

# WHO BLESSES THIS MERGER? ANTITRUST’S ROLE IN MAINTAINING ACCESS TO REPRODUCTIVE HEALTH CARE IN THE WAKE OF CATHOLIC HOSPITAL MERGERS

**Abstract:** Over the past two decades, the number of Catholic health care systems has steadily expanded throughout the United States, while at the same time, the overall number of hospitals in the country has decreased. Today, one in six patients in the United States receives treatment at a Catholic hospital. Catholic hospitals must abide by the Ethical and Religious Directives for Catholic Health Care Services, which restrict the medical procedures delivered at these facilities. Many common reproductive health care services, such as medically-necessary abortions and in-vitro fertilization, are prohibited by these Directives. This Note examines the impact of the Catholic hospital merger trend on access to reproductive health care in the United States. Although reproductive health care advocates have succeeded in developing innovative structural remedies to limit the decrease in reproductive health care services in communities affected by a Catholic hospital merger, this Note argues that the 2018 revision to the Directives threatens these solutions. Further, this Note proposes that antitrust law may be an effective method to regulate the anticompetitive effects of Catholic hospital mergers in the provision of reproductive health care.

## INTRODUCTION

Seventy miles southeast of Tucson, Arizona, in the city of Sierra Vista, a woman fifteen weeks pregnant with twins suffered a dangerous miscarriage.<sup>1</sup> After miscarrying one of the twins at home in a bathtub, an ambulance brought

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<sup>1</sup> Affidavit of Dr. Robert Holder at 1 (Dec. 10, 2010), <https://www.washingtonpost.com/wp-srv/health/documents/abortion/holder-affidavit.pdf> [<https://perma.cc/EYY3-MQAE>]; Sarah Christopherson, *Is the Pope in Charge of Your Hospital Bed?*, NAT’L WOMEN’S HEALTH NETWORK NEWSL. (July 12, 2016), <https://nwhn.org/pope-charge-hospital-bed/> [<https://perma.cc/Y2HN-PHN7>]; Stephanie Mencimer, *Do Bishops Run Your Hospital?*, MOTHER JONES (Nov.-Dec. 2013), <https://www.motherjones.com/politics/2013/10/catholic-hospitals-bishops-contraception-abortion-health-care/> [<https://perma.cc/5DEG-Z6ZJ>]. Sierra Vista is a rural town in southwestern Arizona, and the Sierra Vista Regional Health Center is the only hospital in the region. Religion & Ethics Newsweekly, *Catholic-Secular Hospital Mergers*, PBS (Mar. 25, 2011), <https://www.pbs.org/wnet/religionandethics/2011/03/25/march-25-2011-catholic-secular-hospital-mergers/8431/> [<https://perma.cc/7WEH-9E6L>].

her to the emergency room at Sierra Vista Regional Health Center.<sup>2</sup> The on-call obstetrics and gynecology physician, Dr. Robert Holder, examined the patient, consulted with other specialists, and concluded that the mother was at risk of extreme hemorrhaging and infection, and the second twin was unlikely to survive.<sup>3</sup> He later described the emergency as an “inevitable miscarriage.”<sup>4</sup> Dr. Holder counseled the patient and her husband on the high risk of continuing the pregnancy and the possible treatment options to end the pregnancy.<sup>5</sup> The patient and her husband made the difficult decision to terminate the pregnancy using a medical treatment.<sup>6</sup> The consent form to terminate the pregnancy described the procedure as “a miscarriage completion,” and Dr. Holder prepared to proceed with the treatment.<sup>7</sup>

When the patient came to the emergency room, in November 2010, Sierra Vista Regional Health Center, a secular hospital, was engaged in a trial merger

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<sup>2</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 2. The patient suffered a miscarriage in the early morning of November 26, 2010, and she arrived at the hospital at about 9:30 AM that same day. *Id.*

<sup>3</sup> *Id.* at 1–2; Mencimer, *supra* note 1. Dr. Holder later testified that he gave the patient an ultrasound, and the second fetus had a heartbeat. Affidavit of Dr. Robert Holder, *supra* note 1, at 1. The placenta from the first twin was still inside the patient’s uterus, and the umbilical cord was emerging from the patient. *Id.* Dr. Karen Lesser at University Medical Center in Tucson gave Dr. Holder guidance on possible courses of action. *Id.* To terminate the pregnancy, he could either surgically remove the fetus from the uterus or use a medication. *Id.* The medication treatment was the viable treatment, because Sierra Vista Regional Health Center did not have the proper resources to surgically evacuate a patient at that stage in pregnancy. *Id.* Dr. Holder testified that tying the umbilical cord to protect the second twin has a high risk of infection. *Id.*

<sup>4</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 2. Dr. Holder testified that the chances of a successful pregnancy were “miniscule.” *Id.* at 1–2. He also later told the National Women’s Law Center that the second twin was “in a hopeless situation.” Press Release, Nat’l Women’s L. Ctr., Women’s Health & Lives at Risk Due to Religious Restrictions at Hospitals, New Center Study Shows (Jan. 20, 2011), <https://www.washingtonpost.com/wp-srv/health/documents/abortion/ibis-press-release-final-01202011.pdf> [<https://perma.cc/N6QP-DL7L>]. The National Women’s Law Center is a non-profit organization that defends the legal rights of women and families. *Id.*

<sup>5</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 2. Dr. Holder informed the patient and her husband of the two options to terminate the pregnancy, the medication and the surgical evacuation that Sierra Vista could not perform, as well as the high risk and unlikely success of continuing the pregnancy. *Id.*

<sup>6</sup> *Id.*; Jonathan Cohn, *Unholy Alliance*, NEW REPUBLIC (Feb. 22, 2012), <https://newrepublic.com/article/100960/catholic-church-hospital-health-care-contraception> [<https://perma.cc/9L7A-MZ2L>]. Dr. Holder testified that the patient and her husband were both distressed by the decision. Affidavit of Dr. Robert Holder, *supra* note 1, at 2; Cohn, *supra*. He further noted that the patient’s husband seemed to struggle with the choice. Affidavit of Dr. Robert Holder, *supra* note 1, at 2. When speaking with the National Women’s Law Center about the incident, Dr. Holder described it as a “tragic, heart-wrenching decision” for the patient and her husband. Press Release, Nat’l Women’s L. Ctr., *supra* note 4.

<sup>7</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 2. Attempting to continue the pregnancy would jeopardize the patient’s health because the umbilical cord and placenta from the first twin were still inside her uterus and she could develop a dangerous infection. Christopherson, *supra* note 1. Thus, completing the miscarriage would avoid these severe health complications. *Id.*

with Carondelet Health Network, a Catholic hospital system.<sup>8</sup> Catholic hospitals must abide by the Ethical and Religious Directives for Catholic Health Care Services (Directives), which are published by the United States Conference of Catholic Bishops (USCCB), and outlines ethical and moral limitations on the services that Catholic hospitals may provide their patients.<sup>9</sup> In particular, the Directives prohibit many reproductive health services, including abortions, contraception, tubal ligations, and in vitro fertilization.<sup>10</sup> During the trial merger, Sierra Vista Regional Health Center had to comply with the Direc-

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<sup>8</sup> Mencimer, *supra* note 1. Sierra Vista Regional Health Center affiliated with Carondelet Health Network on April 17, 2010. Affidavit of Dr. Robert Holder, *supra* note 1, at 2. Dr. Holder later spoke to the Public Broadcasting Service (PBS) about the merger, explaining that most of the medical staff opposed the merger, because it would be difficult for a rural, secular hospital like Sierra Vista Regional Health Center to implement the Ethical and Religious Directives for Catholic Health Care Services (Directives). Religion & Ethics Newsweekly, *supra* note 1. A merger occurs when two or more corporate entities agree to combine into one corporation with a shared governance structure, usually in exchange for stock or other financial assets. See DEL. CODE ANN. tit. 8, § 251 (2019) (explaining what constitutes a merger or consolidation under Delaware law); *Merger*, BLACK'S LAW DICTIONARY (11th ed. 2019). In Sierra Vista, the proposed merger between Carondelet and the hospital was intended to be a two-year commitment, as the two entities "assess[ed] the mutual value of formalizing a long-term partnership." Stephanie Innes, *Tucson Health: Carondelet and Sierra Vista Medical Center Dissolve Agreement*, ARIZ. DAILY STAR (Mar. 29, 2011), [https://tucson.com/news/blogs/health/tucson-health-carondelet-and-sierra-vista-medical-center-dissolve-agreement/article\\_e98acc9e-5a52-11e0-9779-001cc4c03286.html](https://tucson.com/news/blogs/health/tucson-health-carondelet-and-sierra-vista-medical-center-dissolve-agreement/article_e98acc9e-5a52-11e0-9779-001cc4c03286.html) [<https://perma.cc/89CH-DJWM>] (quoting a statement from both parties when they dissolved their trial merger).

<sup>9</sup> U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 9 (6th ed. 2018) [hereinafter 2018 ETHICAL AND RELIGIOUS DIRECTIVES]. The Directives dictate health care services in Catholic hospitals across the country. LOIS UTTELY ET AL., MERGERWATCH & AM. CIVIL LIBERTIES UNION, MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE 2 (2013). These rules promulgated by Catholic bishops prohibit medical procedures that conflict with the moral teachings of the Catholic Church, including reproductive health services. *Id.* The Catholic Church describes the Directives as having two purposes, "to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person" and "to provide authoritative guidance on certain moral issues that face Catholic health care today." 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra*, at 4.

<sup>10</sup> UTTELY ET AL., *supra* note 9, at 2; Hayley Penan & Amy Chen, *The Ethical & Religious Directives: What the 2018 Update Means for Catholic Hospital Mergers*, NAT'L HEALTH L. PROGRAM, Jan. 2, 2019, at 1, <https://9kqpww4dcaw91s37k0zm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/Fact-Sheet-ERD-2018-Update-final.pdf> [<https://perma.cc/QZH5-6U9S>]. Contraception refers to methods used to prevent a woman from becoming pregnant, such as daily birth control pills or condoms. MedlinePlus, *Birth Control*, U.S. NAT'L LIBR. MED., <https://medlineplus.gov/birthcontrol.html> [<https://perma.cc/6V6P-CZVW>]. Tubal ligation is a surgical procedure in which a woman's fallopian tubes are cut and closed between the uterus and ovaries, to permanently prevent pregnancy. MedlinePlus, *Tubal Ligation*, U.S. NAT'L LIBR. MED., <https://medlineplus.gov/tuballigation.html> [<https://perma.cc/J8RJ-DN88>]. In vitro fertilization, or IVF, is the process in which an egg and sperm are combined outside the body to grow an embryo, before placing it in a woman's womb. MedlinePlus, *In Vitro Fertilization (IVF)*, U.S. NAT'L LIBR. MED., <https://medlineplus.gov/ency/article/007279.htm> [<https://perma.cc/D7T6-7JSY>].

tives.<sup>11</sup> When Dr. Holder remembered that certain procedures needed approval, he sought the necessary approval to perform the procedure from the hospital administration, as required under the Directives.<sup>12</sup>

The hospital's Vice President of Medical Services only asked Dr. Holder if there was a detectable heartbeat in the second fetus.<sup>13</sup> Upon hearing that there was a heartbeat, she informed Dr. Holder that the patient could not end the pregnancy at Sierra Vista Regional Health Center.<sup>14</sup> She did not inquire into the patient's medical condition or the implications of transferring the patient.<sup>15</sup>

Dr. Holder updated the distraught patient and her husband that Sierra Vista Regional Health Center would not be able to perform the procedure and that she would have to be transferred to another facility to seek such medical care.<sup>16</sup> The patient was then transferred to the University Medical Center, in Tucson, for treatment.<sup>17</sup> The transfer took an hour and a half and put the patient in danger of extreme bleeding and an infection, as well as substantial emotional distress.<sup>18</sup> Her treatment was ultimately postponed by three hours

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<sup>11</sup> Mencimer, *supra* note 1. The trial merger terms required doctors to receive permission from hospital administrators for certain procedures to ensure that the procedure was allowed. Affidavit of Dr. Robert Holder, *supra* note 1, at 2.

<sup>12</sup> *Id.*; Press Release, Nat'l Women's L. Ctr., *supra* note 4. Dr. Holder first discussed the medication treatment for the miscarriage with the Nurse Manager of Obstetrics, Lorena Warren. Affidavit of Dr. Robert Holder, *supra* note 1, at 2. Ms. Warren told Dr. Holder that she needed to verify with the hospital's Vice President of Medical Services, Rebecca McCalmont, that the Directives permitted the treatment. *Id.*

<sup>13</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 2; Cohn, *supra* note 6. Ms. McCalmont, the hospital's Vice President of Medical Services, called Dr. Holder with the hospital's decision regarding the treatment thirty minutes after Ms. Warren, Nurse Manager of Obstetrics, contacted her. Affidavit of Dr. Robert Holder, *supra* note 1, at 2.

<sup>14</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 2.; Cohn, *supra* note 6. Ms. McCalmont told Dr. Holder that he needed to transfer the patient to another facility to receive the care she needed to terminate the pregnancy. Cohn, *supra* note 6. She had to be transferred eighty miles to the University Medical Center in Tucson, the closest major hospital to rural Sierra Vista, simply because the second twin had a heartbeat. *Id.*; Religion & Ethics Newsweekly, *supra* note 1.

<sup>15</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 2-3; Christopherson, *supra* note 1. Ms. McCalmont addressed only the fetal heartbeat, not the risk to the health of the patient. Christopherson, *supra* note 1.

<sup>16</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 3. Dr. Holder told the National Women's Law Center that he was "told to inform this already traumatized couple that their decision was seen as 'unethical' per the Directives." Press Release, Nat'l Women's L. Ctr., *supra* note 4 (emphasis omitted). The patient and her husband may have been aware of the recent affiliation with Carondelet Health Network, but they did not understand its effect on medical treatment. Christopherson, *supra* note 1.

<sup>17</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 3. Dr. Lesser, who originally gave Dr. Holder advice on treatment options for the patient, accepted the patient's transfer to her care at the University Medical Center in Tucson. *Id.*

<sup>18</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 3; Cohn, *supra* note 6. Dr. Holder testified that the transfer mandated by Sierra Vista Regional Health Center risked the health of the patient. Affidavit of Dr. Robert Holder, *supra* note 1, at 3.

because of the transfer.<sup>19</sup> Dr. Holder later testified that the hospital's actions prevented him from treating his patient to the best of his ability and in line with scientifically accepted standards of care.<sup>20</sup> In the wake of local protests coinciding with this patient's experience, the merger between Sierra Vista Regional Health and Carondelet Health Network fell apart.<sup>21</sup>

Today, one out of every six hospital patients in the United States seeks care in a Catholic hospital.<sup>22</sup> In Alaska, Iowa, Washington, Wisconsin, and South Dakota, approximately two out of every five patients are treated in Catholic hospitals.<sup>23</sup> More than one in seven acute care hospitals in the United States were Catholic in 2016.<sup>24</sup> Furthermore, the number of Catholic acute care

<sup>19</sup> Affidavit of Dr. Robert Holder, *supra* note 1, at 3.

<sup>20</sup> *Id.* Dr. Holder later explained to the National Women's Law Center that he was "ashamed and angered" when he had to transfer the patient, because she should have been able to receive this treatment at Sierra Vista. Press Release, Nat'l Women's L. Ctr., *supra* note 4.

<sup>21</sup> Christopherson, *supra* note 1. Although community members were already protesting the trial merger, the outrage following the experience of Dr. Holder's patient and her husband further fueled the protests, and the affiliation ceased a few months thereafter. *Id.* In addition to protesting the patient's treatment and other situations like it, protestors also demonstrated because Sierra Vista Regional Health Center is a rural facility, leaving no other local hospitals for patients to turn to when they needed procedures banned by the Directives. See Religion & Ethics Newsweekly, *supra* note 1 (noting that one protestor was concerned about the merger given the community's high teen pregnancy rate). PBS interviewed several protestors outside of the health center every weekday morning, as well as obstetrics and gynecology physicians who disagreed with the trial merger. *Id.* Dr. Bruce Silva, a colleague of Dr. Holder, introduced the PBS reporter to his patient Jessica Graham, who planned to get a tubal ligation after delivering her second child via caesarian section at Sierra Vista Regional Health Center. *Id.* Due to the trial merger, Ms. Graham had to change her birth plan and undergo a second surgery in a different facility for the tubal ligation, which presented the risk of infection and complications. *Id.* The doctors told PBS that they believed Sierra Vista Regional Health Center could find another larger provider to work with that would not restrict their medical decisions based on the Directives. *Id.*

<sup>22</sup> LOIS UTTLEY & CHRISTINE KHAIKIN, MERGERWATCH, GROWTH OF CATHOLIC HOSPITALS AND HEALTH SYSTEMS: 2016 UPDATE ON THE MISCARRIAGE OF MEDICINE REPORT 1 (2016); Katie Hafner, *As Catholic Hospitals Expand, So Do Limits on Some Procedures*, N.Y. TIMES (Aug. 10, 2018), <https://www.nytimes.com/2018/08/10/health/catholic-hospitals-procedures.html> [<https://perma.cc/V66D-N9MD>]; see CATHOLIC HEALTH ASS'N OF THE U.S., U.S. CATHOLIC HEALTH CARE (2019), [https://www.chausa.org/docs/default-source/default-document-library/cha\\_2019\\_miniprofile.pdf?sfvrsn=0](https://www.chausa.org/docs/default-source/default-document-library/cha_2019_miniprofile.pdf?sfvrsn=0) [<https://perma.cc/D2DK-TJ7S>] (stating that on a daily basis, more than 14% of patients receive care in a Catholic hospital). When a Catholic hospital acquires a non-Catholic hospital, the non-Catholic hospital must agree to abide by the Directives as a condition of the merger. 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Therefore, throughout this Note, "Catholic hospitals" refers to those hospitals that follow all or part of the Directives, whether they became Catholic through acquisition or already were Catholic. See *supra* notes 1–22 and accompanying text; *infra* notes 23–264 and accompanying text. Additionally, because hospitals may be public, non-profit, for-profit, or affiliated with other religious institutions, this Note refers to any hospital that does not abide by the Directives as "non-Catholic." See *supra* notes 1–22 and accompanying text; *infra* notes 23–264 and accompanying text.

<sup>23</sup> UTTLEY & KHAIKIN, *supra* note 22, at 1. In Nebraska, Colorado, Missouri, Oregon, and Kentucky, approximately 35% of patients are treated in Catholic hospitals. *Id.*

<sup>24</sup> JULIA KAYE ET AL., AM. CIVIL LIBERTIES UNION, HEALTH CARE DENIED: PATIENTS AND PHYSICIANS SPEAK OUT ABOUT CATHOLIC HOSPITALS AND THE THREAT TO WOMEN'S HEALTH AND

hospitals in the United States continues to grow, increasing by 22% from 2001 to 2016, although the overall number of acute care hospitals decreased by 6%.<sup>25</sup> In 2016, four of the ten largest hospital systems in the country, Ascension Health, Catholic Health Initiatives, Trinity Health, and Dignity Health, were Catholic.<sup>26</sup> The growth of Catholic hospital systems across the country reduces access to reproductive health services, because when Catholic hospitals acquire non-Catholic hospitals, the non-Catholic hospitals typically must adopt the Catholic Church's Directives.<sup>27</sup>

This Note explores the impact that the increase in Catholic hospital mergers has on access to reproductive health services in the United States.<sup>28</sup> Part I of the Note discusses the factors that contribute to this decrease in services, specifically the revised Directives, the recent growth in hospital merger and acquisition activity since passage of the Affordable Care Act (ACA), and the antitrust regulatory review scheme for Catholic hospital mergers.<sup>29</sup> Part II reviews several innovative legal methods to combat the reduction in reproductive health services that result from these mergers.<sup>30</sup> Further, Part II explains that although reproductive health care advocates have been successful in mitigating the effects of these mergers by creating separate entities that continue to offer services forbidden by the Catholic Church, the recently updated 2018 Directives prohibit these remedies.<sup>31</sup> Part III argues that the reduction in reproductive health services is an anticompetitive effect that harms consumers, and thus antitrust law may be an ef-

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LIVES 22 (2016); UTTLEY & KHAIKIN, *supra* note 22, at 1. This Note specifically examines the provision of reproductive health care at acute care hospitals and uses the terms "acute care hospitals" and "hospitals" interchangeably. See *CMS Data Navigator Glossary of Terms*, CTRS. FOR MEDICARE & MEDICAID SERVS., [https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav\\_Glossary\\_Alpha.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf) [<https://perma.cc/J8TH-FBFV>] (defining an acute care hospital as one "that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition)"); see *supra* notes 1–24 and accompanying text; *infra* notes 25–264 and accompanying text.

<sup>25</sup> UTTLEY & KHAIKIN, *supra* note 22, at 1, 3, 8 ("The[] top [ten] Catholic health systems now control 384 acute care hospitals, up from 330 hospitals in 2011 and 259 in 2001.").

