dec. 6, 2013).
- ³⁸ Bayan Raji, "St. Luke's Sale a 'Done Deal,'" HOUSTON BUS. J., May 31, 2013, available at <http://www.bizjournals.com/houston/news/2013/05/31/st-lukes-chi-merger-a-done-deal.html>.
- ³⁹ Todd Ackerman, *Concerns Mounting About Catholic Acquisition of St. Luke's*, HOUSTON CHRONICLE, Apr. 28, 2013, available at <http://www.houstonchronicle.com/news/houston-texas/houston/article/Concerns-mounting-about-Catholic-acquisition-of-4469559.php?t=d10087c2d622438ca1>.
- ⁴⁰ Ed Green, *Jewish Hospital Parent Merges with Lexington System*, BUSINESS FIRST OF LOUISVILLE, Jan. 6, 2012, available at <http://www.bizjournals.com/louisville/news/2012/01/06/jewish-hospital-parent-to-merge-with.html?page=all>.
- ⁴¹ Laura Ungar, *KentuckyOne Health Takes Over University Hospital Management Friday*, LOUISVILLE COURIER J., Feb. 28, 2013, available at <http://www.courier-journal.com/article/20130227/PRIME01/302280024/KentuckyOne-Health-takes-over-University-Hospital-management-Friday>.
- ⁴² The partnership also curtailed their employee health insurance. See Laura Ungar, *University of Louisville Hospital Pushing Catholic Beliefs Through Health Insurance Changes, Critics Argue*, LOUISVILLE COURIER J., Nov. 24, 2013, available at <http://www.courier-journal.com/article/20131123/NEWS01/311230062/U-L-Hospital-pushing-Catholic-beliefs-through-health-insurance-changes-critics-argue>.
- ⁴³ CATHOLIC HEALTH INITIATIVES, ANNUAL REPORT (2013), available at http://catholichealthinit.org/documents/Financial_Information/CHI%20Reporting%20Group%20Annual%20Report%20-%20FY2013.pdf.
- ⁴⁴ *100 Most Influential People in Healthcare – 2013*, 30. Kevin Lofton, *Catholic Health Initiatives*, MODERN HEALTHCARE, Aug. 24, 2013, available at <http://www.modernhealthcare.com/gallery/20130824/PHOTO/824009999/PH&Params=Itemnr=30&Template=galleryzoom>.
- ⁴⁵ Catholic Health Initiatives, *New Advocacy Action Center Available to All Catholic Health Initiatives Employees*, INITIATIVES ONLINE (Nov.-Dec. 2007), available at <http://www.catholichealthinitiatives.com/body.cfm?id=37785&action=detail&ref=2300>.
- ⁴⁶ New Health Ministry, *About Us*, available at <http://www.newhealthministry.org/about.shtml> (last visited Dec. 6, 2013).
- ⁴⁷ Catholic Health East, *The History of Catholic Health East*, available at <http://www.che.org/about/history.php> (last visited Dec. 6, 2013).
- ⁴⁸ Ashok Selvam, *Trinity Health, Catholic Health East Complete Merger*, CRAIN'S DETROIT BUSINESS, May 2, 2013, available at <http://www.craindetroit.com/article/20130501/NEWS/130509989/trinity-health-catholic-health-east-complete-merger#>.
- ⁴⁹ *Id.*
- ⁵⁰ Ashok Selvam, *Major Merger*, MODERN HEALTHCARE, Oct. 20, 2012, available at <http://www.modernhealthcare.com/article/20121020/MAGAZINE/310209991>.
- ⁵¹ *Id.*
- ⁵² Press Release, Trinity Health, *CHE Trinity Names Richard J. Gilfillan, M.D., to be CEO* (Oct. 29, 2013), available at <http://www.trinity-health.org/body.cfm?id=186&action=detail&ref=51>.

