GOVERNMENT'S RELIGIOUS HOSPITALS

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States are not supposed to own or operate religious institutions, but they now do. This Article uncovers that across the country, church and state have merged, joint ventured, and contracted to form public, yet religious, hospitals. It traces the origins of these curious institutions to dramatic transformations over the last forty years in the political economy of healthcare and the constitutional doctrine of church and state. At stake are the foundational commitments of secular government to equal citizenship and religious freedom.

Yet, constitutional litigation offers limited recourse. In an increasingly religious marketplace, only sustained attention to the political economy can reverse the confluence of church and state. This Article proposes strategies to unite religion law and political economy and to move from religious domination to pluralism and from discrimination to equality. As government-religious institutions proliferate beyond healthcare—in schools, prisons, police departments, and child-welfare agencies—reform efforts must take on broader trends toward consolidation, privatization, and religionization of the economy.

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INTRODUCTION

Waking up in a hospital, you spy a religious painting at the foot of the bed. The doctors who rush in wear white coats with the names of a religious figure and of the state. Your treatment options, they tell you, must comply with the faith tradition. Clerics on the ethics committee will approve your care. As you recover, you learn that the government owns the hospital, pays the staff, and puts the state seal on the front of the building. On the board of directors, some seats are reserved for government bureaucrats, others for members in good standing of the Church.

This experience could describe hospital care in many countries around the world. But the United States is not known for such tight-knit relationships between any church and the state. Under the Establishment Clause, governments are not supposed to own or operate religious institutions. They are not expected to impose religious tests for public office or adopt a denomination as their own.

Nevertheless, they have. This Article reveals that across the country, church and state have fused in powerful entities that deliver critical services. The government's religious hospitals are state-governed, state-run, and/or state-owned. But religion permeates their halls. Faith dictates their charitable missions and ethical decisions. Under the banner of the state, patients may be denied healthcare for religious reasons. Public employees must display religious messages and conform their conduct to religious rules. Positions of governance and leadership, typically open to

all in public hospitals, are reserved for individuals who belong to particular sects.

Sometimes the state owns the religious institution outright—like the University of Alabama's "faith-based health system"[1] with a mission of "witness[ing] to the love of God through Jesus Christ."[2] Sometimes the religious and state entities become joint venturers—like Trinity Health and the University of Michigan, which agreed to run a hospital "consistent with the teachings of the Roman Catholic Church."[3] Other times, a dense network of operational, managerial, or other relationships connects church and government—as at the University of Texas, the University of California, and numerous public health districts, where clinical staff and medical students must conform to religious teachings against abortion, contraception, fertility treatments, and LGBTQ-affirming care.[4]

So how did we end up with institutions that so thoroughly merge public and religious? This Article argues that the answer lies in dramatic transformations in healthcare's political economy and in Religion Clause doctrine over the last forty years. Neoliberalism made government-religious hospitals economically and politically attractive during a period when the Supreme Court's erosion of the Establishment Clause made them legally plausible.[5] These institutions, joining government authority with religious domination, undermine religious freedom and threaten equal citizenship in a pluralistic society.

From the 1980s onward, policies favoring austerity and privatization became ascendant and decimated the public sector. Public hospitals—a mainstay of cities and a natural home for public universities' medical

[1] See Warren Averett CPAs and Advisors, The Health Care Authority for Baptist Health, An Affiliate of UAB Health System: Consolidated Financial Statements, Required Supplementary Information, and Additional Information 3 (2020), https://www.legislature.state.al.us/pdf/eopa/audit_reports/ExaminersPDFFiles/5956_21-091-CPA-Baptist%20HCA.pdf [https://perma.cc/R3XE-J372] [hereinafter Baptist Health Financials].

[2] See Spiritual Care, Baptist Health, https://www.baptistfirst.org/patients-and-visitors/spiritual-care/ [https://perma.cc/6XEB-3W7U] (last visited Oct. 17, 2022).

[3] Amended and Restated Bylaws of St. Joseph Mercy Chelsea, Inc., art. I, § 3, art. II, § 1 [hereinafter Amended and Restated Bylaws] (on file with author).

[4] See infra Section I.D.