<sup>26</sup> *Id.* at 9. In 2019, Catholic Health Initiatives merged with Dignity Health to create CommonSpirit Health, further consolidating the industry. Alex Kacik, *Catholic Health Initiatives, Dignity Health Combine to Form CommonSpirit Health*, MOD. HEALTHCARE (Feb. 1, 2019), <https://www.modernhealthcare.com/article/20190201/NEWS/190209994/catholic-health-initiatives-dignity-health-combine-to-form-commonspirit-health> [<https://perma.cc/NZU9-2JWQ>]. This transaction, worth more than \$29 billion, combined 142 hospitals across the country. *Id.* In late 2018, the Federal Trade Commission (FTC) and the California Department of Justice approved the merger, and it was finalized in early 2019. *Id.*

<sup>27</sup> See UTTLEY & KHAIKIN, *supra* note 22, at 1 (explaining that as Catholic hospitals acquire non-Catholic hospitals, the non-Catholic hospitals must comply with the Directives, leading to removal of reproductive health services that conflict with the Catholic Church's ethical and moral beliefs).

<sup>28</sup> See *infra* notes 34–264 and accompanying text.

<sup>29</sup> See *infra* Part I.

<sup>30</sup> See *infra* Part II.A.

<sup>31</sup> See *infra* Part II.B.

fective tool to address the concerns raised by the decrease in the availability of reproductive care and combat the restrictive 2018 Directives.<sup>32</sup> Finally, Part III addresses the shortcomings of using antitrust to preserve reproductive health care post-merger and offers possible alternative solutions.<sup>33</sup>

## I. THE GROWTH OF CATHOLIC HOSPITAL SYSTEMS AND RESULTING LIMITATIONS ON REPRODUCTIVE CARE

The number of Catholic hospitals is rising as part of the increase in merger activity occurring among U.S. hospitals in the past two decades.<sup>34</sup> As a result, more hospitals in the United States must follow the Catholic health care restrictions outlined by the Directives and cannot offer counseling on several reproductive health services.<sup>35</sup> Section A of this Part discusses the history of the Directives, the medical procedures prohibited by the Directives, and the 2018 revision to the Directives.<sup>36</sup> Section B examines the impact of the ACA on hospital merger activity, the antitrust and Vatican regulatory review process for hospital mergers, and their combined impact on the reduced provision of reproductive health services throughout the country.<sup>37</sup>

### A. The Ethical and Religious Directives for Catholic Health Care Services

Catholic hospitals in the United States follow the Directives, which are published by the USCCB and were recently updated in 2018 to include five additional Directives concerning health care collaborations between Catholic and non-Catholic hospitals.<sup>38</sup> The following Subsections provide an overview

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<sup>32</sup> See *infra* Part III.A.

<sup>33</sup> See *infra* Part III.B–C.

<sup>34</sup> See UTTLEY & KHAIKIN, *supra* note 22, at 1 (discussing the growth in Catholic hospital systems in the United States). This phenomenon was referred to in 1997 as “Catholic hospital merger mania.” Judith C. Appelbaum & Jill C. Morrison, *Hospital Mergers and the Threat to Women’s Reproductive Health Services: Applying the Antitrust Laws*, 26 N.Y.U. REV. L. & SOC. CHANGE 1, 7 (2001) (quoting Rhonda L. Rundle, *Hardly Meek: Catholic Hospitals, in Big Merger Drive, Battle Industry Giants*, WALL STREET J., Mar. 12, 1997, at A1). There have recently been two large increases in general hospital mergers in the United States—in the 1990s and again in the 2010s. Leemore Dafny, *Hospital Industry Consolidation—Still More to Come?*, 370 NEW. ENG. J. MED. 198, 198 (2014).

<sup>35</sup> See UTTLEY & KHAIKIN, *supra* note 22, at 1 (explaining that as Catholic hospitals acquire non-Catholic hospitals, the non-Catholic hospitals must comply with the Directives, leading to the removal of reproductive health services that conflict with the Catholic Church’s ethical and moral beliefs).

<sup>36</sup> See *infra* Part I.A.

<sup>37</sup> See *infra* Part I.B.

<sup>38</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 2, 23–26; Sandra M. DiVarco & Kerrin B. Slattery, *Compliance Concerns for Catholic Health Care Collaborations*, LAW360 (Sept. 5, 2018), <https://www.mwe.com/insights/compliance-concerns-catholic-health-collaborations> [<https://perma.cc/H8ED-FFZS>].

of the Directives, including their history, the services they prohibit, and the 2018 update.<sup>39</sup>

### 1. The History of the Directives

The ethical norms governing Catholic health care have been revised at least eight times over the past century to comport with changing medical standards and the evolving legal landscape.<sup>40</sup> In 1915, the Catholic Hospital Association was established to preserve Catholic health care institutions' rights and to develop a set of ethical directives.<sup>41</sup> Six years later, the first written set of Directives regarding ethical norms was posted in operating rooms of Catholic hospitals throughout the country.<sup>42</sup> These rules specifically pertained to surgical procedures that could terminate fetal life or result in sterilization.<sup>43</sup> The Catholic Hospital Association intended for all Catholic hospitals to follow the Directives, but they had to be approved by the local diocese before being implemented.<sup>44</sup> During the 1960s, however, more liberal dioceses began construing the Directives more leniently with respect to contraception, a phenomenon that became known as "geographical morality."<sup>45</sup> To counteract these inconsistencies, the National Conference of Catholic Bishops developed a new cata-

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<sup>39</sup> See *infra* notes 40–72 and accompanying text.

<sup>40</sup> See Kevin D. O'Rourke et al., *A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services*, HEALTH PROGRESS, Nov.–Dec. 2001, at 19 (listing the six variations of ethical norms published through 2001). See generally 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9; U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009) [hereinafter 2009 ETHICAL AND RELIGIOUS DIRECTIVES]. The 2009 and 2018 updates to the Directives constitute the seventh and eighth revisions to the Directives. 2009 ETHICAL AND RELIGIOUS DIRECTIVES, *supra*; 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9.

<sup>41</sup> CHRISTOPHER J. KAUFFMAN, MINISTRY AND MEANING: A RELIGIOUS HISTORY OF CATHOLIC HEALTH CARE IN THE UNITED STATES 169 (1995); O'Rourke et al., *supra* note 40, at 18. The Catholic Hospital Association is now known as the Catholic Health Association. KAUFFMAN, *supra*, at 303; O'Rourke et al., *supra* note 40, at 18.

<sup>42</sup> O'Rourke et al., *supra* note 40, at 18. In 1921, Reverend Michael Burke of the Archdiocese of Detroit wrote the Surgical Code for Catholic Hospitals. *Id.*

<sup>43</sup> *Id.* Because these rules did not address the theological role in medicine, the Catholic Hospital Association sought to create a more detailed set of Directives, published in 1949 and revised in 1956. *Id.* at 18–19.

<sup>44</sup> *Id.* at 19. The local diocese was authorized to formally parse the Directives in accordance with its individual beliefs, although most interpretations were aligned with that of the Catholic Hospital Association. *Id.*

<sup>45</sup> *Id.* Specifically, the more liberal dioceses interpreted the Directives concerning contraception and family planning more freely than other dioceses. *Id.* The liberal dioceses justified their interpretation on the moral reasoning of "proportionality." *Id.* This theory suggested that the fundamental goal of an action, such as providing a married couple with access to birth control, is of greater moral importance than the deed itself. *Id.* at 19 n.10. Pope John Paul II, however, contradicted this concept in his *Veritatis Splendor*, where he preached that certain behaviors are "intrinsically evil," even if they are done with good intentions. *Id.*



log of Directives in 1971.<sup>46</sup> The Catholic Church pressured dioceses to adopt the 1971 Directives in their entirety after the Supreme Court recognized a women's right to choose to have an abortion in *Roe v. Wade* in 1973.<sup>47</sup>

When the USCCB revised the Directives again in 2001, they addressed hospital mergers and made changes to the section on partnerships and cooperation with other health care providers.<sup>48</sup> They specifically forbade Catholic health care institutions from cooperating in medical procedures that are considered "intrinsically evil" by the Catholic Church, including direct sterilization.<sup>49</sup> The USCCB revised the Directives again in 2009, and more recently in 2018, to significantly change the Directives as they relate to hospital mergers with non-Catholic institutions.<sup>50</sup>

## 2. Prohibited Services

The Directives, which are organized in six parts, list seventy-seven rules that Catholic health care institutions must obey when delivering care to pa-

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<sup>46</sup> KAUFFMAN, *supra* note 41, at 290; O'Rourke et al., *supra* note 40, at 19. The National Conference of Catholic Bishops is today known as the United States Conference of Catholic Bishops (USCCB). O'Rourke et al., *supra* note 40, at 19. The 1971 Directives were more like a set of legal rules, as they strictly prohibited certain reproductive procedures, rather than being rooted in theological teachings like their predecessors. KAUFFMAN, *supra* note 41, at 290; O'Rourke et al., *supra* note 40, at 20. In 1994, the bishops again revised the Directives to include references to the theological bases for the rules. O'Rourke et al., *supra* note 40, at 20. The 1994 Directives, while still focusing on moral and ethical obligations, also discussed the importance of providing access to health care to underserved populations. *Id.*

<sup>47</sup> O'Rourke et al., *supra* note 40, at 19; *see also* *Roe v. Wade*, 410 U.S. 113, 114, 164 (1973) (recognizing that a woman's right to choose to have an abortion falls under the right to privacy, which is protected by the Due Process Clause of the Fourteenth Amendment).

<sup>48</sup> O'Rourke et al., *supra* note 40, at 21. In 2001, the USCCB edited Part Six of the Directives, which focuses on collaborations with other health care systems, due to the complex issues arising out of an increasing number of partnerships between Catholic and non-Catholic hospitals. *Id.*

<sup>49</sup> *Id.* (referencing Directive 70 of U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (4th ed. 2001), which holds that "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization"). Although the bishops addressed cooperation with non-Catholic hospitals in the 1994 revision, they received complaints that the language was confusing with respect to what the Catholic Church meant by "cooperation." *Id.* at 20–21. Thus, in the 2001 revision, the USCCB gave examples of the medical procedures it considered "intrinsically immoral" to provide more explicit guidance. *Id.* at 21.

<sup>50</sup> *See* 2009 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 40, at 34–37 (revising Part Six, titled "Forming New Partnerships with Health Care Organizations and Providers"); 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 3 (adding "Collaborative Arrangements with Other Health Care Organizations and Providers"). One of the goals of the 2018 update was to "reflect the growing number and complexity of collaborative arrangements taking place throughout health care." *U.S. Bishops Revise Part Six of the Ethical and Religious Directives: An Initial Analysis* by CHA Ethicists, HEALTH CARE ETHICS USA (Cath. Health Ass'n, Wash., D.C.), Summer 2018, at 12.

tients.<sup>51</sup> The Directives address “The Social Responsibility of Catholic Health Care Services,” “Pastoral and Spiritual Responsibility,” the relationship between health care professionals and patients, “Beginning of Life” care, “Care for the Seriously Ill and Dying,” and “Collaborative Arrangements with Other Health Care Organizations and Providers.”<sup>52</sup>

Several Directives prohibit reproductive health care services that are otherwise generally accepted by the medical community.<sup>53</sup> For example, Directive 45 states that abortion is never allowed, even when the health of the mother is at risk.<sup>54</sup> Additionally, Directive 53 interdicts direct sterilization for both men and women, and Directive 52 forbids counseling on contraceptive practices.<sup>55</sup> Furthermore, Directives 40 and 41 prohibit in vitro fertilization techniques.<sup>56</sup> Not only must Catholic health care institutions abide by these Directives, but

<sup>51</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 4–5. These Directives are rules that direct how health care and medicine should be administered in all Catholic hospitals across the country. Penan & Chen, *supra* note 10, at 1.

<sup>52</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 3 (listing the six parts of the Directives).

<sup>53</sup> Penan & Chen, *supra* note 10, at 1; *see* 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 18–19. The medical procedures banned by the Directives are universally accepted, including abortion, sterilization, in vitro fertilization, birth control, emergency contraception including in the event of sexual assault, and certain miscarriage procedures. Penan & Chen, *supra* note 10, at 1.

<sup>54</sup> UTTLEY ET AL., *supra* note 9, at 2; *see* 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 18–19 (“Abortion . . . is never permitted.”). For example, in 2009, a twenty-seven-year-old woman was eleven weeks pregnant and suffered from pulmonary hypertension when she arrived at the emergency room of St. Joseph’s Hospital and Medical Center in Phoenix, Arizona. Cohn, *supra* note 6; Mencimer, *supra* note 1; Religion & Ethics Newsweekly, *supra* note 1. The emergency room doctors examined the patient, a mother of four, and decided that because pulmonary hypertension has a high mortality rate, she would not survive unless the pregnancy was terminated. Cohn, *supra* note 6; Mencimer, *supra* note 1; Religion & Ethics Newsweekly, *supra* note 1. Because the patient’s life was in danger, Sister Margaret McBride authorized the abortion, even though it was a Catholic hospital. Cohn, *supra* note 6; Mencimer, *supra* note 1; Religion & Ethics Newsweekly, *supra* note 1. The patient’s life was saved, but Bishop Thomas Olmsted of the Catholic Diocese of Phoenix excommunicated the nun and the hospital lost its 116-year Catholic affiliation. Cohn, *supra* note 6; Mencimer, *supra* note 1; Religion & Ethics Newsweekly, *supra* note 1. Additionally, when a pregnant woman has cancer, the Directives allow doctors to give the woman chemotherapy, even though it will terminate the pregnancy, but doctors cannot directly give the woman an abortion before the chemotherapy. Mencimer, *supra* note 1.

<sup>55</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 19. Directive 53 prohibits both permanent and temporary sterilization. *Id.* It does allow for procedures that may result in sterility if their “direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.” *Id.* For example, if a woman has uterine cancer and the only cure is a hysterectomy, this procedure would be permitted even though it results in sterilization. KAYE ET AL., *supra* note 24, at 7 n.6. Directive 52 states that instead of offering contraceptive counseling, health care providers should offer guidance on the Church’s beliefs with respect to “responsible parenthood.” 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 19.

<sup>56</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 18. Directive 40 explains that heterologous fertilization is “contrary to the covenant of marriage.” *Id.* Heterologous fertilization, a form of IVF, involves combining an egg and sperm outside the body to grow an embryo, before placing it in a woman’s womb. MedlinePlus, *In Vitro Fertilization (IVF)*, *supra* note 10.

providers must agree to follow them as a prerequisite for admitting privileges at Catholic hospitals.<sup>57</sup>

The Directives, especially those highlighted above, are often at issue during merger negotiations when a Catholic hospital or health care provider is seeking to acquire a non-Catholic facility.<sup>58</sup> Directive 70 emphasizes that when a Catholic institution collaborates with a non-Catholic health care organization, the Catholic facility is “not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.”<sup>59</sup> Thus, non-Catholic hospitals acquired by Catholic hospitals are expected to follow the Directives as a precondition of the merger, and may be forced to eliminate certain reproductive health services in order to complete the transaction.<sup>60</sup>

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<sup>57</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 9. A doctor with admitting privileges is authorized to admit patients to a certain hospital or health care facility. *Admitting Privilege Definition*, HEALTHINSURANCE.ORG, [www.healthinsurance.org/glossary/admitting-privilege/](http://www.healthinsurance.org/glossary/admitting-privilege/) [https://perma.cc/PR9H-ZQXA]. Thus, Directive 5’s constraint on admitting privileges limits doctors in private practice who are affiliated with Catholic hospitals. Nina Martin, *Catholic Bishops Vote to Revise Rules for Health Care Partnerships*, PROPUBLICA (Nov. 11, 2014), <https://www.propublica.org/article/catholic-bishops-weigh-tightening-rules-for-health-care-partnerships> [https://perma.cc/V8ST-RG47] [hereinafter Martin, *Catholic Bishops Vote to Revise Rules*]; see 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 9 (“Catholic health care services must . . . require adherence to them within the institution as a condition for medical privileges and employment.”). For instance, in Bartlesville, Oklahoma, Jane Phillips Medical Center, a hospital owned by the large Catholic health system Ascension Health, prohibited all doctors with admitting privileges from prescribing contraceptives in their local practices. Martin, *Catholic Bishops Vote to Revise Rules*, *supra*; Molly Sparks, *JPMC Doctors No Longer Allowed to Prescribe Birth Control*, BARTLESVILLE EXAMINER-ENTERPRISE (Mar. 28, 2014), <https://www.examiner-enterprise.com/article/20140328/NEWS/303289824> [https://perma.cc/N7FB-QEFB].

<sup>58</sup> Lois Uttley et al., *Merging Catholic and Non-Sectarian Hospitals: New York State Models for Addressing the Ethical Challenges*, 17 N.Y. ST. B. ASS’N HEALTH L.J. 38, 38 (2012) [hereinafter Uttley et al., *New York State Model*]. Negotiations surrounding a non-Catholic hospital’s post-merger observance of the Directives are difficult and may determine the outcome of the merger. *Id.* Doctors and the board of directors at the non-Catholic hospital may protest the adoption of the Directives, as they may contradict their ethical beliefs, as well as generally accepted medical practice. *Id.* For example, in May 2019, a proposed affiliation between University of California San Francisco (UCSF), a renowned teaching hospital, and Dignity Health, a hospital system with roots in the Catholic Church, was stopped after more than 1,800 UCSF physicians and medical staff signed a petition opposing the transaction. Nanette Asimov, *Following Outcry, UCSF Ends Talks to Expand Partnership with Dignity Health*, S.F. CHRON., (May 28, 2019), <https://www.sfchronicle.com/bayarea/article/Following-outcry-UCSF-ends-talks-to-expand-13902018.php> [https://perma.cc/7W2R-2CU4]. The petitioners opposed the affiliation because UCSF physicians practicing at Dignity Health hospitals would have to abide by the Directives at those facilities. *Id.*

<sup>59</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25. The footnote to Directive 70 notes that although many acts can be considered “intrinsically evil,” the four listed in the Directive are the most urgent issues in modern medicine. *Id.* at 25 n.48.

<sup>60</sup> UTTLEY ET AL., *supra* note 9, at 1–2; Uttley et al., *New York State Model*, *supra* note 58, at 38. When a Catholic hospital merges with a non-Catholic hospital, the non-Catholic hospital must agree to follow the Directives. Uttley et al., *New York State Model*, *supra* note 58, at 38. As of 2018, about

### 3. 2018 Update to the Directives

The changes to the sixth edition of the Directives, adopted in 2018, concern Catholic hospital mergers and similar collaborations.<sup>61</sup> Part Six of the Directives, formerly entitled “Forming New Partnerships with Health Care Organizations and Providers,” is now called “Collaborative Arrangements with Other Health Care Organizations and Providers.”<sup>62</sup> This section was significantly re-written and expanded, with the goal of addressing the recent surge in Catholic hospital mergers with non-Catholic hospitals and clarifying the Directives’ application in these transactions.<sup>63</sup>

The USCCB added five Directives to the sixth edition to provide additional clarity on how enduring doctrines should be reconciled with modern merger and acquisition activity among Catholic hospitals.<sup>64</sup> First, Directive 73 prevents administrations and employees of a Catholic hospital from engaging with “immoral procedures” in any way after affiliating with a non-Catholic institution.<sup>65</sup> Directive 74 states that “[i]n any kind of collaboration, whatever

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thirty non-Catholic hospitals that recently merged with Catholic institutions must abide by the Directives. Hafner, *supra* note 22.

<sup>61</sup> Penan & Chen, *supra* note 10, at 3.

<sup>62</sup> Compare 2009 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 40, at 34 (titled Part Six as “Forming New Partnerships with Health Care Organizations and Providers”), with 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 23 (revising the title to Part Six to “Collaborative Arrangements with Other Health Care Organizations and Providers”).

<sup>63</sup> See Penan & Chen, *supra* note 10, at 3, 7 (explaining that the additional Directives “are intended to help better manage the growing incidence of Catholic hospital mergers”); *U.S. Bishops Revise Part Six of the Ethical and Religious Directives*, *supra* note 50, at 12 (clarifying that the USCCB revised the Directives in 2018 for two distinct reasons: “to update the Directives to reflect the growing number and complexity of collaborative arrangements taking place throughout health care” and “to reflect the ‘Principles for Collaboration’ that were issued by the Congregation of the Doctrine of the Faith” in 2014). Compare 2009 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 40, at 34–37 (listing only seventy-two Directives), with 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 23–26 (adding Directives 73 through 77, which concern collaborative agreements and cooperation with other health care organizations). The Principles for Collaboration were issued in 2014 in response to an inquiry from U.S. bishops regarding health care affiliations between Catholic and non-Catholic institutions. Congregation for the Doctrine of Faith, *Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services*, 2014 NAT’L CATH. BIOETHICS Q. 337, 337–38; *U.S. Bishops Revise Part Six of the Ethical and Religious Directives*, *supra* note 50, at 12.

<sup>64</sup> See DiVarco & Slattery, *supra* note 38 (noting that the new Directives state “long-standing . . . principles”); *U.S. Bishops Revise Part Six of the Ethical and Religious Directives*, *supra* note 50, at 12 (stating that the revised Directives “do not contain any new teaching” but are intended to address the confusion with respect to the application of the Directives in cooperative arrangements with non-Catholic institutions and give “more explicit direction”).