- ⁵³ *Id.*
- ⁵⁴ Medicare and Medicaid dollars are not, of course, the only sources of government funds the hospitals receive. They are the ones we considered for the purpose of this report.
- ⁵⁵ In 2011, 25 percent of the Medicare population and 74 percent of the Medicaid population were enrolled in these managed care plans. As this type of enrollment increases over time, the degree to which these hospitals rely on public funding is becoming less transparent. The Henry J. Kaiser Family Foundation, *Medicare Advantage Fact Sheet*, Nov. 25, 2013, available at <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>; The Henry J. Kaiser Family Foundation, *Medicaid Managed Care: Key Data, Trends, and Issues*, Feb. 2012, available at <http://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf>.
- ⁵⁶ 42 C.F.R. § 482.13 (2013).
- ⁵⁷ 42 C.F.R. § 482.55 (2013).
- ⁵⁸ 42 U.S.C. § 1395dd(e)(3)(A) (2006) (“Examination and treatment for emergency medical conditions and women in labor.”).
- ⁵⁹ Complaint from ACLU of Colo. to Colo. Dep’t of Pub. Health and Envir. (Nov. 13, 2013), copied to CMS, available at <http://aclu-co.org/sites/default/files/2013-11-13%20CDPHE-Rich.pdf>.
- ⁶⁰ Letter from Alexa Kolbi-Molinas, Staff Attorney, American Civil Liberties Union, and Brooke Tucker, Staff Attorney, ACLU of Michigan, to Pamela J. Para, Nurse Consultant, Centers for Medicare & Medicaid Services (Dec. 17, 2013), available at https://www.aclu.org/sites/default/files/assets/aclu_letter_to_center_for_medicare_and_medicare_services_re_denial_of_reproductive_health_care_at_a_religious_hospital.pdf [hereinafter Means Letter]; Complaint, *Means v. U.S. Conf. of Catholic Bishops*, No. 2:13-cv-14916 (E. D. Mich. Nov. 29, 2013), available at https://www.aclu.org/sites/default/files/assets/complaint_final_1.pdf [hereinafter Means Complaint].
- ⁶¹ Letter from Laura W. Murphy, Director, Washington Legislative Office, American Civil Liberties Union, et al., to Marilyn Tavenner, Acting Administrator, Principal Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services (July 1, 2010), available at https://www.aclu.org/files/assets/Letter_to_CMS_Final_PDF.pdf. See also Letter from Roman Catholic Diocese of Phoenix to Catholic Healthcare West (Nov. 22, 2010), available at <https://www.aclu.org/files/assets/2010-11-22-bishopletter1.pdf>; Media Statement, St. Joseph’s Hospital and Medical Center, St. Joseph’s Resolved in Saving Mother’s Life, Confident Following Bishop’s Announcement (Dec. 21, 2010), available at <http://www.azcentral.com/ic/pdf/1221st-joseph-statement.pdf>.
- ⁶² See Waxman Letter, *supra* note 18.
- ⁶³ CMS enforces its Conditions of Participation in other contexts. For example, it investigates and fines hospitals for refusing to serve or otherwise “dumping” patients who present at the emergency rooms, typically because of the unreimbursed expense of caring for indigent patients. Office of Inspector General, U.S. Dep’t of Health & Human Servs., Enforcement Action: Patient Dumping, available at https://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp (last visited Dec. 6, 2013).
- ⁶⁴ For example, Catholic Health Initiatives’ promotional materials boast of having provided more than \$612 million in charity care and community benefits during fiscal year 2011. See Catholic Health Initiatives, Join Our Amazing Group of Physicians! In Omaha Nebraska United States, available at <http://catholichealth.jobs/omaha-ne/join-our-amazing-group-of-physicians/37454295/job/>.
- ⁶⁵ Charity Care is reported on Worksheet S-10 on the Medicare Cost Report, which defines charity care as “Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital’s policy to provide all or a portion of services free of charge to patients who meet certain financial criteria.”
- ⁶⁶ See Directives 27-28, *supra* note 3.
- ⁶⁷ Bill Hess, *Carondelet Deal to Bring Changes at Local Hospital*, SIERRA VISTA HERALD, Feb. 2, 2010, available at <http://www.svherald.com/content/news/2010/02/20/91284>.