[5] Like other contested concepts, there are debates about the term's core meaning. We focus on two central strands of neoliberal political economy—privatizing social services and valorizing market ordering over democratic governance. See David Singh Grewal & Jedediah Purdy, Introduction: Law and Neoliberalism, 77 Law & Contemp. Probs. 1, 6 (2014) (discussing the definition of neoliberalism).

faculties—closed their doors or privatized as governments divested.[6] Meanwhile, rising costs prompted private hospitals to engage in a relentless drive for revenue.[7] They merged and consolidated at an unprecedented and accelerating rate, nearly eradicating competition in hospital markets.[8]

But healthcare's political economy tells only part of the story.[9] A contemporaneous revolution in Establishment Clause doctrine abandoned principles of separationism and invited more intensive church-state partnerships.[10] Not long ago, the government-religious hospitals we describe would have encountered rather obvious constitutional obstacles.[11] Under the First Amendment's Establishment Clause, a "wall of separation" was supposed to hold church and state apart.[12] States nonetheless could fund religiously affiliated hospitals, provided they delivered secular healthcare services, refrained from discrimination in hiring, and committed to respecting their patients' consciences.[13] But in the last few decades, courts dismantled a number of constitutional constraints on aid to sectarian institutions. By the early 2000s, Establishment Clause doctrine aligned with neoliberal economic policies

[6] See George Aumoithe, Dismantling the Safety-Net Hospital: The Construction of "Underutilization" and Scarce Public Hospital Care, 48 J. Urb. Hist. 1, 2–3 (2021); Michelle Ko, Jack Needleman, Kathryn Pitkin Derose, Miriam J. Laugesen & Ninez A. Ponce, Residential Segregation and the Survival of U.S. Urban Public Hospitals, 71 Med. Care Res. & Rev. 243, 244 (2014).

[7] See, e.g., Andrew T. Simpson, The Medical Metropolis: Health Care and Economic Transformation in Pittsburgh and Houston 121 (2019) ("During the 1980s, 1990s, and 2000s, not-for-profit leaders not only drew organizational inspiration from the for-profit sector by pursuing a wave of mergers and acquisitions . . . , but were also more willing to speak in a language that echoed their corporate counterparts.").

[8] See Jonathan B. Baker, The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry, 51 Law & Contemp. Probs. 93, 93 (1988) ("During the early 1980s, acquisitions or consolidations occurred at the rate of roughly two hundred per year, dramatically higher than the yearly rates of fifty in 1972 and five in 1961.").

[9] We use the term "political economy" to mean "the relation of politics to the economy, understanding that the economy is always already political in both its origins and its consequences." Jedediah Britton-Purdy, David Singh Grewal, Amy Kapczynski & K. Sabeel Rahman, Building a Law-and-Political-Economy Framework: Beyond the Twentieth-Century Synthesis, 129 Yale L.J. 1784, 1792 (2020).

[10] See infra Section III.B.

[11] See infra Section III.A.

[12] Letter from Thomas Jefferson to the Danbury Baptists (Jan. 1, 1802), *in* 36 The Papers of Thomas Jefferson 258, 258 (Barbara B. Oberg ed., 2009).

[13] See infra notes 207–38 and accompanying text.

to galvanize public partnerships with faith-infused institutions. Privatization took on a religious hue.

Faced with demands for healthcare provision and education, cities, counties, and public universities stepped into this constitutionally unsettled space. And they found few options for partnership. No longer was it common to find the public hospitals that once hosted safety-net services and academic medicine. Trends toward consolidation, which escalated with each passing decade, left nearly all cities with highly concentrated hospital markets.[14] The secular options assumed by judges and policymakers had dwindled.

Often, commercially successful religious entities were among the few potential joint venturers and partners. Most commonly, those entities were Catholic. Due to their "hierarchy and interconnectedness," as well as their longstanding significant market share, Catholic healthcare systems had proved well-positioned to consolidate market power as neoliberalism took off.[15] And these religious partners, once motivated to claim nondiscrimination, now typically insisted on a more thickly sectarian identity.[16] In this landscape, governments created new institutions where secular and sacred, public and private, share governance, ownership, and operation.