<sup>65</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26; DiVarco & Slattery, *supra* note 38. It is possible, however, that when a non-Catholic hospital merely affiliates with a Catholic hospital, the employees will remain separately employed by their respective hospitals, and only the Catholic hospital employees are bound by the Directives. See 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26 (emphasizing that the Catholic institution’s employees may not participate in “immoral procedures,” even if the affiliated non-Catholic facility provides them); DiVarco & Slat-

comes under the control of the Catholic institution . . . must be operated in full accord with the moral teaching of the Catholic Church, including the[] Directives.”<sup>66</sup> Thus, when a Catholic hospital affiliates with a non-Catholic institution, but the non-Catholic institution remains independently managed, it does not automatically have to comply with the Directives.<sup>67</sup> Directive 77 specifies that if a Catholic hospital does accommodate any “immoral procedures,” the local bishop must be informed, and the Catholic institution should rectify the divergence from the Directives.<sup>68</sup>

Most significantly, Directive 75 explicitly prohibits merging hospitals from creating a separate entity to provide the abovementioned “immoral procedures,” such as certain reproductive health services.<sup>69</sup> This new Directive appears to ad-

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tery, *supra* note 38 (stressing that post-affiliation, hospital administrators and employees must be kept separate if the non-Catholic facility continues to provide “immoral procedures”). This Directive affects hospital transactions going forward, as any affiliated Catholic hospital must clearly separate its administration and employees from an affiliated non-Catholic hospital that may be providing medical services in conflict with the Directives. DiVarco & Slattery, *supra* note 38. The Directives state that “immoral actions” are those that conflict with “the singular dignity of the human person.” 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 23 (citing Pope John Paul II, *Veritatis Splendor*, ¶ 13 (1993), [http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf\\_jp-ii\\_enc\\_06081993\\_veritatis-splendor.html](http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html) [<https://perma.cc/2MWV-D6VV>]). Examples of “immoral procedures” include “abortion, euthanasia, assisted suicide, and direct sterilization.” *Id.* at 25.

<sup>66</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Directive 74 applies to collaborations or acquisitions where another health care institution is “under the control” of a Catholic facility. *Id.* When referencing the Catholic Church’s “moral teaching,” the Directives focus on moral theology and the “dignity of the human person.” *Id.* at 4.

<sup>67</sup> *See id.* at 26 (noting that only the entity that “comes under the control of the Catholic institution” must follow the Directives); DiVarco & Slattery, *supra* note 38 (explaining that if the Catholic institution is the “controlling party” after the collaboration, such that it manages the non-Catholic health care facility, then the non-Catholic facility must abide by the Directives). If a Catholic hospital merely partners with a non-Catholic hospital as an affiliation, but they are not part of the same corporate entity, the non-Catholic hospital does not have to automatically abide by the Directives. *See* 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26.

<sup>68</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Directive 77 gives additional power to the local bishop to resolve any occurrences of a Catholic organization conducting “immoral procedures.” *Id.* This new Directive could jeopardize the structural remedies that carve out reproductive health services post-merger, as the current arrangements could be reviewed by a local bishop under Directive 77 and rescinded. *See* Harris Meyer, *New Catholic Directives Could Complicate Mergers and Partnerships*, MOD. HEALTHCARE (July 19, 2019), <https://www.modernhealthcare.com/article/20180719/NEWS/180719880/new-catholic-directives-could-complicate-mergers-and-partnerships> [<https://perma.cc/DKD3-EAPS>] (quoting the president of the National Catholic Bioethics Center, who predicted that certain structural remedies that violate the Directives may be re-examined).

<sup>69</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Directive 75 prohibits a variety of possible actions to create another facility, including establishing separate bylaws or procedures for each facility or incorporating a new legal entity. *Id.* Catholic bishops believe that Directive 75 aligns with Vatican Principle 12, as “a system or institution engages in formal cooperation with evil by ‘setting up an administrative body’ that will oversee the provision of immoral services or by setting up ‘an entity such as a clinic’ that will be engaged in immoral procedures.” *U.S. Bishops Revise Part Six of the Ethical and Religious Directives*, *supra* note 50, at 16. In previous transactions between Catholic and non-Catholic hospitals, local advocates and non-Catholic hospital administrators who did not want the community to lose access to reproductive health services would create a separate facility

dress the creative structural solutions, discussed in greater detail in Part II, that health care institutions previously employed to continue offering crucial reproductive health services post-merger that are otherwise forbidden for a Catholic hospital.<sup>70</sup> Although not yet tested, Directive 75 may prevent merging health care institutions from employing these innovative structural remedies to preserve access to reproductive health services.<sup>71</sup> When combined, these new Directives can be understood to be a direct reaction to the increase in merger and collaborative activity between Catholic and non-Catholic health care institutions.<sup>72</sup>

### *B. Increasing Consolidation Between Catholic and Non-Catholic Hospitals*

The recent growth in merger and acquisition activity among Catholic and non-Catholic hospitals is partially attributed to the passage of the ACA in 2010.<sup>73</sup> This phenomenon, combined with the federal antitrust and Catholic Church regulatory review scheme, helps explain the decrease in reproductive

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that did not have to abide by the Directives to provide the prohibited services post-merger. Uttley et al., *New York State Model*, *supra* note 58, at 38 (discussing examples of separate reproductive health care facilities created in response to Catholic hospital mergers in New York State). These tactics are discussed in greater detail in Part II.A. See *infra* notes 158–190 and accompanying text.

<sup>70</sup> See Penan & Chen, *supra* note 10, at 4 (questioning whether the model used in Troy, New York, would be allowed under the 2018 revised Directives). In 2011, in Troy, New York, St. Peter's Health System acquired a non-Catholic hospital, Samaritan Hospital. *Id.*; Press Release, St. Peter's Health Partners, Merger Creates St. Peter's Health Partners; Region's Most Comprehensive Health Care Provider (Oct. 3, 2011), <https://news.sphp.com/news/merger-creates-st-peters-health-partners-regions-most-comprehensive-health-care-provider/> [<https://perma.cc/HLM4-3FT9>]. The hospitals incorporated a separate, non-Catholic hospital entity on the second floor of the existing facility and relocated all maternity providers to the newly incorporated hospital, where post-partum sterilizations were performed. Penan & Chen, *supra* note 10, at 4. Reproductive health advocates and health care lawyers state that it is unknown if these creative solutions would withstand scrutiny under the 2018 Directives. DiVarco & Slattery, *supra* note 38; Penan & Chen, *supra* note 10, at 4, 7.

<sup>71</sup> See DiVarco & Slattery, *supra* note 38 (explaining that health care lawyers still cannot predict how the Catholic Church will assess these organizations in future Catholic hospital mergers); Penan & Chen, *supra* note 10, at 4, 6–7 (stating that because they have yet to be tested, it is still uncertain how the Catholic Church will implement these Directives in future transactions).

<sup>72</sup> See Penan & Chen, *supra* note 10, at 7 (noting that it will be important to focus on the new Directives as they apply to future transactions between Catholic and non-Catholic health care institutions); *U.S. Bishops Revise Part Six of the Ethical and Religious Directives*, *supra* note 50, at 12 (explaining that the updates to the Directives were intended to provide context and guidance for new transactions and affiliations between Catholic and non-Catholic institutions). An additional Directive, Directive 76, also speaks to collaboration in the health care industry. 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Directive 76 addresses Catholic hospital administrators who serve on the boards of non-Catholic health care institutions, stating that they must voice their disapproval of and withhold their authorization for “immoral procedures.” *Id.* Health care lawyers have noted that this Directive could impact the efficacy of hospital boards, but perhaps the Catholic representatives could recuse themselves. DiVarco & Slattery, *supra* note 38.

<sup>73</sup> See Dafny, *supra* note 34 (stating that there were 105 hospital merger transactions in 2012, after the passage of the ACA, as compared to merely fifty to sixty transactions per year prior to the ACA's enactment); DiVarco & Slattery, *supra* note 38 (crediting recent Catholic hospital mergers to ACA's revisions to patient care and insurance reimbursement policies that incentivize consolidation).

health services across the country.<sup>74</sup> The following Subsections discuss the impact of the ACA on hospital mergers, the antitrust regulatory scheme for mergers, the Catholic Church's merger review process, and the resulting decrease in access to reproductive health services.<sup>75</sup>

## 1. The Impact of the Affordable Care Act

Historically, nuns ran Catholic medical facilities and focused on providing compassion and social good.<sup>76</sup> Over the past century, however, Catholic health care institutions have become dominant businesses, and since the 1990s, Catholic hospitals have increasingly consolidated into large health care systems as part of the overall hospital merger trend occurring throughout the United States.<sup>77</sup> After the passage of the ACA, hospital merger activity in the country grew exponentially, and Catholic hospitals partook in this trend.<sup>78</sup>

Although individual hospital mergers occur for a variety of reasons, many recent hospital mergers are in direct response to the ACA.<sup>79</sup> Following the pas-

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<sup>74</sup> See 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25 (referencing the Catholic Church's role in approving a merger); CAL. HEALTHCARE FOUND., BALANCING ACT: CONSOLIDATION AND ANTITRUST ISSUES IN HEALTH CARE 2 (2015), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-BalancingConsolidationAntitrust.pdf> [<https://perma.cc/3YQT-JUPX>] (describing the ACA's financial incentives and mandates for increased collaboration); HEALTHCARE FIN. MGMT. ASS'N, HEALTHCARE 2020: TRANSITION TO VALUE 13 (2016), [https://www.hfma.org/content/dam/hfma/document/research\\_reports/PDF/49981.pdf](https://www.hfma.org/content/dam/hfma/document/research_reports/PDF/49981.pdf) [<https://perma.cc/7JCY-CLQP>] (suggesting that merging hospitals must show the federal antitrust agencies ways in which the merger will improve value in line with the Affordable Care Act (ACA) mandate to improve quality of care); Uttley et al., *New York State Model*, *supra* note 58, at 38 (emphasizing that if a non-Catholic hospital is permitted to continue offering reproductive health services that are outlawed by the Directives, the Catholic Church may not approve the deal).

<sup>75</sup> See *infra* notes 76–153 and accompanying text.

<sup>76</sup> Hafner, *supra* note 22; see Cohn, *supra* note 6 (addressing the rise of Catholic hospitals in the beginning of the 1900s).

<sup>77</sup> See UTTLEY ET AL., *supra* note 9, at 7 (explaining that hospitals were merging in the 1990s to gain market share, which better situates them for insurance negotiations). The large hospital merger surge in the 1990s was motivated by concerns upon the introduction of managed care and the growth of HCA Healthcare, one of the largest for-profit hospital systems in the United States. Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. TIMES (Aug. 12, 2013), <https://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html> [<https://perma.cc/5GY2-R3LL>]. In the early 2000s, the merger rate slowed before accelerating again in the wake of the passage of the ACA. Dafny, *supra* note 34; Creswell & Abelson, *supra*; see Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001–18121 (2018) (codifying the ACA).

<sup>78</sup> See Dafny, *supra* note 34 (calling the uptick in post-ACA mergers “impressive”); DiVarco & Slattery, *supra* note 38 (noting that Catholic hospitals have engaged in mergers and affiliations due to the changes in patient care and insurance reimbursement policies after the passage of the ACA, which encourages consolidation).

<sup>79</sup> Lawrence E. Singer, *Considering the ACA's Impact on Hospital and Physician Consolidation*, 46 J.L. MED. & ETHICS 913, 913–14 (2018); Creswell & Abelson, *supra* note 77; Sally Pipes, *Obamacare Drives Hospital Consolidation, Raising Prices for Patients*, FORBES (Sept. 16, 2019), <https://www.forbes.com/sites/sallypipes/2019/09/16/obamacare-drives-hospital-consolidation-raising->

sage of the ACA, there was significant uncertainty as health care systems attempted to understand its impact on the health care marketplace.<sup>80</sup> Hospitals merged to increase their market share, giving them bargaining leverage when negotiating with insurance companies.<sup>81</sup> Additionally, the ACA encourages a variety of cost-savings measures, which are often more attainable when employed on a larger scale in conjunction with other hospitals.<sup>82</sup> For example, the ACA moves away from the fee-for-service model, where insurance companies pay hospitals back based on the volume of services and procedures administered.<sup>83</sup> Instead, the ACA urges hospitals to switch to a value-based care reimbursement model, where insurance companies reimburse hospitals based on the quality of care and patient health outcomes, leaving hospitals more accountable for the complete cost of patient care.<sup>84</sup> Population health manage-

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prices-for-patients/ [https://perma.cc/J3WC-XTQ5]. See generally 42 U.S.C. §§ 18001–18121 (codifying the ACA, which led to uncertainty amongst hospitals). Singer argues that “cost, uncertainty, and the need for essentiality” together contribute to the post-ACA mergers. Singer, *supra*, at 914.

<sup>80</sup> Singer, *supra* note 79, at 914–15. The ACA proposed sweeping changes to reimbursement models and aimed to increase the number of Americans with health insurance coverage. *Id.* at 914; see 42 U.S.C. §§ 18001–18121 (deeming more individuals eligible for Medicare). Observers often note that hospitals merge out of the “bigger is better” idea, meaning that there is a conception that hospitals can protect themselves from uncertainty if they are larger institutions. Martin Gaynor, *New Health Care Symposium: Consolidation and Competition in U.S. Health Care*, HEALTH AFF. BLOG (Mar. 1, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160301.053529/full/> [https://perma.cc/2NLR-SJ9P] (arguing that “bigger isn’t always better”); see Singer, *supra* note 79, at 914 (“Managements’ response to this type of convoluted business and regulatory environment has been to consolidate.”).

<sup>81</sup> See Dafny, *supra* note 34 (explaining that hospitals merged after the ACA was passed to stabilize their position in the market); Creswell & Abelson, *supra* note 77 (noting that hospitals merged post-ACA to “increase their size and their negotiating clout with insurers”); Gaynor, *supra* note 80 (discussing how consolidation can engender greater bargaining strength in insurance negotiations).

<sup>82</sup> See 42 U.S.C. §§ 18001–18121 (introducing cost-savings initiatives such as reforming Medicare reimbursement programs); Singer, *supra* note 79, at 914 (explaining the benefits of cost-sharing across a larger hospital system). It is expensive to operate a large hospital system, as “new technology, treatment modalities, and pharmaceuticals” are costly, as are regulatory compliance and reporting rules. Singer, *supra* note 79, at 914. Thus, economies of scale push hospitals to merge with larger health care systems. *Id.*

<sup>83</sup> Singer, *supra* note 79, at 914; Creswell & Abelson, *supra* note 77; see 42 U.S.C. §§ 18001–18121 (departing from the fee-for-service model). Under the fee-for-service model, doctors were paid based on each individual patient they served on a visit. Nat’l Inst. of Diabetes & Digestive & Kidney Diseases, *Changing Landscape: From Fee-for-Service to Value-Based Reimbursement*, U.S. DEP’T HEALTH & HUMAN SERVS., <https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams/why-transform/changing-landscape-fee-service-value-based-reimbursement> [https://web.archive.org/web/20200110072757/https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams/why-transform/changing-landscape-fee-service-value-based-reimbursement]. Because patients had to pay per visit, they may have been reluctant to go see a doctor for a primary care visit, minimizing the opportunity for preventative care. *Id.*

<sup>84</sup> Singer, *supra* note 79, at 914; Creswell & Abelson, *supra* note 77; see 42 U.S.C. § 1395ww(o) (2018) (establishing a “value-based purchasing program” for hospitals under the Medicare program).



ment, a health care system that approaches patient well-being and health outcomes in a holistic manner, is a vital technique for health care systems to thrive in a value-based reimbursement model.<sup>85</sup> By managing overall population health to improve patient outcomes, hospital systems operating under a value-based care model should receive more favorable reimbursement rates from insurers.<sup>86</sup> Managing population health, however, is a daunting task, and many hospitals may need to merge with larger health care systems to achieve the necessary patient volume to allow for investment in the appropriate technology, analytics, and resources.<sup>87</sup>

Population health management encourages clinical integration, where different health care providers share patients and their health data because they can mutually benefit from positive health outcomes under a value-based reimbursement model.<sup>88</sup> The ACA creates financial incentives for health care providers to clinically integrate such that quality of care improves and health care costs decrease under a value-based system.<sup>89</sup> Many hospitals seek to merge

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Value-based care models aim to account for patient health outcomes when insurance plans reimburse health care providers. Nat'l Inst. of Diabetes & Digestive & Kidney Diseases, *supra* note 83. Rather than using a fee-for-service model, which reimburses doctors for service regardless of outcome, value-based care may reimburse providers at different rates based on both healthcare quality and cost factors. *Id.* Fee-for-service models, however, remain common as the U.S. healthcare market struggles to switch reimbursement models, so hospitals continue to use both systems. Singer, *supra* note 79, at 914–15. This uncertainty has also encouraged hospital mergers to better manage both models. *Id.*

<sup>85</sup> STEVE BURRILL & ARIELLE KANE, DELOITTE 2017 SURVEY OF US HEALTH SYSTEM CEOs 2 (2017), <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-ceo-medicaid-reimbursement.pdf> [<https://perma.cc/D2GY-C6P4>]. Population health management allows health care systems to use both preventative and acute medical care to advance the overall health of its patient population. *Id.*

<sup>86</sup> *Id.* If patients are generally healthier because their providers work together to deliver quality health care that boosts patient health outcomes, it benefits the health care systems under a value-based reimbursement model, as they will receive more favorable insurance reimbursement rates. *Id.*; Creswell & Abelson, *supra* note 77.

<sup>87</sup> HEALTHCARE FIN. MGMT. ASS'N, *supra* note 74, at 12; MONICA NOETHER & SEAN MAY, CHARLES RIVER ASSOCS., HOSPITAL MERGER BENEFITS: VIEWS FROM HOSPITAL LEADERS AND ECONOMETRIC ANALYSIS 3 (Jan. 2017), <https://www.crai.com/sites/default/files/publications/Hospital-Merger-Full-Report-FINAL-1.pdf> [<https://perma.cc/MKJ3-KQEF>]. For example, hospitals need to invest in expensive electronic health records systems to track patient data and outcomes. NOETHER & MAY, *supra*. Furthermore, to truly manage a population's overall health, hospital systems need to offer walk in clinics, nutritionists, and other costly services. HEALTHCARE FIN. MGMT. ASS'N, *supra* note 74, at 12. If a hospital does not have enough patients, it is not financially prudent to invest in these resources. *Id.* Thus, it needs to consolidate with other hospital systems to increase its patient population and justify these investments based on economies of scale. *Id.* at 12–13; NOETHER & MAY, *supra*.

<sup>88</sup> CAL. HEALTHCARE FOUND., *supra* note 74, at 2, 5. The ACA incentivizes providers to coordinate in the care that they deliver to patients, with the goal of lowering health care costs and improving the quality of care that patients receive. *Id.*

<sup>89</sup> *Id.* at 2; see 42 U.S.C. § 1395ww(o) (discussing the calculation process for value-based incentive payments based on hospital quality and performance).

with other health care providers to achieve such clinical integration.<sup>90</sup> The ACA's impact on reimbursement models and clinical integration incentives is a substantial contributing factor to the recent increase in health care system mergers across the country, including those involving Catholic hospitals.<sup>91</sup>

## 2. Antitrust Regulatory Review

When a hospital or health care system, Catholic or non-Catholic, is involved in a merger or acquisition, it often needs to receive approval from federal antitrust regulatory agencies, as well as occasionally from state regulatory bodies.<sup>92</sup> Large transactions that satisfy certain threshold requirements under the Hart-Scott-Rodino Act (HSR) must file notice of the transaction with the Department of Justice (DOJ) and Federal Trade Commission (FTC) before closing the deal.<sup>93</sup> These agencies have thirty days to review the transaction, and then they will either approve the deal or issue a Second Request for additional documents and information, which enables the agencies to conduct a more thorough investigation for possible antitrust violations.<sup>94</sup>

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<sup>90</sup> CAL. HEALTHCARE FOUND., *supra* note 74, at 5; Singer, *supra* note 79, at 914. Although health care providers can engage in affiliations and networks to coordinate care and achieve clinical integration, some merge to attain the benefits of clinical integration as well as the economies of scale to invest in the other technology and resources required for value-based care. CAL. HEALTHCARE FOUND., *supra* note 74, at 5. A merger is not needed to realize clinical integration, however, and it can be considered anticompetitive under the antitrust laws if it merely increases market power without promoting quality of care and lowering health care costs. *See id.* (discussing the need to avoid a consolidation of market power). Even as hospitals cite integration goals when merging, economic experts suggest that hospital consolidation does not immediately result in integration, and it is very difficult to achieve quality and cost-savings benefits by integrating, indicating a possible gap in hospitals' reasoning when conducting mergers. HEALTHCARE FIN. MGMT. ASS'N, *supra* note 74, at 13 (quoting Dr. Leemore Dafny, explaining that mergers do not usually result in lower costs for consumers); Gaynor, *supra* note 80 ("Merely changing ownership via consolidation does not imply integration.").

<sup>91</sup> *See* DiVarco & Slattery, *supra* note 38 (noting that Catholic hospitals have engaged in mergers and affiliations due to the changes in patient care and insurance reimbursement policies after the passage of the ACA, which encourages consolidation). *See generally* 42 U.S.C. §§ 18001–18121.