- ⁶⁸ Affidavit of Dr. Robert Holder at 6 (Dec. 10, 2010), available at <http://www.washingtonpost.com/wp-srv/health/documents/abortion/ibis-press-release-final-01202011.pdf>.
- ⁶⁹ See Cohn, *supra* note 17.
- ⁷⁰ Interview by Jackie Ochs with Dr. Robert Holder, OB/GYN, Sierra Vista Regional Health Center, Sierra Vista, AZ (Apr. 9, 2012).
- ⁷¹ Interview by Jackie Ochs with Dr. Bruce Silva, OB/GYN, Sierra Vista Regional Health Center, Sierra Vista, AZ (Apr. 9, 2012).
- ⁷² Bill Hess, *Hospital, Carondelet to Terminate Deal*, SIERRA VISTA HERALD, Mar. 30, 2011, available at <http://www.svherald.com/content/news/2011/03/30/hospital-carondelet-terminate-deal>.
- ⁷³ Means Letter, *supra* note 60; Means Complaint, *supra* note 60.
- ⁷⁴ These percentages are based on our study methodology, which focused on the number of acute-care hospitals only. ACLU-WA has used a different methodology counting acute-care, critical access and long-term care facilities by number of hospital beds. They found that 45% of these hospital beds in Washington are Catholic-controlled. If all proposed transactions go through, 48% of these hospital beds would become Catholic-controlled.
- ⁷⁵ *State OKs San Juan Island Hospital Certificate of Need*, PUGET SOUND BUS. J., Jan. 29, 2010, available at <http://www.bizjournals.com/seattle/stories/2010/01/25/daily36.html>.
- ⁷⁶ Aaron Corvin, *Southwest, PeaceHealth Finalize Merger*, THE COLUMBIAN, Dec. 8, 2010, available at <http://www.columbian.com/news/2010/dec/08/southwest-washington-medical-center-and-peacehealth/>.
- ⁷⁷ Valerie Bauman, *Catholic System PeaceHealth Wins Affiliation With Two Northern Hospitals*, PUGET SOUND BUS. J., Aug. 29, 2013, available at <http://www.bizjournals.com/seattle/blog/health-care-inc/2013/08/catholic-system-peacehealth-wins.html?page=all>.
- ⁷⁸ Press Release, Franciscan Health System, Franciscan Health System Welcomes Highline Medical Center (Apr. 12, 2013), available at <http://www.fhshealth.org/news/Franciscan-Health-System-Welcomes-Highline-Medical-Center/>.
- ⁷⁹ Susan Riemer, *Islanders Express Skepticism Over Recent Health Care Merger*, VASHON-MAURY ISLAND BEACHCOMBER, Apr. 30, 2013, available at <http://www.vashonbeachcomber.com/news/205435131.html>.
- ⁸⁰ Rachel Pritchett, *Harrison Affiliation Plan Filed With State*, KITSAP SUN, June 22, 2013, available at <http://www.kitsapsun.com/news/2013/jun/22/harrison-affiliation-plan-filed-with-state/>.
- ⁸¹ Rachel Pritchett, *Harrison-Franciscan Affiliation Comes Amid Wave of Secular-Religious Partnerships*, KITSAP SUN, May 11, 2013, available at <http://www.kitsapsun.com/news/2013/may/11/harrison-franciscan-affiliation-comes-amid-wave-se/#axzz2md0UKYsN>.
- ⁸² Carol M. Ostrom, *Swedish Alliance With Providence is Now Complete*, SEATTLE TIMES, Feb. 1, 2012, available at http://seattletimes.com/html/localnews/2017392462_swedishprovidence02m.html.
- ⁸³ Carol M. Ostrom, *Under Pressure on Abortion, Swedish Backs Planned Parenthood Clinic*, SEATTLE TIMES, Oct. 14, 2011, available at http://seattletimes.com/html/localnews/2016503475_swedish15m.html.
- ⁸⁴ This group includes organizations dedicated to protecting patients' rights and access to reproductive health care and end-of-life choices, as well as LGBT organizations.
- ⁸⁵ Valerie Bauman, *ACLU to Inslee: Put a Moratorium on Hospital Mergers*, PUGET SOUND BUS. J., June 4, 2013, available at <http://www.bizjournals.com/seattle/news/2013/06/04/aclu-calls-on-inslee-to-issue.html?page=all>.
- ⁸⁶ Carol M. Ostrom, *Inslee Orders State to Update Hospital-Merger Rules*, SEATTLE TIMES, July 7, 2013, available at http://seattletimes.com/html/localnews/2021351035_mergerrulesxml.html.
- ⁸⁷ Carol M. Ostrom, *Hospitals in State May Face New Disclosure Rules*, SEATTLE TIMES, Nov. 4, 2013, available at http://seattletimes.com/html/localnews/2022192738_hospitalrulesxml.html.

⁸⁸ Joel Connelly, *State AG: Public Health Districts Must Offer Birth Control, Abortion*, SEATTLE POST INTELLIGENCER, Aug. 21, 2013, available at <http://blog.seattlepi.com/seattlepolitics/2013/08/21/public-health-districts-must-offer-contraception-abortion-services-ag/>.

⁸⁹ See, e.g., GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES, (Dec. 1, 2013), available at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf; see also Consolidated Appropriations Act, 2005. Pub. L. No. 108-447, § 508(d), 118 Stat. 2809 (2004) (appropriations rider prohibiting government agencies from “discriminat[ing]” against health care entities on the ground that they do not provide or refer for abortion, among other provisions).

⁹⁰ 42 C.F.R. § 482.13 (2013).

⁹¹ PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP, VOL. 1 (1982) 76.

⁹² 42 C.F.R. § 482.13 (2013).

⁹³ 42 C.F.R. § 482.55 (2013).

⁹⁴ See 42 C.F.R. § 489.102 (2013).

⁹⁵ Consolidated Appropriations Act, 2005. Pub. L. No. 108-447, § 508(d), 118 Stat. 2809 (2004).

⁹⁶ Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 How L.J. 855, 864 (2012).

⁹⁷ See Medicare and Medicaid Programs: Changes to the Hospital and Critical Access Hospital Conditions of Participation To Ensure Visitation Rights for All Patients, 75 Fed. Reg. 70831 (Nov. 19, 2010) (codified at 42 C.F.R. §§ 482, 485).

⁹⁸ The *Directives* are available in full at <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.