Depending on one's point of view, the central problem of these hospitals might be privatization of public services, restriction of

[14] Ninety-five percent of metropolitan statistical areas have highly concentrated hospital markets. Jaime S. King et al., Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States 1, 6–7 (June 2020), https://sourceonhealthcare.org/wp-content/uploads/2020/06/PreventingAnticompetitiveHealthcareConsolidation.pdf [https://perma.cc/5RRX-87FJ].

[15] Allison Roberts, Selling Salvation: Catholic Hospitals in the Healthcare Marketplace, Canopy Forum (2019), https://canopyforum.org/2019/12/19/selling-salvation-catholic-hospitals-in-the-healthcare-marketplace-by-allison-roberts/ [https://perma.cc/T99U-54PC]. Today, Catholic systems hold a dominant or high market share in more than one-third of U.S. counties, where 38.7% of women of reproductive age live. Coleman Drake, Marian Jarlenski, Yuehan Zhang & Daniel Polsky, Market Share of US Catholic Hospitals and Associated Geographic Network Access to Reproductive Health Services, 3 JAMA Network Open 1, 6 (2020).

[16] Melinda Cooper, Family Values: Between Neoliberalism and the New Social Conservatism 271–73 (2017) (detailing this shift in social service providers and government's role); Stephen Monsma, Putting Faith in Partnerships 270–73 (2009) (describing empirically the spectrum of religious social services from deeply sectarian and faith-infused to more ecumenical); Barbra Mann Wall, American Catholic Hospitals: A Century of Changing Markets and Missions 181–86 (2011) (describing Catholic hierarchy's increasing extent and rigidity of control over Catholic hospitals and their conflicts with the women religious traditionally sponsoring the hospitals).

healthcare access, or discrimination based on sex. While we are concerned about each of these issues, our focus is on the threat to religious freedom as dominance in healthcare has been converted into religious domination backed not only by private power but by the authority of the government.[17] This confluence undermines equal citizenship and religious freedom in distinct and novel ways.

The promise of secular government is that equal membership in the political community will not depend on one's religion and that the state will not impose religion on its citizens.[18] Government's institutions will be open to all, controlled by the people, and able to give public reasons for decisions.[19] America's religious churches and charities, by contrast, can serve co-religionists, discriminate in their choice of leaders, and give religious reasons that people of other faiths cannot understand.[20]

Government-religious hospitals upend this settlement and confound theories on both the left and the right about the relationship between church and state. Across the political spectrum, religion law scholars assume the existence of secular options and the absence of religious domination in the marketplace.[21] They broadly agree that equal membership in the political community cannot depend on one's religion and that the state cannot prefer any denomination. One need not be a strict separationist to draw the line at a state institution that proclaims a

[17] For an extended argument against converting power in one social sphere into domination in another, see Michael Walzer, Spheres of Justice: A Defense of Pluralism and Equality (1983).

[18] See Christopher L. Eisgruber & Lawrence G. Sager, Religious Freedom and the Constitution 52–53 (2007); Alan Schwarz, No Imposition of Religion: The Establishment Clause Value, 77 Yale L.J. 692, 694–95 (1968); James Madison, Memorial and Remonstrance Against Religious Assessments (June 20, 1785), *in* James Madison: Writings 29, 29–36 (Jack N. Rakove ed., 1999); Thomas Jefferson, A Bill for Establishing Religious Freedom, *in* 2 The Papers of Thomas Jefferson 545, 546 (Julian P. Boyd ed., 1950).

[19] See generally Micah Schwartzman, The Sincerity of Public Reason, 19 J. Pol. Phil. 375 (2011) (discussing the idea of public reason); John Rawls, The Idea of Public Reason Revisited, 64 U. Chi. L. Rev. 765 (1997) (same).

[20] See Ira C. Lupu & Robert W. Tuttle, Secular Government, Religious People 73 (2014).

[21] See, e.g., Kent Greenawalt, When Free Exercise and Nonestablishment Conflict 69 (2017) ("If the government is the direct and primary source of funding for a program, religious discrimination by an organization in its employment should probably be regarded as unconstitutional, just as it would be for the government itself."); Thomas C. Berg, Religious Accommodation and the Welfare State, 38 Harv. J.L. & Gender 104, 150–51 (2015) ("It is sensible to rely in some part on the workings of markets to achieve accommodation's purpose.").

denominational identity, imposes religious tests, and uses religious reasons.