<sup>92</sup> Alexis J. Gilman et al., *Healthcare Providers and Insurers: FTC Approach to Provider Mergers and Acquisitions*, LEXIS PRAC. ADVISOR J. (Apr. 19, 2019), <https://www.lexisnexis.com/lexis-practice-advisor/the-journal/b/lpa/posts/healthcare-providers-and-insurers-ftc-approach-to-provider-mergers-and-acquisitions> [<https://perma.cc/V9JL-QZXW>]. Section 7 of the Clayton Act outlaws mergers if "the effect of such acquisition may be substantially to lessen competition." 15 U.S.C. § 18 (2018). The Department of Justice (DOJ) and FTC are the federal agencies tasked with enforcing the antitrust laws, including the Clayton Act. *Id.*; Gilman et al., *supra*.

<sup>93</sup> 15 U.S.C. § 18a (2018) (listing the pre-merger notification filing requirements); Gilman et al., *supra* note 92. The Hart-Scott-Rodino Act (HSR) is contained in Section 7A of the Clayton Act, and it requires transactions worth over two hundred million dollars be reported to the antitrust agencies, and the parties must wait thirty days after filing the pre-merger notification to close the transaction. 15 U.S.C. § 18a(a)–(b); Gilman et al., *supra* note 92. The purpose of an HSR filing is to alert the federal antitrust agencies of a transaction that may present anticompetitive concerns, so they can preemptively investigate before the deal closes. Gilman et al., *supra* note 92.

<sup>94</sup> 15 U.S.C. § 18a; Gilman et al., *supra* note 92. After reviewing the HSR file during the thirty-day waiting period, FTC staff may clear the deal by allowing the waiting period to expire or by termi-

Mergers are typically reviewed under Section 7 of the Clayton Act, which prohibits mergers that result in a reduction in competition.<sup>95</sup> When investigating a hospital merger for antitrust concerns, the FTC conducts a “fact-specific process,” using the Horizontal Merger Guidelines (Guidelines) to inform its analysis.<sup>96</sup> The FTC and DOJ issue the Guidelines jointly, most recently in 2010, and the Guidelines explain the agencies’ evaluation and enforcement policies with respect to mergers.<sup>97</sup> Although the Guidelines are a policy statement, not law, both federal agencies and courts look to them when evaluating the potential anticompetitive effects of a proposed merger, and thus they are helpful guidance for merging parties to predict how a transaction may be evaluated.<sup>98</sup> In particular, the Guidelines focus on transactions that could result in increased market power and consumer harm.<sup>99</sup> Although price increases are the

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nating the waiting period early, referred to as Early Termination. FED. TRADE COMM’N, *Premerger Notification and the Merger Review Process*, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-merger-review> [<https://perma.cc/K6WT-BCLX>]. If the transaction presents anticompetitive concerns, FTC staff will issue a Request for Additional Information, commonly referred to as a Second Request, which is essentially an investigatory subpoena that asks for documents, data, and informational interviews from the merging parties. *Id.*

<sup>95</sup> 15 U.S.C. § 18; U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES 1 (2010) [hereinafter HORIZONTAL MERGER GUIDELINES]; Gilman et al., *supra* note 92. Section 7 of the Clayton Act specifically makes unlawful mergers “in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.” 15 U.S.C. § 18.

<sup>96</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95. The Horizontal Merger Guidelines (Guidelines), most recently updated in 2010, are promulgated jointly by the FTC and the DOJ Antitrust Division and act as a policy statement on the analysis that the antitrust agencies use to evaluate a proposed transaction. *Id.* Although the FTC and DOJ share antitrust enforcement authority, the FTC’s Mergers IV division has been responsible for investigating hospital mergers since the 1990s. Gilman et al., *supra* note 92; *see also* FED. TRADE COMM’N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 1 & n.1, 2 (2019), [https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview\\_health\\_care\\_june\\_2019.pdf](https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_june_2019.pdf) [<https://perma.cc/JE6R-HEBB>] (noting that Mergers IV primarily investigates hospital and health care provider mergers). In the 1990s, the antitrust agencies sued to block seven hospital merger lawsuits and lost every one. Gilman et al., *supra* note 92. As a result, the FTC put together a task force to review its health care provider merger analysis. *Id.* The FTC has consistently prevailed in hospital merger litigations in the past decade. *Id.*

<sup>97</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95. The Guidelines describe the various types of evidence and analytical processes that the agencies use when reviewing a proposed transaction. *Id.*

<sup>98</sup> *Id.*; Gilman et al., *supra* note 92. The Guidelines are intended to provide insight into the agencies’ antitrust analysis for the commercial world and the antitrust lawyers that represent them. HORIZONTAL MERGER GUIDELINES, *supra* note 95. They are also helpful for the courts in evaluating antitrust cases that the agencies may bring to block a proposed transaction, and courts cite them as authority in opinions. *Id.*; Gilman et al., *supra* note 92. The Guidelines emphasize that they are merely a variety of tools, however, and not an exhaustive list of analyses. HORIZONTAL MERGER GUIDELINES, *supra* note 95.

<sup>99</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 2. The Guidelines emphasize that market power is the “unifying theme” of the Guidelines in their entirety. *Id.* A transaction can result in an increase in market power if the combined firms can “raise price, reduce output, diminish innovation, or otherwise harm consumers.” *Id.* Minimizing competition in the relevant market is a way for the merging parties to enhance their market power, and thus it is an area of concern under antitrust law.

clearest evidence of consumer harm, the agencies typically examine price and non-price competition when examining a hospital merger for antitrust violations.<sup>100</sup> Because hospitals operate in a two-sided market, they compete first on price when negotiating reimbursement rates with health insurance companies, before competing on non-price factors like quality, location, and service offerings to attract patients.<sup>101</sup>

To evaluate the potential anticompetitive effects of a merger or acquisition, the FTC often, but not always, begins with the market definition.<sup>102</sup> Market definition analysis helps agencies understand both the possible product market and the geographic market where a post-merger reduction in competition could harm consumers.<sup>103</sup> The product market is defined by the group of products that have a function or use so similar that they can act as substitutes, which different entities compete to sell to consumers.<sup>104</sup> When defining the product market in a hospital merger, the agencies often examine the inpatient general acute care (GAC) services offered by the hospital.<sup>105</sup> The geographic

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*Id.* The dominant standard for evaluating potentially anticompetitive mergers is consumer welfare. Christine Wilson, Comm'r, Fed. Trade Comm'n, Keynote Address at the *George Mason Law Review* Symposium: Welfare Standards Underlying Antitrust Enforcement: What You Measure Is What You Get 1 (Feb. 15, 2019), [https://www.ftc.gov/system/files/documents/public\\_statements/1455663/welfare\\_standard\\_speech\\_-\\_cmr-wilson.pdf](https://www.ftc.gov/system/files/documents/public_statements/1455663/welfare_standard_speech_-_cmr-wilson.pdf) [<https://perma.cc/2PW5-4C75>]. If the transaction could harm consumers, presumably by an increase in market power, the transaction may violate the antitrust laws. *Id.*

<sup>100</sup> Wilson, *supra* note 99, at 5–6. The Guidelines state that “[f]or simplicity of exposition,” they discuss market power and merger analysis through a price effects lens. HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 2. They note that an increase in market power can be observed through non-price effects which also harm consumers. *Id.* Non-price increases in market power can include a reduction in services or products. *Id.*

<sup>101</sup> *FTC v. Advocate Health Care Network*, 841 F.3d 460, 470–71 (7th Cir. 2016); Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 672 (2000); Wilson, *supra* note 99, at 6. Hospitals compete in two stages, and thus, the antitrust agencies often analyze anticompetitive effects on both price and non-price factors. Wilson, *supra* note 99, at 6.

<sup>102</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 7. Defining a market assists agency staff by enabling them to focus on a set of products in a certain area that may suffer from anticompetitive effects post-merger. *See id.* at 7–8 (explaining that agencies often first define the market broadly to understand which products compete in that region, before narrowing in on a specific product market). Antitrust cases often turn on how the relevant market is defined, because it establishes the amount of control firms have over their pricing. *See United States v. E.I. du Pont de Nemours*, 351 U.S. 377, 403 (1956) (holding that the relevant market for E.I. du Pont’s (du Pont) cellophane product was not cellophane, but rather, flexible packaging materials, and thus, du Pont did not illegally monopolize the market per the antitrust laws).

<sup>103</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 7.

<sup>104</sup> *Id.* at 8; Gilman et al., *supra* note 92; *see Brown Shoe Co. v. United States*, 370 U.S. 294, 325, 336 (1962) (defining the relevant product markets in a merger between shoe manufacturers as “men’s, women’s and children’s shoes”).

<sup>105</sup> Gilman et al., *supra* note 92. Of course, not all inpatient hospital services are substitutes for each other, and different services could constitute several smaller product markets. *Id.* Despite this, the FTC typically uses a “cluster market” containing all general acute care (GAC) services in hospital mergers, as it is more feasible to analyze the competitive effects using one product market. Jonathan

market is the region that would suffer from a reduction in competition, especially if consumers are unable to travel to replace the relevant products.<sup>106</sup> In a hospital merger, determining the geographic market that the merging hospitals serve can be challenging, and it often turns on case-specific facts.<sup>107</sup> Additionally, the agencies use this market definition to calculate the merging parties' market concentration and market share to determine if the potential merger raises competitive concerns.<sup>108</sup>

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Baker, *Market Definition: An Analytical Overview*, 74 ANTITRUST L.J. 129, 157, 158 (2007) (noting that it is "a matter of analytical convenience"); Gilman et al., *supra* note 92. GAC services broadly include emergency, internal medicine, and surgical procedures, but they do not encompass complex specialty services. *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1075–76 (N.D. Ill. 2012). Courts usually accept the GAC cluster market when reviewing the agencies' challenges to hospital mergers. *See, e.g., id.* (applying the GAC cluster market); *FTC v. ProMedica Health Sys.*, 2011 U.S. Dist. LEXIS 33434, at \*146 (N.D. Ohio 2011) (same); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290 (W.D. Mich. 1996) (same).

<sup>106</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 13. The geographic market focuses on the region in which a supplier of products is located, as well as the consumers' location. *Id.* Both "consumers' ability and willingness" to travel are important factors when defining a geographic market. *Id.* Once the agencies define a product market containing a certain product sold by one of the merging parties and its substitutes, it uses the hypothetical monopolist test as a check to verify if these products are indeed "reasonably interchangeable" within a certain geographic market. *Id.* at 8–9. The test imagines that a hypothetical monopolist would implement a "small but significant and non-transitory increase in price (SSNIP)" on the chosen product. *Id.* If the hypothetical monopolist test and SSNIP impact the price of sales of similar products in the relevant geographic market, such that the price is higher than "competitive levels," it could indicate the possibility of a price increase post-merger. *Advocate Health Care Network*, 841 F.3d at 468; *see* HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 8–10 (providing examples of how the agencies employ the hypothetical monopolist test). The FTC performs the SSNIP test in an "iterative" manner and repeats the test by adding different customers and suppliers to confirm the geographic market. *Advocate Health Care Network*, 841 F.3d at 468.

<sup>107</sup> Gilman et al., *supra* note 92 (explaining that the geographic market is "often one of the most difficult and contested issues in a provider-merger investigation and litigation"). Hospital merger geographic markets are often quite small because patients tend to travel to their closest hospital for services. *Advocate Health Care Network*, 841 F.3d at 470. Furthermore, because hospitals operate in a unique two-stage competition model, where they compete on price with insurance providers and on non-price factors like quality of care with patients, the geographic market analysis differs from other competitive markets. *Id.* at 470–71; Vistnes, *supra* note 101.

<sup>108</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 18. Agencies consider the merging firms' market shares pre- and post-merger to measure their market concentration. *Id.* A highly concentrated market is more likely to present anticompetitive concerns. *Id.* at 18–19. The Supreme Court held in *United States v. Philadelphia. National Bank* in 1963 that a combined 33% market share is a competitive harm under the antitrust laws, and the FTC continues to abide by this presumption. 374 U.S. 321, 365 (1963); Gilman et al., *supra* note 92. To measure market concentration, the agencies use the Herfindahl-Hirschman Index (HHI), which requires "summing the squares of the individual firms' market shares," resulting in significantly more HHI for firms with greater market share. HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 18. Typically, HHI can be classified into three markets: "Unconcentrated Markets: HHI below 1500," "Moderately Concentrated Markets: HHI between 1500 and 2500," and "Highly Concentrated Markets: HHI above 2500." *Id.* at 19. Highly concentrated markets raise the presumption of increased market power post-merger. *Id.*

The agencies also focus on evidence of adverse competitive effects that could potentially result from the transaction, which includes market share and concentration.<sup>109</sup> This also includes the historical precedent of similar mergers that resulted in less competition and price increases, and examples of “head-to-head competition” between the merging parties.<sup>110</sup> In addition, the Guidelines instruct the agencies to study the possible unilateral effects of a transaction—the impact the elimination of competition between just the merging parties could have upon overall competition in the market.<sup>111</sup> A merger could also result in coordinated effects, by encouraging other parties in the market to alter their conduct in such a way that results in a loss of competition.<sup>112</sup>

Merging parties may assert defenses to antitrust scrutiny and litigation.<sup>113</sup> The Guidelines encourage the agencies to consider the ease of entry for another firm to join the market and provide the competition that would otherwise be lost as a result of the merger.<sup>114</sup> In a hospital merger, this is often difficult for the hospitals to prove, as hospitals are large, expensive institutions that cannot easily enter an established health care market.<sup>115</sup> The Guidelines also discuss

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<sup>109</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 2–3. The FTC and DOJ will examine any evidence that details the probable anticompetitive effects of a transaction. *Id.* at 2.

<sup>110</sup> *Id.* at 3. Here, the Guidelines list a variety of examples of evidence of adverse competitive effects that could occur post-merger. *Id.* “Head-to-head” competition occurs when two parties compete directly with each other. *Id.* at 3. For example, in *Federal Trade Commission v. Staples, Inc.* in 2016, the district court found that defendants Staples and Office Depot consistently engaged in head-to-head competition for large business-to-business customers, and an elimination of this behavior could lessen competition in the market. 190 F. Supp. 3d 100, 131 (D.D.C. 2016). Thus, the court granted the agency’s preliminary injunction blocking the proposed merger. *Id.* at 138.

<sup>111</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 20. Unilateral effects may be most obvious in a transaction where the merging parties will combine to form a monopoly in the relevant market. *Id.* They can also be readily noticeable, however, if the merging parties are engaged in “head-to-head competition.” *Id.* at 3. Unilateral effects can harm consumers in several ways, including differential product pricing, bargaining between supplier and consumer, and reduced innovation as a result of a lack of competition. *Id.* at 20–24.

<sup>112</sup> *Id.* at 24. Coordinated effects refers to the post-merger phenomenon where the remaining firms in the relevant market are incentivized to coordinate or collude. *Id.* at 24–26.

<sup>113</sup> Gilman et al., *supra* note 92. Commonly raised defenses include future entry by another competitor, efficiencies as a result of the merger, failing firm (i.e., the firm must merge with a competitor or it will fail), state action immunity, and safe harbor provisions. *Id.*

<sup>114</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 27–28. In evaluating ease of entry, the agencies analyze three factors: timeliness, likelihood, and sufficiency. *Id.* at 29. First, the new firm must enter the relevant market soon after the merger to counteract any anticompetitive effects. *Id.* Second, it is likely another firm would enter the market if it would be lucrative for that firm to do so. *Id.* Third, the new entrant to the market must sufficiently combat the agencies’ antitrust concerns. *Id.*

<sup>115</sup> Gilman et al., *supra* note 92. A new hospital entering the market is rarely timely, because the facility must be built and physicians acquired, and state and local regulatory requirements for health care providers can be significant hurdles. *Id.* Additionally, some states have a Certificate of Need law, requiring new health care providers to get approval from state regulators confirming that there is sufficient need for a hospital before entering the market. *Id.*

efficiencies, a common defense for mergers undergoing antitrust scrutiny.<sup>116</sup> Although efficiencies can promote competition, agencies only allow them as a defense to merger scrutiny if they are (1) merger-specific, meaning that the parties could not achieve them but for the merger, (2) verifiable, and (3) not a result of anticompetitive behavior.<sup>117</sup> Efficiency claims are also fact-specific, and the merging parties must provide specific projections to substantiate them.<sup>118</sup> In hospital mergers, efficiency claims are often framed in the context of the ACA's cost-savings incentives for achieving clinical integration between health care systems and different providers.<sup>119</sup>

Despite the potential need for antitrust review, many small hospital and provider mergers do not meet the HSR threshold value, so they do not have to file a pre-merger notification with the DOJ and FTC.<sup>120</sup> Because these smaller hospital merger transactions are non-reportable under the HSR Act, the FTC is not obligated to investigate them for antitrust concerns, but it can choose to do

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<sup>116</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 29. Merging parties often justify their merger by claiming efficiencies they can achieve as a result of the transaction. *Id.* Lower courts have accepted an efficiencies defense in merger litigation, with the caveat that the efficiencies must be sufficient to overcome the anticompetitive harm of a merger. *See* FTC v. H.J. Heinz Co., 246 F.3d 708, 720 (D.C. Cir. 2001) (stating that “the trend among lower courts is to recognize the defense”); FTC v. Tenet Healthcare Corp., 186 F.3d 1045, 1054–55 (8th Cir. 1999) (finding that the district court should have considered the merging hospitals’ efficiencies defense, as the two hospitals combined could provide higher quality service and attract better doctors).

<sup>117</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 30. Merging parties may claim efficiencies, but if one of the parties can achieve these efficiencies but for the merger, they are not merger-specific, and the agencies likely will not consider them to be an acceptable defense to an otherwise anticompetitive merger. *See* H.J. Heinz Co., 246 F.3d at 721–22; HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 30. For example, in *H.J. Heinz Co.*, the court blocked the merger of two baby food manufacturers, holding that H.J. Heinz Co.’s (Heinz’s) efficiencies defense—that it could create a better product by acquiring Beech-Nut’s recipes—was not merger-specific because Heinz could develop better recipes on its own without the merger. 246 F.3d at 722.

<sup>118</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 30. Efficiencies are inherently speculative, and often cannot be verified by the agencies, especially if the merging parties are reluctant to share competitive information. *See id.* (“[M]uch of the information relating to efficiencies is uniquely in the possession of the merging firms.”) Agencies do not accept ambiguous claims of efficiencies. *Id.* In contrast, agencies will accept cognizable efficiencies, which are merger-specific and are not anticompetitive in nature. *Id.*

<sup>119</sup> *See* Dafny, *supra* note 34 (discussing the effect of the ACA on hospital mergers intended to achieve efficiencies); Gilman et al., *supra* note 92 (explaining that health care systems often merge for efficiencies reasons including population health management). For example, in *Federal Trade Commission v. Penn State Hershey Medical Center*, the merging hospitals argued that a merger would allow them to engage in risk-based contracting, an alternative to fee-for-service, where the provider takes on more of the risk and upside in health care costs. 838 F.3d 327, 350–51 (3d Cir. 2016). The parties alleged that this was an efficiency, as a larger hospital system would enable them to spread out the costs associated with risk-based contracting. *Id.* at 351. The Third Circuit, however, held that this was not a cognizable efficiency and blocked the merger, as it was unclear how the consumers would benefit and how it would offset any anticompetitive harms of the merger. *Id.*

<sup>120</sup> Gilman et al., *supra* note 92; *see* 15 U.S.C. § 18a (providing the necessary threshold amounts).

so.<sup>121</sup> Although these transactions are non-reportable, they do not always avoid federal antitrust scrutiny, as consumers, state attorneys general, and other third parties may bring their concerns about a proposed merger to the agencies, who can investigate it for anticompetitive effects under the Guidelines analysis described above.<sup>122</sup> The FTC may work in conjunction with the antitrust divisions in state attorneys general offices to investigate the proposed transaction if state officials are concerned.<sup>123</sup> Both the FTC and state attorneys general are authorized to block the transaction or require a divestiture.<sup>124</sup>

Additionally, some rural hospital mergers are immune from antitrust scrutiny.<sup>125</sup> In 1996, the antitrust agencies outlined a “safety zone” for mergers between certain small general acute care hospitals.<sup>126</sup> If one of the merging hospitals contains less than one hundred licensed beds and cares for fewer than forty patients per day, the antitrust agencies will not interfere in the merger, “absent extraordinary circumstances.”<sup>127</sup> The agencies state that these mergers

<sup>121</sup> Gilman et al., *supra* note 92. Even though smaller, non-reportable hospitals mergers do not have to be reported to the FTC under the HSR Act, it can be advisable to inform the antitrust agencies of the transaction if the merging parties’ attorneys are concerned about the agencies investigating the merger after it is consummated. *Id.*

<sup>122</sup> *Id.* Although the FTC is not required to review non-reportable mergers, it may still investigate the merger if there are complaints from the community. *Id.*

<sup>123</sup> Brijesh Dave, *Trust the (Local) Process: Advantages State Attorneys General Enjoy in Merger Review*, A.B.A. TYL (2018), [https://www.americanbar.org/groups/young\\_lawyers/publications/tyl/topics/antitrust/trust-local-process-advantages-state-attorneys-general-enjoy-merger-review/](https://www.americanbar.org/groups/young_lawyers/publications/tyl/topics/antitrust/trust-local-process-advantages-state-attorneys-general-enjoy-merger-review/) [<https://perma.cc/GRC4-HSEP>]. Federal antitrust agencies and state attorneys general have similar investigatory structures and powers with respect to merger review. *Id.*

<sup>124</sup> *Id.*; Gilman et al., *supra* note 92. Although the FTC and DOJ are authorized to investigate and block anticompetitive transactions under Section 7 of the Clayton Act, state attorneys general can also sue merging parties under *parens patriae*. 15 U.S.C. § 18; Dave, *supra* note 123. The HSR Act, which established pre-merger notification filing requirements when it was enacted in 1976, also gave state attorneys general the right to litigate antitrust suits under the Clayton Act through the *parens patriae* doctrine. 15 U.S.C. § 15c (2018). *Parens patriae* enables a state to act on behalf of “natural persons” in the state. *Id.*; Dave, *supra* note 123.

<sup>125</sup> U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 8–9 (1996) [hereinafter STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE]; Gilman et al., *supra* note 92.

<sup>126</sup> STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 125; Gilman et al., *supra* note 92. Although these statements are several decades old, the antitrust agencies continue to apply them. Gilman et al., *supra* note 92.

<sup>127</sup> STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 125. Two conditions must be met: one of the hospitals must have “an average of fewer than [one hundred] licensed beds over the three most recent years, and . . . an average daily inpatient census of fewer than [forty] patients over the three most recent years.” *Id.* If these conditions are met, the merger will not be challenged, “absent extraordinary circumstances.” *Id.* Also, the safety zone does not pertain to hospitals built within the past five years. *Id.* at 9. The safety zone does not include specialty hospitals either. Gilman et al., *supra* note 92.



may be procompetitive, as rural hospitals can benefit from merging with a larger hospital system and realize efficiencies.<sup>128</sup>

### 3. Catholic Hospital Merger Review Process

When a Catholic hospital is involved in a merger or acquisition, there is an additional step of scrutiny before the deal can close, as the local bishop, and occasionally the Vatican, must approve the deal.<sup>129</sup> Directive 68 authorizes the governing bishop to approve or deny health care collaborations within a diocese.<sup>130</sup> The Directives instruct the local bishops to contemplate the broader consequences of approving a health care collaboration involving Catholic institutions on both a regional and national level.<sup>131</sup> Additionally, Directive 69 states that if the transaction spans several dioceses, the bishop in each affected diocese must approve the collaboration before the merger can close.<sup>132</sup> In particu-

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<sup>128</sup> STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 125, at 9. Presumably, if a merging hospital with fewer than one hundred beds was the only hospital in the rural area, a merger with a larger health care system would not result in a loss in competition, as it would not be competing with another hospital to begin with. *See id.* (explaining that the rural hospital that is the only hospital in the market is unlikely to compete with other hospitals).

<sup>129</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25; Melanie Evans, *Is This Hospital Takeover Permitted? Ask the Catholic Church*, WALL STREET J. (May 14, 2018), <https://www.wsj.com/articles/is-this-hospital-takeover-permitted-ask-the-catholic-church-1526290201> [<https://perma.cc/3TY4-D4S6>]. A bishop is an “ecclesiastical dignitary” who is the governing authority for a specific diocese. *Bishop*, NEW ADVENT CATHOLIC ENCYCLOPEDIA, <http://www.newadvent.org/cathen/02581b.htm> [<https://perma.cc/NL52-2GA6>].

<sup>130</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25. The local bishop has complete authority to evaluate and approve collaborations between Catholic and non-Catholic health care providers within his diocese. *Id.* A diocese is a certain geographic area containing churches and other Catholic facilities, including hospitals, under a bishop’s authority. *Diocese*, NEW ADVENT CATHOLIC ENCYCLOPEDIA, <http://www.newadvent.org/cathen/05001a.htm> [<https://perma.cc/N5GJ-YA6R>].

<sup>131</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25. Directive 67 grants this “ultimate responsibility” to the local bishop of each diocese, but commands him to consider not only the impact on his diocese, but the possible effects of his decision on the region and nation as well. *Id.* In making this decision, the local bishop should consider factors such as whether the transaction would “involve wrongful cooperation, give scandal, or undermine the Church’s witness.” *Id.* Directives 67 and 71 both address the issue of avoiding scandal, a word that was used in earlier versions of the Directives as well when referring to immoral procedures such as abortion. *Id.* The Catholic Church defines scandal as “an attitude or behavior which leads another to do evil.” *Catechism of the Catholic Church* § 2284, LIBRERIA EDITRICE VATICANA, [http://www.vatican.va/archive/ENG0015/\\_P80.HTM](http://www.vatican.va/archive/ENG0015/_P80.HTM) [<https://perma.cc/8W7D-7KCQ>] (last visited Oct. 26, 2020).

<sup>132</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25. Furthermore, the bishop in the diocese where the health care institution’s headquarters is located is responsible for collaborating with bishops in other affected dioceses. *Id.* The requirement to coordinate with the bishop governing the hospital’s corporate headquarters was a new addition to the 2018 Directives. DiVarco & Slattery, *supra* note 38. Health care lawyers warn that this additional coordination may result in lengthier transactions because many health care systems span the United States. *Id.*

larly large or complicated transactions, if the bishops cannot come to an agreement, they must seek guidance from the Vatican.<sup>133</sup>

Even if a transaction withstands antitrust scrutiny, it can fall apart if one of the merging parties does not agree to abide by the Directives.<sup>134</sup> An agreement to abide by the Directives is a precondition for the merger.<sup>135</sup> Without a negotiated understanding to adhere to the Directives, the local bishop will likely block the transaction from proceeding.<sup>136</sup> Thus, in order to ensure that a transaction involving a Catholic hospital can proceed without encountering barriers from the Catholic Church, merging parties are incentivized to agree to comply with the Directives early in the process.<sup>137</sup>

#### 4. The Resulting Decrease in Access to Reproductive Services

ACA incentives for clinical integration between health care providers and the expectation that a non-Catholic hospital must agree to abide by the Directives to merge with a Catholic hospital have contributed to a reduction in reproductive health services across the country, especially in rural areas where

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<sup>133</sup> Evans, *supra* note 129. For example, in 2018, Catholic Health Initiatives and Dignity Health proposed a \$28 billion merger that would combine 139 hospitals across twenty-eight states, and the Archbishop of Denver sought review from the Vatican's Congregation for the Doctrine of the Faith. Tara Bannow & Harris Meyer, *CHI-Dignity Merger Cleared by Vatican*, MOD. HEALTHCARE (Oct. 16, 2018), <https://www.modernhealthcare.com/article/20181016/NEWS/181019911/chi-dignity-merger-cleared-by-vatican> [<https://perma.cc/5FGZ-SDZF>]; Evans, *supra* note 129. The Congregation for the Doctrine of the Faith is a group of bishops, cardinals, and other religious leaders in the Vatican who resolve issues concerning Catholic doctrine and theology. Evans, *supra* note 129. Catholic Health Initiatives and Dignity Health received moral analyses from four ethicists before seeking additional guidance from the Vatican. Bannow & Meyer, *supra*. The Vatican ultimately approved the transaction, but the Vatican has challenged Catholic hospital mergers in the past. *Id.*; see Evans, *supra* note 129 (discussing a 2012 transaction in St. Louis involving the sale of a Catholic hospital owned by Mercy to a non-Catholic company, which fell apart due to challenges in receiving Vatican and FTC approval).

<sup>134</sup> Uttley et al., *New York State Model*, *supra* note 58 (explaining that if a non-Catholic hospital is permitted to continue offering procedures outlawed by the Directives, the local bishop may not approve the deal).

<sup>135</sup> Martin, *Catholic Bishops Vote to Revise Rules*, *supra* note 57.

<sup>136</sup> Uttley et al., *New York State Model*, *supra* note 58; see 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26 (stating in Directive 74 that any acquired facility must observe the Directives). Directive 74 emphasizes that any hospital that is acquired by a Catholic facility during the transaction must abide by the Directives, and Directive 67 reiterates that the local bishop must evaluate if a transaction within his diocese will "involve wrongful cooperation, give scandal, or undermine the Church's witness." 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25–26.

<sup>137</sup> See Uttley et al., *New York State Model*, *supra* note 58 (discussing how future compliance with the Directives is often a crucial issue during merger negotiations between Catholic and non-Catholic health care institutions); Hafner, *supra* note 22 (noting that about thirty non-Catholic hospitals involved in mergers with Catholic hospitals have agreed to comply with "some or all" of the Directives).

there are less hospitals and those hospitals tend to be Catholic.<sup>138</sup> When a Catholic hospital combines with a non-Catholic hospital, the non-Catholic hospital must adopt the Directives to gain approval from the local bishop, but it also needs to standardize its medical procedure offerings with the Catholic hospital to achieve clinical integration.<sup>139</sup>

Clinical integration between different health care providers, which enables providers to collaborate to provide high quality care to patients, is a key goal of hospital mergers for several reasons.<sup>140</sup> First, as discussed above, the ACA developed financial incentives for hospital systems that engage in clinical integration programs.<sup>141</sup> Second, real clinical integration that improves the quality of health care and lowers costs will be viewed more favorably by antitrust regulators who are concerned about mergers that concentrate market share.<sup>142</sup> The ACA's incentives encourage hospitals to combine to clinically integrate, but a consolidation in market power may violate antitrust law.<sup>143</sup> Consequently, in order to pass antitrust scrutiny, merging hospitals must

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<sup>138</sup> 42 U.S.C. § 18001; see 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25 (referencing the local bishop's role in approving a transaction); CAL. HEALTHCARE FOUND., *supra* note 74, at 2 (describing the ACA's financial incentives and mandates for increased collaboration); Uttley et al., *New York State Model*, *supra* note 58 (explaining that if a non-Catholic hospital is permitted to continue offering reproductive health services that are outlawed by the Directives, the local bishop may not approve the deal).

<sup>139</sup> Uttley et al., *New York State Model*, *supra* note 58 (explaining that if a non-Catholic hospital is permitted to continue offering reproductive health services that are outlawed by the Directives, the local bishop may not approve the deal); Elizabeth B. Deutsch, Note, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 YALE L.J. 2470, 2486–87 (2015) (discussing how clinical integration and FTC antitrust review policy force non-Catholic hospitals to adopt the Directives). Post-merger, it is crucially important for health care systems to adapt to a common, unified culture. NOETHER & MAY, *supra* note 87, at 12. To achieve this “common culture,” the merging hospitals need to both financially and clinically integrate, such that they share similar values. *Id.*

<sup>140</sup> Gaynor, *supra* note 80 (explaining that true integration is necessary to achieve cost savings and other positive results from a transaction).

<sup>141</sup> 42 U.S.C. § 18001; CAL. HEALTHCARE FOUND., *supra* note 74, at 2 (describing the ACA's financial incentives and mandates for increased collaboration, including “[b]undled [p]ayment,” accountable care organizations, and “[p]atient-[c]entered [m]edical [h]omes”). The ACA intended for different health care providers to work together to coordinate all of a patient's care, with the goal of improving quality of care and bettering patient health outcomes. CAL. HEALTHCARE FOUND., *supra* note 74, at 2.

<sup>142</sup> CAL. HEALTHCARE FOUND., *supra* note 74, at 5 (noting that merging hospitals should have legitimate reasons that they need to merge rather than affiliate to achieve clinical integration); HEALTHCARE FIN. MGMT. ASS'N, *supra* note 74, at 13 (suggesting that merging hospitals must show antitrust agencies ways in which the merger will improve value by improving the quality of care and lowering health care costs for patients and the community). Hospitals and health systems need to ensure that their clinical integration plans are merger-specific, meaning that they could not be achieved but for the merger. NOETHER & MAY, *supra* note 87, at 10.

<sup>143</sup> 42 U.S.C. § 18001; CAL. HEALTHCARE FOUND., *supra* note 74, at 1 (referencing the complicated interaction between the ACA's integration goals and the role of antitrust regulators).

demonstrate genuine, necessary clinical integration.<sup>144</sup> This incentivizes merging parties to fully integrate, which includes adoption of the Directives, so that the merging parties offer the same set of medical procedures and services.<sup>145</sup> Thus, adopting the Directives to achieve clinical integration may facilitate a more favorable antitrust review, and it will also lead to a greater likelihood of the merger receiving the blessing of the Catholic Church.<sup>146</sup>

As more hospitals in the country become Catholic, the number of hospitals offering reproductive health services decreases.<sup>147</sup> These trends are especially notable in rural areas, where a Catholic hospital may be the only hospital in the region.<sup>148</sup> In 2016, there were forty-six Catholic “sole community hospitals” in the country, which the Centers for Medicare and Medicaid Services defines as being “located more than [thirty-five] miles from other like hospitals.”<sup>149</sup> In these rural areas where Catholic hospitals are the only hospitals, patients are without another provider to turn to if they need a procedure that is banned by the Directives.<sup>150</sup> In the event of a medical emergency, such as a

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<sup>144</sup> See CAL. HEALTHCARE FOUND., *supra* note 74, at 5 (listing questions about integration that merging hospitals should consider in the context of an antitrust review); Gaynor, *supra* note 80 (explaining that hospitals need to truly integrate their clinical programs to gain the quality of care and cost reduction benefits of integration, while noting that this is incredibly difficult to achieve).

<sup>145</sup> Deutsch, *supra* note 139 (drawing a connection between clinically integrating to survive antitrust scrutiny with adopting the Directives).

<sup>146</sup> See 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 25 (referencing the local bishop’s role in approving a transaction); CAL. HEALTHCARE FOUND., *supra* note 74, at 2 (describing the ACA’s financial incentives and mandates for increased collaboration); Uttley et al., *New York State Model*, *supra* note 58 (explaining that if a non-Catholic hospital is permitted to continue offering reproductive health services that are outlawed by the Directives, the local bishop may not approve the deal).

<sup>147</sup> See Hafner, *supra* note 22 (noting that about thirty non-Catholic hospitals involved in recent mergers with Catholic hospitals have agreed to comply with “some or all” of the Directives).

<sup>148</sup> KAYE ET AL., *supra* note 24, at 24; UTTLEY & KHAIKIN, *supra* note 22, at 5–6. In fact, this was a significant issue in the proposed transaction between Sierra Vista Regional Health Center, where Dr. Holder worked, and Carondelet Health Network, a Catholic hospital system. See Affidavit of Dr. Robert Holder, *supra* note 1, at 1; Religion & Ethics Newsweekly, *supra* note 1; *supra* notes 1–21 and accompanying text. Sierra Vista is a rural community in Arizona, and the closest hospital was eighty miles away in Tucson. See Affidavit of Dr. Robert Holder, *supra* note 1, at 1; Religion & Ethics Newsweekly, *supra* note 1; *supra* notes 1–21 and accompanying text. Thus, when Dr. Holder’s patient suffered a miscarriage and needed to terminate the second twin fetus, she had to be transferred eighty miles to the closest facility, putting her health at risk. See Affidavit of Dr. Robert Holder, *supra* note 1, at 3; Cohn, *supra* note 6; *supra* notes 1–21 and accompanying text.

<sup>149</sup> See 42 C.F.R. § 412.92 (2019) (defining the Centers for Medicare and Medicaid Services’ “[c]riteria for classification as a sole community hospital”); UTTLEY & KHAIKIN, *supra* note 22, at 5–6 (listing the number of Catholic sole community hospitals in the United States). In Iowa, South Dakota, and Texas, multiple different geographic regions of the state have only one Catholic hospital as a provider. UTTLEY & KHAIKIN, *supra* note 22, at 5–6.

<sup>150</sup> See KAYE ET AL., *supra* note 24, at 24 (giving examples of patients in rural areas whose only hospital was Catholic); UTTLEY & KHAIKIN, *supra* note 22, at 5–6 (listing the sole community hospitals in the United States that are Catholic); Natalie Langlois, Note, *Life-Sustaining Treatment Law: A Model for Balancing a Woman’s Reproductive Rights with a Pharmacist’s Conscientious Objection*,

miscarriage, individuals living near Catholic sole community hospitals have no choice other than the hospital closest to them, even if it cannot provide the necessary medical care.<sup>151</sup> In summation, a wide variety of factors—including the passage of the ACA, the financial state of hospitals, the uptick in merger activity, and the revised Directives—have converged over the past decade to create a decrease in access to reproductive health services across the country.<sup>152</sup> The following Part will provide examples of creative structure remedies that attempt to combat the reduction in access to reproductive health care and the new Directives that threaten these solutions.<sup>153</sup>

## II. REMEDIES TO COMBAT THE REDUCTION IN ACCESS TO REPRODUCTIVE CARE

As concerns about the effect of Catholic hospital mergers grew, advocates developed creative structural remedies to maintain access to reproductive health services.<sup>154</sup> Although some of these solutions have been effective, they can be challenging to implement.<sup>155</sup> Section A of this Part discusses the structural remedies that have succeeded and those that did not.<sup>156</sup> Section B addresses the new Directive 75 in the 2018 Directives update, which bans the establishment of a separate entity to provide prohibited services, one of the innovative remedies used to provide access to reproductive care in Catholic hospitals, and describes the effect it could have on future Catholic hospital mergers.<sup>157</sup>

### A. Creative Structural Remedies

Over the past decade, reproductive health care advocates have developed structural remedies to ensure access to reproductive health services following a

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47 B.C. L. REV. 815, 831 (2006) (“[F]or a woman located in a rural area, the only practically available hospital may be Catholic; as such, her ability to access many reproductive services may be severely limited.”).

<sup>151</sup> KAYE ET AL., *supra* note 24, at 24.

<sup>152</sup> See *supra* Part I.

<sup>153</sup> See *infra* Part II.

<sup>154</sup> UTTLEY & KHAIKIN, *supra* note 22, at 11–13 (describing recent Catholic hospital mergers and the methods used when adopting the Directives); Uttley et al., *New York State Model*, *supra* note 58 (evaluating two Catholic hospital mergers in New York State and the remedies implemented to continue access to reproductive care services in the local communities); Penan & Chen, *supra* note 10, at 4 (discussing hospital within hospital arrangements to satisfy the Directives after a Catholic hospital merger).

<sup>155</sup> Uttley et al., *New York State Model*, *supra* note 58, at 42 (emphasizing that these remedies can only be accomplished through cooperation with hospital officials, local community advocates, and state officials); Cohn, *supra* note 6 (explaining that although the creative structural remedies may seem to be false distinctions, they achieve their purpose in preserving reproductive health care after a Catholic hospital merger).

<sup>156</sup> See *infra* Part II.A.

<sup>157</sup> See *infra* Part II.B.

merger with a Catholic hospital.<sup>158</sup> When a Catholic hospital system announces its plan to acquire a non-Catholic hospital, concerned community members, including physicians at the non-Catholic hospital, women's health organizations, lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) organizations, and local officials work together to create a solution that preserves local reproductive health care services.<sup>159</sup> These remedies can be characterized in two ways: (1) as a hospital within a hospital or (2) a hospital beside a hospital.<sup>160</sup>

In the hospital within a hospital model, a formerly non-Catholic hospital that becomes Catholic-owned carves out a floor or wing in the physical building as a separate entity.<sup>161</sup> This distinct facility then provides services prohibited under the Directives.<sup>162</sup> The Burdett Birth Center, originally the Burdett Care Center, in Troy, New York is one of the most well-known examples of this model.<sup>163</sup> In 2011, St. Peter's Health Care Services and Seton Health, both Catholic health care systems, merged with Northeast Health, a non-Catholic system, to become St. Peter's Health Partners.<sup>164</sup> There were only two hospi-

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<sup>158</sup> See UTTLEY & KHAIKIN, *supra* note 22, at 11–13 (listing case studies of Catholic hospital mergers and the subsequent adoption of the Directives); Uttley et al., *New York State Model*, *supra* note 58, at 38 (discussing examples of creative solutions to Catholic hospital mergers in New York State); Penan & Chen, *supra* note 10, at 4 (examining hospital within hospital arrangements to satisfy the Directives in the wake of a Catholic hospital merger).

<sup>159</sup> Uttley et al., *New York State Model*, *supra* note 58, at 42 (noting that it takes an extraordinary amount of work and commitment on the part of these various constituencies to advocate and create these separate entities that continue to offer services prohibited under the Directives).

<sup>160</sup> UTTLEY & KHAIKIN, *supra* note 22, at 12; Uttley et al., *New York State Model*, *supra* note 58, at 38; Penan & Chen, *supra* note 10, at 4. These two different models refer to separate corporate entities that are physically located either directly inside or nearby the new Catholic hospital. Uttley et al., *New York State Model*, *supra* note 58, at 38.

<sup>161</sup> Uttley et al., *New York State Model*, *supra* note 58, at 41; Penan & Chen, *supra* note 10, at 4. This structure establishes a separate, smaller hospital where patients can still receive prohibited services, although the larger, but corporately separate hospital surrounding it, must follow the Directives. Penan & Chen, *supra* note 10, at 4.

<sup>162</sup> Uttley et al., *New York State Model*, *supra* note 58, at 38, 41–42; Penan & Chen, *supra* note 10, at 4.