The embrace of joint church-state institutions may not be inexorable. Preserving principles of secular government in an increasingly religious marketplace is still possible, if not through constitutional litigation, then by addressing broader trends toward consolidation, privatization, and religionization of the economy. This Article considers a range of concrete reform measures, from embracing competition policy to state provision of social services to transacting for church-state separation. In combination, these reforms would move, albeit incrementally, from religious domination toward pluralism and from religious preference toward equality.

This Article proceeds in four Parts. Examining articles of incorporation, asset purchase agreements, and management contracts, Part I explores the details of government-religious hospitals and presents a rough taxonomy of the forms they take. Parts II and III argue that major shifts in healthcare's political economy and in Religion Clause doctrine over the last forty years together spurred the merger of church and state. The establishment of government-owned, -directed, and -operated religious hospitals came to threaten equal citizenship and religious freedom. Part IV turns to reforms. It demonstrates how antitrust enforcement, public options, and public utility regulation could reshape the political economy to remedy and forestall government-religious hospitals.

The setting of our law and political economy tale is the hospital sector, but evidence mounts that government-religious institutions may exist elsewhere. The legacy of neoliberalism, with its emphasis on privatization, drove and continues to drive religious-public collaborations—in schools, prisons, police departments, child-welfare agencies, and beyond.[22] Alliances between religious and economic conservatives have generated transfers of public funds, services, and decision-making to religious institutions. And as in the hospital sector, seemingly unrelated changes in constitutional doctrine increasingly create a path toward merger of church and state.

[22] See infra notes 379–83 and accompanying text.

I. GOVERNMENT-RELIGIOUS HOSPITALS

This Part documents the existence of a puzzling institution—a public, yet religious, hospital. Looking to articles of incorporation, asset purchase agreements, and management contracts, we unearth examples across the country. These arrangements vary in their organizational form and in the intensity of state engagement. In some cases, they are "zombie religious hospitals"—formerly religious hospitals that continue to abide by religious doctrine after they are sold to a secular, and in this case governmental, owner.[23] In others, the entity is a joint venture with governmental and religious co-owners. In others still, joint operations or long-term management contracts define the religion-state relation.

In each instance, the religiosity of the enterprise comes from some combination of the origins of its name, compliance with religious doctrine, governance by religious directors, and connections to religious authorities. The religion is typically Catholicism, because four of the ten largest hospital systems boast Catholic affiliation.[24] We also identify several examples of Baptist-public partnerships in markets where Baptist healthcare holds market power.[25] In these entities, religious officials hold designated governance roles, exercising authority side-by-side or occasionally over the government partner. Religion dictates care, with Adventist and Baptist healthcare typically limiting access to abortion and Catholic restrictions applying more widely to assisted reproductive technology, abortion, contraception, condoms, sterilization, treatments derived from fetal tissue or embryonic stem cells, and end-of-life care.[26]

[23] Elizabeth Sepper, Zombie Religious Institutions, 112 Nw. U. L. Rev. 929, 930–31 (2018).

[24] See Tess Solomon, Lois Uttley, Patty HasBrouck & Yoolim Jung, Bigger and Bigger: The Growth of Catholic Health Systems, Community Catalyst 3 (2020). As of 2016, seventy percent of religious hospitals were Catholic. See Lois Uttley & Christine Khaikin, Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report Table 2 (2016).

[25] See Emily E. Fountain, Tracing Blurred Lines: Catholic Hospital Funding and First Amendment Conflicts, 74 N.Y.U. Ann. Surv. Am. L. 417, 433–34 (2019) (observing that denominations have different degrees of strength of affiliation, formal mechanisms for identification and association, and integration of faith into mission statements or corporate charters).

[26] See U.S. Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services 18–19, 22 (6th ed. 2018) [hereinafter ERDs], https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf [https://perma.cc/2ZTT-442K]; Elizabeth Reiner Platt, Katherine Franke, Candace Bond-Theriault & Lilia Hadjiivanova, Colum. L. Sch., The Southern Hospitals Report: Faith, Culture, and Abortion Bans in the U.S. South 15,

Yet, the entity is often branded as public, sometimes staffed with public employees, and typically governed by state appointees. The publicness of each hospital manifests in its public name, taxpayer funding, and connection to governmental authorities. Some clearly qualify as state actors for constitutional and statutory purposes.[27] But the organizational forms and governance structures elide easy categorization. This Part provides a rough typology, running from the deepest state-religious fusion to less integrated affiliations.