<sup>163</sup> Uttley et al., *New York State Model*, *supra* note 58, at 41–42; Cohn, *supra* note 6; Martin, *Catholic Bishops Vote to Revise Rules*, *supra* note 57; Penan & Chen, *supra* note 10, at 4; Press Release, *supra* note 70. After years of proposals, the merging parties created this independently licensed, non-Catholic facility. Martin, *Catholic Bishops Vote to Revise Rules*, *supra* note 57. Lois Uttley, a women's and LGBTQ health activist who founded the MergerWatch Project and was involved in the negotiations, later told ProPublica that the "compromise" has "worked very well." *Id.* The Burdett Care Center changed its name to the Burdett Birth Center in 2017. Claire Hughes, *Troy Maternity Hospital's Name Changes to Burdett Birth Center*, NEWS TIMES (Jan. 3, 2017), <https://www.newstimes.com/business/article/Troy-maternity-hospital-s-name-changes-to-Burdett-10833587.php> [<https://perma.cc/9LUC-7JYD>].

<sup>164</sup> Uttley et al., *New York State Model*, *supra* note 58, at 41; Press Release, *supra* note 70. The merger brought together 125 health care facilities in seven counties in northeastern New York State. Press Release, *supra* note 70. The Catholic organizations, St. Peter's Health Care Services and Seton Health, kept their Catholic identity, whereas Northeast Health continued to be a non-Catholic organi-

tals in the city of Troy, Samaritan Hospital, part of Northeast Health, and St. Mary's, part of Seton Health.<sup>165</sup> Because Northeast Health had to follow the Directives pursuant to the merger agreement, but for the Burdett Birth Center, Troy's residents would have been left without a hospital providing certain critical reproductive health care services.<sup>166</sup> Thus, Northeast Health administrators, local community officials, and reproductive health advocates worked together to create the Burdett Birth Center, an independently licensed hospital, contained on a separate floor of the Samaritan Hospital.<sup>167</sup> The Burdett Birth Center offers both maternity and sterilization services, including tubal ligations and vasectomies.<sup>168</sup> The Northeast Health administrators were successful in continuing to provide some prohibited services to Troy residents, but the merger agreement prevented Burdett Birth Center from offering elective abortions, so patients still must travel to other providers for these services.<sup>169</sup>

The hospital within a hospital model was also employed in Austin, Texas, when University Medical Center-Brackenridge (UMCB) affiliated, rather than formally merged, with Seton Healthcare Family, a Catholic health care system.<sup>170</sup> This affiliation was originally structured as a lease agreement in 1995,

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zation. *Id.* Post-merger, however, the entirety of St. Peter's Health Partners was required to abide by the Directives. Uttley et al., *New York State Model*, *supra* note 58, at 41.

<sup>165</sup> Uttley et al., *New York State Model*, *supra* note 58, at 41. In the 1990s, there were three hospitals in the city. *Id.* Along with non-Catholic Samaritan Hospital and Catholic St. Mary's, Leonard Hospital was non-Catholic. *Id.* In 1994, St. Mary's and Leonard merged into Seton Health, and Leonard Hospital stopped providing contraceptive services. *Id.*

<sup>166</sup> *Id.* Non-profit women's reproductive rights organizations got involved in the negotiations when it became apparent that the city of Troy could be left without access to reproductive health care services post-merger if both Samaritan and Seton Health became part of the merged entity. *Id.*

<sup>167</sup> *Id.*; Martin, *Catholic Bishops Vote to Revise Rules*, *supra* note 57; Press Release, *supra* note 70. The Burdett Birth Center is on the second floor of Samaritan Hospital and contains fifteen beds. Uttley et al., *New York State Model*, *supra* note 58, at 41. All maternity services in the hospital were relocated to the Burdett Birth Center. *Id.* The Burdett Birth Center's accounting, employees, and board of directors are separate from St. Peter's Health Partners. Cohn, *supra* note 6; Penan & Chen, *supra* note 10, at 4.

<sup>168</sup> Press Release, *supra* note 70.

<sup>169</sup> Uttley et al., *New York State Model*, *supra* note 58, at 41. During merger negotiations, the Catholic health care systems demanded that Northeast Health and the Burdett Birth Center prohibit elective abortions. *Id.* Patients seeking elective abortions must either go to other local providers who agreed to accept them, or if hospital services are necessary, they are referred to Albany Medical Center. *Id.* The merger eliminated all hospital abortions in Rensselaer County. Cathleen F. Crowley, *Birth Services to Be Merged*, TIMES UNION (Nov. 20, 2009), <https://www.timesunion.com/local/article/Birth-services-to-be-merged-557636.php> [<https://perma.cc/7C2R-V6E5>].

<sup>170</sup> UTTLEY & KHAIKIN, *supra* note 22, at 12. A merger typically combines corporate assets and governance, whereas in an affiliation, there may still be a separate ownership structure, without one hospital acquiring the assets of another entity. See Valerie Bauman, *Hospital Affiliation vs. Merger: There Is a Difference*, PUGET SOUND BUS. J. (Aug. 23, 2013), <https://www.bizjournals.com/seattle/blog/health-care-inc/2013/08/hospital-affiliation-vs-merger-there.html> [<https://perma.cc/KA3X-8794?type=image>] (explaining that although the difference between the two terms can merely be "semantics" to hide an association with the Catholic Church, "affiliations can also be a separate partnership structure with varying degrees of commingling"); see also *supra* note 8. University Medical Center-

such that Seton merely leased the hospital property, but it did not gain corporate control of UMCB, a public hospital owned by the city of Austin, so UMCB did not become a Catholic hospital.<sup>171</sup> Through this technicality, UMCB did not have to follow the Directives, and thus access to reproductive health services could continue.<sup>172</sup> Although the local Catholic diocese initially approved the lease agreement, the Vatican ultimately challenged it, leading the UMCB to turn to the hospital within a hospital model, even though the partnership was an affiliation and not a merger.<sup>173</sup> In 2001, the Austin Women's Hospital opened on the fifth floor of the hospital as a separate corporate entity run by the University of Texas Medical Branch.<sup>174</sup> The Austin Women's Hospital provided services prohibited by the Directives until 2012, when funding for the hospital ran out.<sup>175</sup> The Austin Women's Hospital's patients were transferred to a nearby hospital that provided reproductive health services.<sup>176</sup>

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Brackenridge (UMCB) is a public safety net hospital owned by the city of Austin. UTTLEY & KHAIKIN, *supra* note 22, at 12. The Institute of Medicine defines a safety net hospital as one that "offer[s] care to patients regardless of their ability to pay for those services," "either by legal mandate or explicitly adopted mission." INST. OF MED., NAT'L ACAD. OF SCI., AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 1 (2000), <http://www.idph.state.il.us/tfhpr/materials/Carvalho%20handout.pdf> [<https://perma.cc/G43H-6C2X>]. UMCB is also the highest-level trauma hospital in the Austin region. Mary Ann Roser & Ralph K.M. Haurwitz, *Public Health, Religion Collide*, AUSTIN AM.-STATESMAN, Dec. 9, 2012, at A01. When the affiliation between the two health care systems began in 1995, Seton Healthcare Family was known as the Daughters of Charity, and today it is part of Ascension Health, one of the largest health care systems in the country. UTTLEY & KHAIKIN, *supra* note 22, at 12; Reed Abelson, *Catholic Hospitals Expand, Religious Strings Attached*, N.Y. TIMES (Feb. 20, 2012), <https://www.nytimes.com/2012/02/21/health/policy/growth-of-catholic-hospitals-may-limit-access-to-reproductive-care.html> [<https://perma.cc/A9EJ-XEYH>]; Roser & Haurwitz, *supra*. Under the terms of the affiliation, the city of Austin continued to own the hospital, but Seton managed the facility. UTTLEY & KHAIKIN, *supra* note 22, at 12.

<sup>171</sup> UTTLEY & KHAIKIN, *supra* note 22, at 12. This arrangement of using a lease agreement rather than a merger allowed UMCB to continue to provide access to reproductive health services. *Id.*

<sup>172</sup> *Id.* A privately-contracted company, paid by the city of Austin, managed the reproductive health services, rather than Seton physicians, to maintain separation between the Catholic and non-Catholic services. *Id.*; Roser & Haurwitz, *supra* note 170. Under the lease agreement, UMCB continued to offer sterilization services, but not elective abortions. Roser & Haurwitz, *supra* note 170.

<sup>173</sup> UTTLEY & KHAIKIN, *supra* note 22, at 12; Roser & Haurwitz, *supra* note 170. The Vatican informed Bishop John McCarthy of Austin that the lease agreement between Seton and UMCB was unacceptable, and the Austin City Council authorized a hospital within a hospital. Roser & Haurwitz, *supra* note 170.

<sup>174</sup> UTTLEY & KHAIKIN, *supra* note 22, at 12. The Austin Women's Hospital was built with a separate entrance and elevator to the fifth floor of the hospital, so it was truly separate from the rest of the hospital that was still run by Seton and followed the Catholic Directives. *Id.* The entrance and elevator cost \$9 million to build. *Id.*

<sup>175</sup> *Id.* The University of Texas Medical Branch (UTMB) lost the financial backing to run the hospital. *Id.* UTMB suffered a \$114 million budget cut by the Texas legislature, which contributed to the decision to close the Austin Women's Hospital. Mary Ann Roser, *UTMB to Leave Women's Hospital*, AUSTIN AM.-STATESMAN, Sept. 1, 2011, at B05.

<sup>176</sup> UTTLEY & KHAIKIN, *supra* note 22, at 12. The patients were transferred to St. David's Hospital, an Episcopalian hospital located a mile away from UMCB. *Id.*; Roser & Haurwitz, *supra* note 170. Although the change in location was difficult for patients, medical residents also had to travel between



Creating a hospital beside a hospital is another frequent mechanism for continuing to deliver reproductive health services after a Catholic hospital merges with a non-Catholic institution.<sup>177</sup> In Kingston, New York, Benedictine Hospital, a Catholic institution, and Kingston Hospital, a non-Catholic facility, merged in 2004.<sup>178</sup> Because community organizers were vocal regarding the need to preserve reproductive health services in Kingston, the hospitals decided to create a separate corporate facility for reproductive services.<sup>179</sup> The hospitals, Archdiocese of New York, and state officials worked together to con-

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UMCB and St. David's to receive training in obstetrics and gynecology, creating a considerable increase in time spent traveling than when the Austin Women's Hospital was in the same building as UMCB. See Roser & Haurwitz, *supra* note 170 (interviewing a medical resident about the difficulties presented by moving the patients to St. David's). Additionally, shifting the patients to another hospital is possible in an urban city like Austin, but this solution may not be viable in a rural area where a Catholic facility is the only hospital in the region. See UTTELY & KHAIKIN, *supra* note 22, at 5–6, 12 (explaining that there are at least forty-six Catholic “sole community hospitals,” meaning that they are at least thirty-five miles from another hospital, in the United States).

<sup>177</sup> See Uttley et al., *New York State Model*, *supra* note 58, at 38 (explaining both a hospital within a hospital and hospital beside a hospital model); Cohn, *supra* note 6 (describing situations where hospitals and surgery centers were set up in the parking lot or next door to the original health care facility).

<sup>178</sup> Uttley et al., *New York State Model*, *supra* note 58, at 39. Kingston and Benedictine Hospital were within a mile of each other. *Id.* The two hospitals first proposed a merger in 1997 with non-Catholic Northern Dutchess Hospital, but the transaction failed a year later due to concerns about compliance with the Directives and the merger's impact on reproductive health care services, as well as an FTC investigation into antitrust violations. Appelbaum & Morrison, *supra* note 34, at 33–36; Uttley et al., *New York State Model*, *supra* note 58, at 39. Several outspoken community groups in the Hudson River Valley contacted public officials, signed petitions, posted lawn signs, wrote editorials, and organized rallies in their opposition to the merger. Appelbaum & Morrison, *supra* note 34, at 34. Although they were not required to file with federal antitrust agencies under the HSR Act, the FTC began investigating the merger a year later, with the assistance of MergerWatch and the National Women's Law Center. *Id.* at 34–35. Subsequently, Northern Dutchess Hospital dropped out of the agreement, but Kingston and Benedictine Hospitals continued to seek a merger. *Id.* at 35. Around the same time, the FTC won a hospital merger case in Missouri, and perhaps reading the tea leaves, Kingston and Benedictine dissolved their merger agreement. See *FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937, 949 (E.D. Mo. 1998) (granting the FTC's motion for a preliminary injunction enjoining the merger between Tenet Healthcare Corporation and Poplar Bluff Physicians Group, later overturned by the 8th Circuit), *rev'd*, 186 F.3d 1045 (8th Cir. 1999); Appelbaum & Morrison, *supra* note 34, at 35–36 (suggesting that the FTC's success in the Missouri hospital case contributed to the failure of the Kingston and Benedictine merger).

<sup>179</sup> Uttley et al., *New York State Model*, *supra* note 58, at 39–40. Because the 1997 merger dissolved partly due to concerns over access to reproductive health services, community advocates and the two hospitals worked with New York's Berger Commission to develop a feasible plan for the transaction. *Id.* In 2005, the Commission issued a report on health care systems in New York State and addressed the proposed merger. COMM'N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, N.Y. HEALTH CARE COMM'N, A PLAN TO STABILIZE AND STRENGTHEN NEW YORK'S HEALTH CARE SYSTEM: FINAL REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE 21ST CENTURY 12 (2006), <https://nyhealthcarecommission.health.ny.gov/docs/final/commissionfinalreport.pdf> [<https://perma.cc/S8BC-EK2S>]; Uttley et al., *New York State Model*, *supra* note 58, at 39–40. The Commission recommended that Kingston and Benedictine should merge, but only if the Catholic Church allowed Kingston to “continue[] to provide access to reproductive services in a location proximate to the hospital.” COMM'N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, *supra*.

struct the Foxhall Ambulatory Surgery Center in Kingston Hospital's parking lot.<sup>180</sup> The outpatient ambulatory surgery center offers all maternity services that used to be provided separately at Kingston Hospital and Benedictine Hospital, as well as services prohibited by the Directives including abortions and tubal ligations.<sup>181</sup> The center offers some non-reproductive health care services as well.<sup>182</sup>

In 2012 in Seattle, Swedish Medical Center affiliated with Providence Health & Services, a Catholic health care system.<sup>183</sup> By merely affiliating with a Catholic facility, rather than merging, Swedish Medical Center remained a secular facility and did not have to abide by the Directives as they existed in 2012.<sup>184</sup> Thus, Swedish Medical Center continued to offer sterilization services, but it ceased performing elective abortions.<sup>185</sup> As a compromise, Swedish Medical Center gave two million dollars to Planned Parenthood so the organization could build and operate a facility in a building next door to the

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<sup>180</sup> Uttley et al., *New York State Model*, *supra* note 58, at 40. The Archdiocese signed off on the compromise, but he would not allow Kingston to create a separate hospital within the hospital. *Id.* The New York State government provided \$4 million to construct the Foxhall Ambulatory Surgery Center. *Id.*

<sup>181</sup> *Id.* The Foxhall Ambulatory Surgery Center is 5,500 square feet and immediately next door to Kingston Hospital, but it is a separate corporate entity. *Id.* Several staff at both Kingston Hospital and the Foxhall Ambulatory Surgery Center were moved to a separate, unaffiliated company's payroll, and they are leased back to both the Catholic hospitals and the ambulatory surgery center. *Id.* This arrangement allows Benedictine Hospital to avoid violating the Directives by not directly paying its staff for services provided at the ambulatory surgery center. *Id.*

<sup>182</sup> *Id.* Kingston Hospital decided to provide some non-reproductive services at the Foxhall Ambulatory Surgery Center to encourage more revenue for the facility and to offer some privacy for its patients, so it would not be obvious that they were visiting the center for reproductive health care. *Id.*

<sup>183</sup> Carol M. Ostrom, *Swedish Alliance with Providence Is Now Complete*, SEATTLE TIMES (Feb. 1, 2012), <https://www.seattletimes.com/seattle-news/swedish-alliance-with-providence-is-now-complete/> [<https://web.archive.org/web/20200404110033/https://www.seattletimes.com/seattle-news/swedish-alliance-with-providence-is-now-complete/>]. Because the Swedish Medical Center (Swedish) and Providence Health & Services (Providence) combined through an affiliation rather than a merger, Swedish was able to stay secular and continue to provide birth control, tubal ligations, and vasectomies. Nina Martin, *As Catholic Hospitals Grow Will Women and Gays Be Left Without Care?*, PAC. STANDARD (Jun. 14, 2017), <https://psmag.com/social-justice/catholic-hospitals-grow-questions-care-69840> [<https://perma.cc/9PC8-UURG>] [hereinafter Martin, *As Catholic Hospitals Grow*]; Ostrom, *supra*. Under the terms of the affiliation, Swedish became a division of Providence Health Services. Ostrom, *supra*. But see Bauman, *supra* note 170 (highlighting that although the Providence-Swedish affiliation was promoted and advertised as an affiliation, instead of a merger, to maintain Swedish's independence from the Catholic Church, in hindsight it appears similar to a merger, as the transaction did in fact create a new entity with a new board of directors).

<sup>184</sup> Martin, *As Catholic Hospitals Grow*, *supra* note 183; Ostrom, *supra* note 183. Swedish told ProPublica that "[t]o ensure Providence remained Catholic and Swedish remained secular, the partnership was intentionally structured as an affiliation." Martin, *As Catholic Hospitals Grow*, *supra* note 183.

<sup>185</sup> Martin, *As Catholic Hospitals Grow*, *supra* note 183; Ostrom, *supra* note 183. Although Swedish previously provided elective abortions, it stopped "out of respect for the affiliation." Ostrom, *supra* note 183.

hospital.<sup>186</sup> Although Swedish Medical Center continues to provide emergency abortions when medically necessary, patients seeking elective abortions must go to the Planned Parenthood clinic next door.<sup>187</sup> The Providence-Swedish affiliation is an exceptionally “progressive” Catholic affiliation, as Swedish Medical Center does not follow the Directives and the hospital beside a hospital model allows it to work in conjunction with Planned Parenthood.<sup>188</sup>

These creative structural remedies have worked with varying degrees of success to allow for the continuance of reproductive health services after a Catholic hospital merger.<sup>189</sup> Although there are some shortcomings to the hospital within a hospital and hospital beside a hospital models, on the whole they have been effective techniques to preserving access to care.<sup>190</sup>

### *B. Updated Directives Threaten the Separate Entity Solution*

In 2018, the USCCB updated the Directives, specifically revising Part Six, “Collaborative Arrangements with Other Health Care Organizations and Providers.”<sup>191</sup> Reproductive health care advocates became concerned that the

<sup>186</sup> Cienna Madrid, *Faith Healers*, THE STRANGER (Feb. 20, 2013), <https://www.thestranger.com/seattle/faith-healers/Content?oid=16050396> [<https://perma.cc/5PMQ-JQPG>]; Martin, *As Catholic Hospitals Grow*, *supra* note 183; Ostrom, *supra* note 183; Kristen Glundberg-Prossor, *PPGNW and Swedish Work Together to Ensure Abortion Care for Clients in Response to Swedish's New Alliance with Providence*, FOCUS ON PLANNED PARENTHOOD, Fall 2001, at 1, 4, [https://www.plannedparenthood.org/files/7114/0519/5068/Focus\\_Fall\\_2011\\_web.pdf](https://www.plannedparenthood.org/files/7114/0519/5068/Focus_Fall_2011_web.pdf) [<https://perma.cc/629H-4A6F>]. The Planned Parenthood facility was built next door to Swedish, in the Nordstrom Tower. Glundberg-Prossor, *supra*. Patients can enter the clinic from the hospital through a breezeway. Madrid, *supra*.

<sup>187</sup> Madrid, *supra* note 186; Mencimer, *supra* note 1. Even though Swedish has conducted emergency abortions, the assumption that a Planned Parenthood facility can ameliorate the loss in access to reproductive health care after a Catholic hospital merger can be misguided. Mencimer, *supra* note 1. Certain abortions must take place in a hospital, not a clinic, to ensure medical safety. *Id.*

<sup>188</sup> Madrid, *supra* note 186; Glundberg-Prossor, *supra* note 186, at 1. Some Catholic hospital transactions merely donate money to Planned Parenthood, with the assumption that the organization can fill the gap in reproductive health care services. Glundberg-Prossor, *supra* note 186, at 4. Swedish Medical Center, however, worked closely with Planned Parenthood of the Great Northwest and its CEO, Chris Charbonneau, to connect the clinic to the hospital. Madrid, *supra* note 186.

<sup>189</sup> See Uttley et al., *New York State Model*, *supra* note 58, at 42 (noting that although the New York State remedies were successful when originally implemented, their long-term efficacy is uncertain). For example, the downside of creating a separate corporate entity for reproductive health services is that it separates these services from other primary care services. *Id.* Additionally, because these reproductive health care facilities only offer certain limited services, they may not be as profitable and likely to survive financially. *Id.*

<sup>190</sup> Cohn, *supra* note 6 (“Convoluting solutions may be the only way for this convoluted mix of public purpose and private institution to survive.”). Dr. Peter Hasselbacher of the University of Louisville, when commenting on a proposed hospital within a hospital in Louisville, described these solutions as “‘don’t ask, don’t tell’ medicine” and noted that they are merely “one ‘work around’ after another” to preserve access to reproductive health services when public hospitals are acquired by Catholic hospital systems. Roser & Haurwitz, *supra* note 170.

<sup>191</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 23–26; DiVarco & Slattery, *supra* note 38; *US Bishops Vote to Expand Directives for Catholic Healthcare*, CONSCIENCE (Aug. 31, 2018), <https://consciencemag.org/2018/08/31/us-bishops-vote-to-expand-directives-for-catholic->

new Directives would be used to ban the formation of creative structural remedies that protect reproductive services.<sup>192</sup> In fact, prior to the update, the president of the National Catholic Bioethics Center described these creative structural remedies as a “ruse,” arguing that they should not have been permitted by local bishops.<sup>193</sup>

Unfortunately, the reproductive health care advocates’ fears were well-founded, as the addition of Directive 75 may be interpreted to restrict the use of the hospital within a hospital and hospital beside a hospital tactics to protect reproductive care.<sup>194</sup> Directive 75 explicitly prohibits “establish[ing] another entity that would oversee, manage, or perform immoral procedures.”<sup>195</sup> It then defines this as executing “civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity.”<sup>196</sup> The Burdett Birth Center in Troy, the Austin Women’s Hospital, and the Foxhall Ambulatory Surgery Center in Kingston were all separately incorporated entities, built to provide the reproductive health services designated as “immoral procedures” in the Directives.<sup>197</sup> The Swedish Medical Center in Seattle gave Planned Parenthood the financial backing to build a clinic next door to the hospital.<sup>198</sup> Not only could Directive 75 stop future arrangements, but it could also jeopardize existing arrangements, such as the Burdett Birth Center, Foxhall Am-

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healthcare/ [https://perma.cc/3X9E-KG99]; *Changes to Catholic Ethical and Religious Directives Impact Mergers and Partnerships Between Catholic and Non-Catholic Entities*, HALL RENDER BLOG: HEALTH L. NEWS (Aug. 2, 2018), <https://www.hallrender.com/2018/08/02/changes-to-catholic-ethical-and-religious-directives-impact-mergers-and-partnerships-between-catholic-and-non-catholic-entities/> [https://perma.cc/M537-4VEW].

<sup>192</sup> See Penan & Chen, *supra* note 10, at 4 (noting that the future of these innovative structural remedies is uncertain, and the revised Directives “could threaten the survival of these institutions”). Directive 75 prohibits “establish[ing] another entity” to “perform immoral procedures.” 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26.

<sup>193</sup> Meyer, *supra* note 68. The president of the National Catholic Bioethics Center, John Haas, suggested that bishops may request that the Center review existing structural remedies, or “carve-out arrangements,” for compliance with the Directives. *Id.*

<sup>194</sup> See Penan & Chen, *supra* note 10, at 4 (“It is unclear whether these types of arrangements would be possible under the revised [Directives] . . .”).

<sup>195</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Catholics believe Directive 75 displays the sentiment of Vatican Principle 12, which decrees that “setting up an administrative body” or “an entity such as a clinic” that offers “immoral procedures” is considered “formal cooperation with evil.” *U.S. Bishops Revise Part Six of the Ethical and Religious Directives*, *supra* note 50, at 16.

<sup>196</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Observers note that the specific language of Directive 75 removes any “discretion” that local bishops previously had to approve mergers between Catholic and non-Catholic hospitals where one hospital remained non-Catholic on the condition that it was legally separate. DiVarco & Slattery, *supra* note 38.

<sup>197</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26; UTTLEY & KHAIKIN, *supra* note 22, at 12; Uttley et al., *New York State Model*, *supra* note 58, at 41–42.

<sup>198</sup> Madrid, *supra* note 186; Martin, *As Catholic Hospitals Grow*, *supra* note 183. Swedish Medical Center gave Planned Parenthood of the Greater Northwest \$2 million to establish a clinic in the medical tower next to the hospital. Martin, *As Catholic Hospitals Grow*, *supra* note 183.

bulatory Surgery Center, and Swedish Medical Center.<sup>199</sup> Depending on the local bishop's understanding of the new Directives in the 2018 update, the Catholic Church could "rescind the arrangement."<sup>200</sup> Directive 75 thus expressly targets and outlaws these inventive solutions hospitals have used in the past to sustain reproductive health services.<sup>201</sup> Without further guidance from the Catholic Church, health care advocates and lawyers cannot predict whether these solutions will be allowed in future mergers.<sup>202</sup> The new Directives, however, certainly cast doubt on their viability.<sup>203</sup>

Additionally, Swedish Medical Center affiliated with Providence Health & Services, rather than merging to become one corporate entity, to avoid compliance with the Directives post-transaction.<sup>204</sup> The hospital systems intentionally chose this technique so that Swedish Medical Center could remain secular and continue to provide birth control, tubal ligations, and vasectomies, all of which are banned by the Directives.<sup>205</sup> The new Directive 73, however, makes these transactions unacceptable.<sup>206</sup> Directive 73 instructs that when a Catholic facility considers "affiliating" with a non-Catholic institution, it must confirm that its officials and employees will not be involved in "immoral procedures"

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<sup>199</sup> See Meyer, *supra* note 68 (suggesting that the Burdett Birth Center could be reviewed for compliance with the new Directives).

<sup>200</sup> *Id.* Philip Boyle, the senior vice president of mission and ethics for Trinity Health, which owns St. Peter's Health Partners and Samaritan Hospital where the Burdett Birth Center is located, agreed that the Burdett Birth Center might appear to be "smoke and mirrors." *Id.* Furthermore, he emphasized that at the time, the local bishop permitted this hospital within a hospital model. *Id.* Despite this assurance, Mr. Boyle told Modern Healthcare there is a chance that the Catholic Church could "rescind the arrangement" if the local bishop chose to review the carve-out solution for compliance with the new Directives. *Id.*

<sup>201</sup> See Penan & Chen, *supra* note 10, at 4 (illustrating how facilities like the Burdett Birth Center may no longer be allowed under the new Directives); *Changes to Catholic Ethical and Religious Directives*, *supra* note 191 (noting that the updated Directives implicate these arrangements that are intended to maintain reproductive health services).

<sup>202</sup> DiVarco & Slattery, *supra* note 38 (explaining that health care lawyers still cannot predict how the Catholic Church will assess these organizations in future Catholic hospital mergers).

<sup>203</sup> See Penan & Chen, *supra* note 10, at 4 (stating that it is still uncertain how the Catholic Church will implement these Directives in future transactions); Meyer, *supra* note 68 (quoting Bishop Robert McManus of Massachusetts, explaining that existing partnership arrangements may have to be reviewed in light of the revised Directives). Not only is the possibility of using structural remedies in the future at risk, but also the current arrangements may be rescinded by local bishops if they are found to be in violation of the revised Directives. Meyer, *supra* note 68.

<sup>204</sup> Martin, *As Catholic Hospitals Grow*, *supra* note 183. Swedish Medical Center purposefully affiliated with Providence Health & Services, rather than merging, to be able to continue offering services banned by the Directives. *Id.*

<sup>205</sup> *Id.* Swedish Medical Center gave a statement to ProPublica, explaining that "[t]o ensure Providence remained Catholic and Swedish remained secular, the partnership was intentionally structured as an affiliation, not a merger or acquisition." *Id.*

<sup>206</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26; DiVarco & Slattery, *supra* note 38; *Changes to Catholic Ethical and Religious Directives*, *supra* note 191.

in any form.<sup>207</sup> Thus, even in affiliations, hospital administrations must be kept completely distinct, but in the Swedish-Providence affiliation, Swedish Medical Center became a division of Providence Health & Services.<sup>208</sup> In the future, progressive affiliations like Swedish-Providence, where Swedish Medical Center continued to provide services prohibited by the Directives even though it was a division of Providence Health & Services, may not be possible because they contradict the principles in Directive 73.<sup>209</sup> The following Part evaluates the potential role that federal antitrust law could hold in maintaining access to reproductive health care, while addressing the possible obstacles and alternative approaches to regulating these mergers.<sup>210</sup>

### III. EVALUATING ANTITRUST'S POTENTIAL ROLE IN PRESERVING ACCESS TO REPRODUCTIVE HEALTH CARE POST-CATHOLIC HOSPITAL MERGER

The 2018 update to the Directives demands a new approach to maintain access to reproductive health care in the wake of a Catholic hospital merger.<sup>211</sup> Antitrust law presents a unique opportunity to scrutinize certain mergers for anticompetitive harm and ensure that reproductive health services are preserved for the community post-merger.<sup>212</sup> Although women's health advocates, concerned about the reproductive health consequences of Catholic hospital mergers, have encouraged applying antitrust laws to the mergers for more than two decades, antitrust review may be an even more vital tool after the 2018 update to the Directives abolished the ability to create a separate entity to pro-

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<sup>207</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26. Directive 73 focuses on hospital administration and employees, explicitly stating that individuals at all levels must avoid engaging in "immoral procedures." *U.S. Bishops Revise Part Six of the Ethical and Religious Directives*, *supra* note 50, at 15.

<sup>208</sup> DiVarco & Slattery, *supra* note 38 (noting that Directive 73 seems to require completely separate administrations in any type of affiliation where the non-Catholic hospital continues to offer prohibited services); Ostrom, *supra* note 183.

<sup>209</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26; *see* DiVarco & Slattery, *supra* note 38 (noting that the separation demanded by Directive 73 may force current affiliations to reorganize); Madrid, *supra* note 186 (describing the Swedish-Providence affiliation as "one of the most progressive Catholic hospital partnerships in the state" of Washington).

<sup>210</sup> *See infra* Part III.

<sup>211</sup> 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9; *see* DiVarco & Slattery, *supra* note 38 (addressing the new Directives and their unknown impact on future collaborations between Catholic and non-Catholic hospitals); *Changes to Catholic Ethical and Religious Directives*, *supra* note 191 (noting that the new Directives "raise questions about the future of carve-out arrangements designed to preserve access to health care services forbidden by Catholic doctrine").

<sup>212</sup> JUDITH C. APPELBAUM, NAT'L WOMEN'S L. CTR., HOSPITAL MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES: USING ANTITRUST LAWS TO FIGHT BACK 1 (1998); Appelbaum & Morrison, *supra* note 34, at 1.

vide these vital services.<sup>213</sup> Section A of this Part explains how a Catholic hospital merger could raise antitrust concerns.<sup>214</sup> Section B addresses possible problems and critiques of this approach, especially with respect to smaller, rural hospital mergers.<sup>215</sup> Section C suggests that state attorneys general can play a role in counteracting the effects of Catholic hospital mergers on reproductive health care access.<sup>216</sup>

### *A. Catholic Hospital Mergers May Result in Anticompetitive Unilateral Effects Under the Horizontal Merger Guidelines*

The antitrust laws are intended to preserve competition and avoid consumer harm by preventing mergers that create market power.<sup>217</sup> The FTC and DOJ's Guidelines define a merger that increases market power as one that "raise[s] price, reduce[s] output, diminish[es] innovation, or otherwise harm[s] consumers as a result of diminished competitive constraints or incentives."<sup>218</sup> A merger between Catholic and non-Catholic hospitals that results in the unilateral effect of eliminating competition for reproductive health services may be considered anticompetitive under the antitrust laws.<sup>219</sup>

The FTC staff often begins their merger review by defining the market, which is a crucial method for understanding the competitive effects of a Catholic hospital merger.<sup>220</sup> Although the FTC frequently uses inpatient GAC ser-

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<sup>213</sup> See 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26 (updating the Directives with respect to collaborative arrangements); APPELBAUM, *supra* note 212 (describing the antitrust laws as a "powerful weapon" to challenge Catholic hospital mergers in 1998); Appelbaum & Morrison, *supra* note 34, at 1 (advocating for the use of antitrust laws to confront Catholic hospital mergers in 2000); Penan & Chen, *supra* note 10, at 4 (remarking that it is uncertain if the hospital within a hospital model will be permitted by the Catholic Church in future transactions); DiVarco & Slattery, *supra* note 38 (explaining that the updates concerning collaborative arrangements make the legality of separate legal entities questionable).

<sup>214</sup> See *infra* Part III.A.

<sup>215</sup> See *infra* Part III.B.

<sup>216</sup> See *infra* Part III.C.

<sup>217</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 1–2. Preventing mergers that expand market power is "[t]he unifying theme of the[] Guidelines." *Id.* at 2.

<sup>218</sup> *Id.* at 2. Evaluating potential consumer harm is crucial in the merger review process, as the current antitrust policy advocates for promoting consumer welfare and limiting market power. Wilson, *supra* note 99.

<sup>219</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 20; APPELBAUM, *supra* note 212, at 16; Appelbaum & Morrison, *supra* note 34, at 17. Post-merger, when the non-Catholic hospital is required to abide by the Directives and stop providing reproductive health services, there is a reduction in competition for them. APPELBAUM, *supra* note 212, at 16; Appelbaum & Morrison, *supra* note 34, at 17.

<sup>220</sup> See HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 7 (remarking that the antitrust agencies often begin their investigation with market definition, but it is not required); APPELBAUM, *supra* note 212, at 16–17 (explaining how reproductive health services could be a relevant product market under the Guidelines); Appelbaum & Morrison, *supra* note 34, at 17–18 (delineating how reproductive health services can fit into a Guidelines product market analysis).

vices as the product market when investigating a hospital merger, individual hospital services can also be their own product markets, depending on the relevant evidence and economic data.<sup>221</sup> The products in a chosen product market should be substitutes for each other, and the FTC primarily chooses GAC services for ease of analysis and administrability.<sup>222</sup> If the evidence and data indicated a possible reduction in access to reproductive services, however, FTC staff could instead define the product market as reproductive health care services, as they have done in previous hospital merger cases.<sup>223</sup> In fact, when evaluating a merger between Catholic and non-Catholic hospitals, it is crucial to define the reproductive health care services product market separately from the GAC services market, as there will be unique competitive effects when not all of the merging parties offer reproductive health services.<sup>224</sup>

Once the FTC defines the product market, staff must identify the geographic market that would suffer as a result of the merger.<sup>225</sup> Although the ge-

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<sup>221</sup> See Appelbaum & Morrison, *supra* note 34, at 18 (highlighting that although GAC services are usually the designated product market in hospital mergers, the FTC has defined the market along more specific services lines in some cases); Gilman et al., *supra* note 92 (“The product market in hospital cases is typically inpatient general acute care (GAC) hospital services sold to commercial health plans.”). A product market contains products or services that are substitutes for each other, which allows the antitrust agencies to measure the competition in the relevant market for these products. HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 7–8.

<sup>222</sup> *Id.* at 7; Gilman et al., *supra* note 92. Hospitals often offer hundreds of services to patients, so it would be incredibly difficult and time-consuming for FTC staff to analyze every service line as an independent product market. Gilman et al., *supra* note 92. The GAC services market is a cluster market. *Id.* A cluster market contains various products that are not substitutes, but “the competitive conditions—such as the number of competitors and entry conditions—are similar for the products or services included in the cluster market.” Gilman et al., *supra* note 92; see FTC v. Advocate Health Care Network, 841 F.3d 460, 467–68 (7th Cir. 2016) (describing cluster product markets).

<sup>223</sup> APPELBAUM, *supra* note 212, at 16; Appelbaum & Morrison, *supra* note 34, at 18. The FTC has litigated narrower, more specific product markets in hospital merger cases in the past. See FTC v. ProMedica Health Sys., 2011 U.S. Dist. LEXIS 33434, at \*147–48 (N.D. Ohio 2011) (analyzing both a GAC and inpatient obstetrical services product market); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1290 (W.D. Mich. 1996) (utilizing both a GAC and primary care inpatient services product market).

<sup>224</sup> See *ProMedica Health Sys.*, 2011 U.S. Dist. LEXIS 33434, at \*147–48 (defining inpatient obstetrical services as a distinct product market because two of the hospitals did not provide them, and thus, the competitive conditions were different than those for GAC services). The FTC does not include services that only one of the merging parties provides in a GAC services product market, because the competitive effects are different. Gilman et al., *supra* note 92. This situation occurred in *ProMedica Health Systems*, where two of the merging parties did not offer obstetrical services, so the FTC alleged a separate product market for them. 2011 U.S. Dist. LEXIS 33434, at \*147–48. The court held that it would be “inappropriate – and misleading – to include obstetrical services in the GAC cluster market,” and they must be “separately analyzed.” *Id.*

<sup>225</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 13; Gilman et al., *supra* note 92. The geographic market is the area in which customers are willing and able to substitute the product at issue, in this case, reproductive health services, with a competitor’s product. HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 13; APPELBAUM, *supra* note 212, at 17–18; Appelbaum & Morrison, *supra* note 34, at 19–21; Gilman et al., *supra* note 92.



ographic market definition for hospital mergers is fact-specific, patients often prefer to visit local hospitals, and it is quite possible that patients seeking reproductive health services would not be willing to travel far from home.<sup>226</sup> For example, services like an abortion or a tubal ligation after a caesarian section are time-sensitive procedures, so patients may not be able to travel long distances for them.<sup>227</sup> Transportation can also be expensive and may prevent lower income patients from being able to access necessary reproductive health services.<sup>228</sup> If so, this would indicate that the merging hospitals compete in a narrow geographic market.<sup>229</sup> If there are no other or very few competing hospitals in the same geographic market that provide these reproductive health services, there is a strong argument that the proposed merger would enhance market power, which is illegal under Section 7 of the Clayton Act.<sup>230</sup>

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<sup>226</sup> See *Advocate Health Care Network*, 841 F.3d at 474 (explaining that patients usually seek treatment at local hospitals); HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 13 (“The scope of geographic markets often depends on transportation costs.”); APPELBAUM, *supra* note 212, at 17–18 (highlighting that patients often may not be willing or able to travel to other hospitals for reproductive health care services if those services were eliminated post-merger due to expense and timing); Appelbaum & Morrison, *supra* note 34, at 21 (emphasizing that people typically do not like to travel far for hospital treatment); Gilman et al., *supra* note 92 (explaining that geographic market definition is highly debated in litigation and depends on “qualitative and quantitative evidence from the merging” hospitals, competitors, and consumers).

<sup>227</sup> APPELBAUM, *supra* note 212, at 18; Appelbaum & Morrison, *supra* note 34, at 21. Medical services like an abortion or the morning after pill are time-sensitive, and it may not be practical or possible for patients to travel long distances for these procedures. APPELBAUM, *supra* note 212, at 18; Appelbaum & Morrison, *supra* note 34, at 21. Doctors often give patients tubal ligations immediately after delivery, but if that service is not offered at a certain hospital, patients would have to deliver at one facility and then receive tubal ligation surgery at another, which is a time-consuming and risky arrangement. See Religion & Ethics Newsweekly, *supra* note 1 (interviewing Dr. Bruce Silva at Sierra Vista Health Center about his patient who planned to get a tubal ligation after her caesarean section, but, because of the Directives, had to undergo the second surgery in a different city).

<sup>228</sup> APPELBAUM, *supra* note 212, at 18; Appelbaum & Morrison, *supra* note 34, at 21. Some states require a waiting period between an abortion consultation and the actual procedure. APPELBAUM, *supra* note 212, at 18; Appelbaum & Morrison, *supra* note 34, at 21. This could force the patient to travel twice to a different facility, and the patient may be unwilling or unable to do so due to the financial and time expenses. APPELBAUM, *supra* note 212, at 18; Appelbaum & Morrison, *supra* note 34, at 21.

<sup>229</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 13; APPELBAUM, *supra* note 212, at 17–18; Appelbaum & Morrison, *supra* note 34, at 20–21; Gilman et al., *supra* note 92. If a patient is unable or unwilling to travel outside a small geographic region to access reproductive health services, the geographic market is constrained to where the patient will travel. HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 13; APPELBAUM, *supra* note 212, at 17–18; Appelbaum & Morrison, *supra* note 34, at 20–21; Gilman et al., *supra* note 92.

<sup>230</sup> See 15 U.S.C. § 18 (2018) (outlawing mergers or acquisitions that may “substantially lessen competition”); HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 1–2 (emphasizing that mergers that “enhance market power” are not allowed); APPELBAUM, *supra* note 212, at 17–18 (illustrating how a narrow geographic market with few other hospitals providing reproductive health services presents anticompetitive concerns); Appelbaum & Morrison, *supra* note 34, at 21–22 (explaining that market power speaks to the merger’s anticompetitive effects).

When litigating a proposed merger under Section 7, the antitrust agencies usually argue that the combined firm's high market concentration in the relevant market leads to a presumption that the merger will "substantially lessen competition."<sup>231</sup> If the defendant merging parties rebut the presumption, the agency has the burden of demonstrating further anticompetitive effects of the proposed merger.<sup>232</sup> In this scenario, however, where a Catholic hospital merger results in the elimination of the reproductive health services product market, the agency would not be able to argue that the combined entity has an unlawfully high market concentration in the relevant market, as it would no longer operate in the relevant market post-merger.<sup>233</sup> Although it is unusual for the agencies to block a merger without market concentration evidence, a Catholic hospital merger's elimination of a service line should be a persuasive adverse competitive effect, such that the FTC could consider it in an antitrust analysis.<sup>234</sup>

The elimination of reproductive health care services post-merger not only "lessen[s] competition" for these services—it *eliminates* competition because the services are no longer offered.<sup>235</sup> The Guidelines emphasize that the ability to eliminate competition is indicative of a combined firm's enhanced market power, and thus a Catholic hospital's prohibition on certain reproductive health ser-

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<sup>231</sup> 15 U.S.C. § 18; *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990); *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 36 (D.D.C. 2009); HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 18. As discussed *supra*, the antitrust agencies use the Herfindahl-Hirshman Index (HHI) to measure pre- and post-merger market shares to evaluate if they are unlawful. HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 18–19; *see supra* note 108 and accompanying text.

<sup>232</sup> *Baker Hughes, Inc.*, 908 F.2d at 983–84; *CCC Holdings, Inc.*, 605 F. Supp. 2d at 36. This analytical framework for a Section 7 case is referred to as the "*Baker Hughes* Burden-Shifting Framework." *FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 115 (D.D.C. 2016).

<sup>233</sup> *See* HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 18 (illustrating how the antitrust agencies calculate the likely change in market concentration in the relevant market pre- and post-merger). Presumably, if the merger eliminated all reproductive health service offerings, then the combined health care system would not have a significant, or any, share of the reproductive health care market. *See id.* at 18–19 (explaining the use of HHI to determine market shares).

<sup>234</sup> *See Brown Shoe Co. v. United States*, 370 U.S. 294, 322 n.38 (1962) (noting that although market shares "are . . . the primary index of market power[,] . . . only a further examination of the particular market—its structure, history, and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger"); *CCC Holdings, Inc.*, 605 F. Supp. 2d at 37 (explaining that the court must examine the actual impact on competition in the market to understand potential anticompetitive effects); HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 18 (stating that "[m]arket shares may not fully reflect the competitive significance of . . . the impact of a merger[, and] . . . [t]hey are used in conjunction with other evidence of competitive effects").

<sup>235</sup> *See* 15 U.S.C. § 18 (prohibiting mergers or acquisitions that may "substantially lessen competition"); *Appelbaum & Morrison, supra* note 34, at 17 (arguing that limiting reproductive health care service offerings results in a decrease in competition). Although this is far from the classic antitrust merger analysis, it is conceivable that removing a product line from the market post-merger "substantially lessen[s] competition" by eliminating competition altogether. *See* 15 U.S.C. § 18 (outlawing mergers or acquisitions that may "substantially lessen competition").

vices should be evidence of its enhanced market power post-merger.<sup>236</sup> The antitrust agencies consider whether a combined firm will stop offering a service as evidence of unilateral effects.<sup>237</sup> Because the elimination of reproductive health services would result in a reduction in overall competition in the market, the agencies could argue it is an anticompetitive unilateral effect.<sup>238</sup> Additionally, the Guidelines emphasize that enhanced market power can result in consumer harm through non-price factors including a reduction in product or service offerings.<sup>239</sup> Removing reproductive health services from the relevant market should be evidence of consumer harm, which is of utmost importance in the antitrust agencies' analysis of the anticompetitive effects of a proposed merger.<sup>240</sup> Thus, when defining the relevant market to specifically address the unilateral effects of elimination of reproductive health services, Catholic hospital mergers should demand additional antitrust scrutiny under a Guidelines analysis.<sup>241</sup>

### *B. Obstacles to Using Antitrust Law to Combat the Reproductive Health Care Effects of Rural Catholic Hospital Mergers*

Although antitrust law could be a useful method to regulate the effects of Catholic hospital mergers on reproductive health services, it is not a perfect

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<sup>236</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 20; APPELBAUM, *supra* note 212, at 15–16; Appelbaum & Morrison, *supra* note 34, at 17. Eliminating a service line reduces competition for that service post-merger. APPELBAUM, *supra* note 212, at 15–16. When the merging parties “eliminat[e] . . . competition” in the market, it is considered a unilateral effect. HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 20. Unilateral effects are obvious in a transaction where the merging parties will combine to form a monopoly in the relevant market, but this is not a prerequisite. *Id.*

<sup>237</sup> See HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 24 (stating that the antitrust agencies “consider whether a merger is likely to give the merged firm an incentive to cease offering one of the relevant products sold by the merging parties.”).

<sup>238</sup> See *id.* (noting that the agencies may find eliminating a product or service line to be anticompetitive); APPELBAUM, *supra* note 212, at 16 (“The fact that a post-merger hospital is to be governed by religious directives prohibiting certain reproductive health services constitutes strong evidence that there will be a reduction of competition for these services.”).

<sup>239</sup> See HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 2 (explaining that although the antitrust analysis often primarily focuses on price effects, evidence of enhanced market power can include non-price considerations that harm consumers, such as a decline in the variety of products and services offered post-merger); Appelbaum & Morrison, *supra* note 34, at 22 (arguing that a reviewing court should examine a Catholic hospital merger’s impact on the variety of reproductive health services offered post-merger as part of the antitrust analysis).

<sup>240</sup> See HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 2 (noting that the antitrust agencies “normally evaluate mergers based on their impact on customers”). If consumers are harmed due to a lack of competition post-merger, the merger likely enhances market power. *Id.*

<sup>241</sup> See HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 24 (discussing the anticompetitive, unilateral effects of eliminating a product post-merger); APPELBAUM, *supra* note 212, at 20 (emphasizing that Catholic hospital mergers should be analyzed under the Guidelines for antitrust concerns); Appelbaum & Morrison, *supra* note 34, at 18 (explaining that when the relevant product market is reproductive health services, there may be antitrust concerns about the legality of the merger).

solution.<sup>242</sup> First, Catholic hospital mergers present significant challenges in rural areas where there are no non-Catholic hospitals for patients to turn to as an alternative to access reproductive health services.<sup>243</sup> Due to the cost-savings measures in the ACA that encourage consolidation, however, many small rural hospitals must merge with larger hospitals in order to survive.<sup>244</sup> If regulators blocked a proposed merger between a large Catholic hospital system and a small rural hospital because of the anticompetitive effects of eliminating reproductive health care services, the small rural hospital may potentially go out of business without the resources of the larger hospital system.<sup>245</sup> Then, if there were no other hospitals in the rural area, patients would be left without any local health care.<sup>246</sup> Thus, when deciding whether to block the proposed merger on antitrust grounds, regulators may be presented with a difficult choice: sue to stop the merger and risk the hospital closing, thus reducing access to all local health care, or let the merger proceed without crucial reproductive health care services.<sup>247</sup>

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<sup>242</sup> APPELBAUM, *supra* note 212, at 16, 20 (discussing how the reduction in competition for reproductive health services in a relevant market is an antitrust concern, but whether antitrust enforcers bring a case depends on the specific facts and procompetitive justifications for the transaction).

<sup>243</sup> See KAYE ET AL., *supra* note 24, at 24 (giving examples of patients in rural areas whose only hospital was Catholic); UTTLEY & KHAIKIN, *supra* note 22, at 5–6 (listing rural hospitals across the country). As of 2016, there were forty-six Catholic sole community hospitals in rural areas. UTTLEY & KHAIKIN, *supra* note 22, at 5; see 42 C.F.R. § 412.92 (2019) (“CMS classifies a hospital as a sole community hospital if it is located more than [thirty-five] miles from other like hospitals . . .”).

<sup>244</sup> See Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001–18121 (2018) (codifying the ACA and introducing cost-savings measures, including expansive changes to reimbursement models); Singer, *supra* note 79, at 914 (describing the advantages of cost-sharing across a larger hospital system, as compared to a small local facility); see also notes 79–91 and accompanying text (detailing the impact of the ACA on hospital mergers). It is increasingly expensive to operate a hospital, and the ACA’s financial incentives for clinical integration encourage small hospitals to merge with larger hospital systems that have the requisite technology and infrastructure. Singer, *supra* note 79, at 914.

<sup>245</sup> See Singer, *supra* note 79, at 914 (noting that the cost of running a hospital or physician practice has increased exponentially, and hospitals are consolidating due to economies of scale); 175 *Rural Hospital Closures: January 2005—Present (133 Since 2010)*, U.N.C. CHAPEL HILL CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES., <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures> [<https://perma.cc/X9X7-Z8E2>] (last visited Oct. 26, 2020) (revealing that since 2010, when the ACA was passed, 133 rural hospitals have closed, as compared to only forty-two rural hospital closures between 2005 and 2010).

<sup>246</sup> See UTTLEY & KHAIKIN, *supra* note 22, at 5 (stating that in 2016, there were forty-six Catholic sole community hospitals in rural regions of the country). Because CMS defines a sole community hospital as one that is more than thirty-five miles from another hospital, patients that rely on these hospitals would be without access to any health care within thirty-five miles if the hospital closed. See 42 C.F.R. § 412.92 (defining “sole community hospital”).

<sup>247</sup> See 2018 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 9, at 26 (stating in Directive 74 that any acquired facility must observe the Directives); Singer, *supra* note 79, at 914 (highlighting that hospitals merge to achieve economies of scale in an increasingly expensive industry post-ACA); 175 *Rural Hospital Closures*, *supra* note 245 (listing the increase in rural hospital closures since the passage of the ACA). Importantly, if a hospital is truly at risk of going out of business, it can raise a failing or flailing firm defense to antitrust scrutiny, as a merger involving a firm that will soon exit the

Additionally, many of these small hospital mergers do not meet the HSR size threshold for federal antitrust scrutiny, so unless a consumer or state attorney general brings the proposed merger to the agency's attention, it could be consummated without undergoing an antitrust review.<sup>248</sup> Although the agencies can still review the proposed merger for antitrust violations, a concerned party would have to report the acquisition, and the antitrust agencies may not challenge these smaller transactions.<sup>249</sup> The small, rural hospital mergers that impact local reproductive health care services most significantly, therefore, may not even be reviewed by the antitrust agencies, so antitrust law may not be the best solution to concerns about access to reproductive health care.<sup>250</sup>

Finally, rural hospital mergers that do catch the FTC's attention may be exempt from antitrust scrutiny under the federal antitrust agencies' "safety zone" for certain small general acute care hospital mergers.<sup>251</sup> This policy exists to promote procompetitive mergers.<sup>252</sup> Therefore, if a rural hospital satisfy-

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market will rarely "enhance market power." See HORIZONTAL MERGER GUIDELINES, *supra* note 95, at 32 (describing the requirements for a failing firm defense). In order to successfully plead a failing firm defense, the hospital must be (1) "unable to meet its financial obligations in the near future"; (2) lack the ability to reorganize under Chapter 11; and (3) have solicited other proposals to stay in the market and be a lesser risk to competition than the proposed merger. *Id.* If a rural hospital meets these strict requirements, it may have a defense to an otherwise anticompetitive merger and could avoid violating the antitrust laws. See *id.* (noting that the agencies will credit this claim as a defense).

<sup>248</sup> See 15 U.S.C. § 18a (stating that transactions worth more than \$200 million must be reported to the antitrust agencies); Gilman et al., *supra* note 92 (noting that many health care mergers are worth less than this threshold number, and therefore are not automatically reported to the FTC and DOJ).

<sup>249</sup> See Gilman et al., *supra* note 92 (warning that competitors, insurance companies, and state attorneys general may report an otherwise non-reportable transaction to the FTC for antitrust concerns either before or after the deal has closed). Although the FTC has challenged some recent health care merger cases, it has also let many others proceed. *Id.* For example, in 2016, the FTC settled with CentraCare Health, a health care system in St. Cloud, Minnesota, that acquired St. Cloud Medical Group, a small physician practice group in the area. Press Release, Fed. Trade. Comm'n, Healthcare Provider in St. Cloud, MN Settles FTC Charges That Its Acquisition of Rival Provider Would Likely Lessen Competition for Certain Physician Services (Oct. 6, 2016), <https://www.ftc.gov/news-events/press-releases/2016/10/healthcare-provider-st-cloud-mn-settles-ftc-charges-its> [<https://perma.cc/82JH-9XS3>]. Although the merging parties were the "two largest providers of adult primary care, pediatric, and OB/GYN services in the St. Cloud area," St. Cloud Medical Group was struggling financially, so the FTC approved the merger under certain conditions in a consent order. *Id.*

<sup>250</sup> See KAYE ET AL., *supra* note 24, at 24 (providing examples of patients in rural areas whose only hospital was Catholic and describing their experiences attempting to access reproductive health care); UTTLEY & KHAIKIN, *supra* note 22, at 5–6 (listing rural Catholic hospitals across the country); Gilman et al., *supra* note 92 (explaining that small health care mergers may not be reportable under the HSR Act, and thus the antitrust agencies do not automatically investigate them).

<sup>251</sup> STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 125; APPELBAUM, *supra* note 212, at 18–19; Gilman et al., *supra* note 92.

<sup>252</sup> STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 125. Thus, antitrust law would not be an appropriate remedy to challenge this type of merger. See *id.* at 9 (noting that a hypothetical merger would not "reduce competition substantially" under these facts). In fact, a merger with a larger health care system could provide value to the community, as the rural hospital may benefit from the resources of a large health care system. See *id.* (discussing the efficiencies that a rural hospital could achieve through merging with a larger health care system). If the acquiring health

ing these conditions is acquired by a large Catholic health system that abides by the Directives, that region loses access to reproductive health services, and antitrust is not a potential tool to remedy that situation.<sup>253</sup>

The practice of antitrust law is incredibly case-specific, and the agencies' decision to challenge transactions often turns on the facts.<sup>254</sup> Antitrust law can be a useful tool to address Catholic hospital mergers that eliminate reproductive health care services in a community, but it will not be an effective remedy in all circumstances.<sup>255</sup> Moreover, antitrust law is not a viable solution to counteract the reduction of reproductive health care services post-merger for the small, rural hospital mergers that federal antitrust agencies decline to investigate.<sup>256</sup>

### C. Alternative Methods to Combat Catholic Hospital Mergers

For those hospital mergers that federal antitrust agencies do not review, state attorneys general may play a valuable role in preserving access to reproductive health care.<sup>257</sup> Most health care mergers may be reviewed not only at the federal level, but also by state regulators.<sup>258</sup> State attorneys general may

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care system were Catholic, however, the Directives' prohibition on valuable reproductive health services could hurt the community. See UTTLEY & KHAIKIN, *supra* note 22, at 5–6 (discussing the increasing number of Catholic rural hospitals in the United States). Because the federal antitrust agencies would be unable to challenge this merger under antitrust law, community advocates could seek the assistance of state antitrust regulators instead. APPELBAUM, *supra* note 212, at 18.

<sup>253</sup> See STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 125 (explaining the conditions for a merger to be cleared without antitrust challenges under the safety zone); APPELBAUM, *supra* note 212, at 18 (noting the federal antitrust safety zone exception exists, but explaining that it does not apply to state attorneys general).

<sup>254</sup> See HORIZONTAL MERGER GUIDELINES, *supra* note 95 (explaining that when reviewing a proposed transaction, antitrust agencies rely on the facts and their expertise to analyze the competitive effects of a merger).

<sup>255</sup> See STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 125, at 9 (stating that small hospitals falling within the "safety zone" will not be challenged by antitrust enforcers); APPELBAUM, *supra* note 212, at 15–16, 20 (discussing how the Directives reduce competition for reproductive health services in a relevant market, but the merits of an antitrust case under the Guidelines will depend on any procompetitive efficiencies).

<sup>256</sup> See KAYE ET AL., *supra* note 24, at 24 (describing patients in rural areas with access to Catholic hospitals only and detailing their reproductive health care experiences); Gilman et al., *supra* note 92 (explaining that small hospital mergers may not be reportable under the HSR Act, and thus the antitrust agencies do not automatically investigate them for violations of antitrust law).

<sup>257</sup> See APPELBAUM, *supra* note 212, at 18 (suggesting that, for those mergers that the federal antitrust agencies may not review, consumers could bring potential complaints to state attorneys general); Dave, *supra* note 123 (explaining that state involvement in hospital merger challenges is beneficial); Gilman et al., *supra* note 92 (noting that state attorneys general may also review hospital mergers).

<sup>258</sup> Dave, *supra* note 123. Although the federal antitrust agencies are authorized to investigate and challenge anticompetitive transactions under Section 7 of the Clayton Act, state attorneys general can also sue merging parties under the *parens patriae* doctrine. 15 U.S.C. § 18; Dave, *supra* note 123. *Parens patriae* enables a state to "prosecute a lawsuit on behalf of a citizen." *Parens Patriae*, BLACK'S LAW DICTIONARY, *supra* note 8; Dave, *supra* note 123. The HSR Act, enacted in 1976, established pre-merger notification filing requirements and gave state attorneys general the right to

challenge a potentially anticompetitive merger under the antitrust laws, but they may also preserve access to reproductive health care through other means, such as conditioning approval of a merger upon certain requirements.<sup>259</sup>

For example, in 2018, both the California Justice Department and the FTC approved the merger of Catholic Health Initiatives and Dignity Health, a twenty-nine billion dollar transaction that brought together 142 hospitals under the name CommonSpirit Health.<sup>260</sup> As a prerequisite of the approval, however, the California Attorney General imposed specific conditions requiring the continued provision of emergency and reproductive health care services.<sup>261</sup> Specifically, the Attorney General required the hospitals to “maintain and provide” reproductive health care services at pre-transaction levels for ten years following the merger, and during years six through ten, to alert the Attorney General in writing of any proposed changes, so that the state may assess their impact on the local population.<sup>262</sup>

State attorneys general, who are often more attuned to local transactions and their potential effect on their respective communities, are well-situated to regulate and condition mergers that may threaten local access to reproductive health care services.<sup>263</sup> Thus, their authority may be influential on those mergers that are not challenged by the federal antitrust agencies.<sup>264</sup>

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litigate antitrust suits under the Clayton Act via the *parens patriae* doctrine, but state attorneys general are not limited to investigating mergers that meet a certain threshold size. 15 U.S.C. § 15c.

<sup>259</sup> See 15 U.S.C. § 15c (allowing state attorneys general to bring antitrust suits under Section 7 of the Clayton Act through the *parens patriae* doctrine); Kacik, *supra* note 26 (describing the California Attorney General’s role in preserving access to reproductive health care services in the merger of Dignity Health and Catholic Health Initiatives).

<sup>260</sup> Kacik, *supra* note 26; Press Release, Dignity Health, Dignity Health and Catholic Health Initiatives Alignment Clears Regulatory Review in California (Nov. 21, 2018), <https://www.dignityhealth.org/about-us/press-center/press-releases/2018-11-21-dignity-health-and-catholic-health-initiatives-alignment-clears-regulatory-review-in-california> [<https://perma.cc/4EQS-RRSW>]; see also *supra* notes 26, 133 and accompanying text.

<sup>261</sup> Kacik, *supra* note 26; Letter from Wendi A. Horwitz, Deputy Att’y Gen., State of Cal. to Rick L. Grossman, Exec. Vice President & Gen. Counsel, Dignity Health 4 (Nov. 21, 2018), <https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofitosp/dignity-ag-decision-112118.pdf>? [<https://perma.cc/LLW3-BA9D>].

<sup>262</sup> Letter from Wendi A. Horwitz, *supra* note 261, at 4. The California Attorney General’s Office engaged in a significant review of the proposed transaction, which included a public comment period, the solicitation of independent “Health Care Impact Statements,” and seventeen community forums for local involvement. Press Release, Dignity Health, *supra* note 260.

<sup>263</sup> See Dave, *supra* note 123 (“[S]tate AGs are uniquely positioned when it comes to knowledge of local markets and access to local market participants.”).

<sup>264</sup> See *id.* (explaining that state attorneys’ general “intimate knowledge of the relevant local market” makes them an “impactful force” in regulatory enforcement, especially with respect to mergers); Press Release, Dignity Health, *supra* note 260 (noting that the transaction was approved by the FTC).

## CONCLUSION

The number of Catholic hospitals in the United States is increasing, as part of the overall rise in hospital merger activity since Congress passed the ACA. When large Catholic hospital systems acquire non-Catholic hospitals, they require that the non-Catholic institutions abide by the Directives, which prohibit a variety of medically accepted procedures, including reproductive health services. Thus, as Catholic hospitals amass an increasing share of the hospital market across the country, access to reproductive health services has decreased. Reproductive health care advocates have managed to combat this shortage in care by creating separate structural entities to continue to provide necessary reproductive health services that are otherwise eliminated after a hospital merges with a Catholic organization. The United States Catholic Conference of Catholic Bishops, however, updated the Directives in 2018 to forbid Catholic hospitals from establishing these separate corporate entities to deliver prohibited medical services post-merger. This revision jeopardizes the efficacy of the separate structural entity remedy to preserve reproductive health services in communities affected by Catholic hospital mergers.

Going forward, antitrust law may be an effective solution to combat the elimination of reproductive health services in a merger. Removing a hospital service line like reproductive health care in a relevant market substantially lessens competition for that product, a unilateral effect that could constitute a violation of the Clayton Act. Antitrust law thus presents a unique opportunity to evaluate and counteract the anticompetitive and consumer harms presented by a Catholic hospital merger's impact on access to reproductive health care services in a community. Of course, federal antitrust law is not a perfect solution to prevent a post-merger decrease in reproductive health services, and as an alternative, state attorneys general can also act decisively when approving hospital mergers to ensure continued access to care.

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