A. Public Ownership

Religious hospitals fully owned and operated by state entities present the starkest examples of the phenomenon. In such arrangements, the hospitals' governance, finances, human resources, and organizational messaging are tightly bound up with the apparatus of the state. Nonetheless, the hospitals proclaim a commitment to sectarian identity, mission, and message. Community members may find that religious doctrine restricts services and requires discrimination in leadership and board positions.

Our initial example comes from a system of Baptist hospitals in Alabama organized as a governmental health authority. It originated in 2005 when Baptist Health encountered financial problems with its three hospitals and sought assistance from the University of Alabama ("UA").[28] The UA Board of Trustees authorized the creation of a health authority and made the hospitals affiliates of the University of Alabama at Birmingham Health System ("UAB Health System").[29]

https://lawrightsreligion.law.columbia.edu/sites/default/files/content/Reports/The_Southern_Hospitals_Report.pdf [https://perma.cc/YF8T-37Q9].

[27] For cases determining that these institutions are state actors, see *Napata v. University of Maryland Medical System Corp.*, 12 A.3d 144, 151 (Md. 2011); *Hammons v. University of Maryland Medical System Corp.*, 551 F. Supp. 3d 567, 584 (D. Md. 2021); *Health Care Authority for Baptist Health v. Central Alabama Radiation Oncology, LLC*, 292 So. 3d 623, 632 (Ala. 2019).

The vast majority of our examples involve affiliations with state academic medicine, not because these arrangements exhaust the universe of public-religious partnerships but rather because religious affiliations with county and small-town hospitals are often more difficult to identify with precision. See infra notes 98 and 191 for examples of Catholic-managed or -owned county hospitals.

[28] See UAB, Montgomery's Baptist Health Ink Formal Affiliation, Birmingham Bus. J. (June 28, 2005), https://www.bizjournals.com/birmingham/stories/2005/06/27/daily19.html [https://perma.cc/P9W6-7J9J].

[29] See Health Care Auth. for Baptist Health v. Davis, 158 So. 3d 397, 400–01 (Ala. 2013).

The Baptist Health Care Authority was born. Under Alabama law, public entities—including educational institutions—can create healthcare authorities: public corporations with authority to operate hospitals. Unlike private entities, these authorities enjoy governmental powers (eminent domain), privileges (receipt of public-hospital taxes), and exemptions.[30] They also operate under distinct constraints, including a prohibition on selling "substantially all [their] assets" without approval from the public entity that created them.[31]

Public entities own, operate, and manage the three Baptist hospitals. Under an affiliation agreement with the UA Trustees and UAB Health System, Baptist Health transferred the hospitals and their related assets to the public Baptist Health Authority.[32] The UAB Health System took over management.[33] Twenty-five percent of the operating income was designated to the University of Alabama.[34] By contrast, as an independent auditor's report explains, the former owner "Baptist Health remains in existence as a corporation, [but] it no longer has significant assets or operations."[35]

As a matter of law, the Baptist Health Care Authority is an instrumentality of the government. The Health Care Authorities Act provides that "a health-care authority is designated as an instrumentality of its authorizing subdivision"—here, the UA Board of Trustees, which is "unquestionably a state educational institution."[36] The Act further specifies that in "the operation and management of health care facilities, [the Authority] acts as an agency or instrumentality of its authorizing subdivisions and as a political subdivision of the state."[37] In several cases, the Alabama Supreme Court has explained that in choosing to partner with the University of Alabama, the Baptist hospital system became "a government-authorized health-care authority" and a "public

[30] See Tenn. Valley Printing Co. v. Health Care Auth. of Lauderdale Cnty., 61 So. 3d 1027, 1034 (Ala. 2010) (reviewing features of healthcare authorities).

[31] Id. (quoting Ala. Code § 22–21–318(a)(7) (1975)).

[32] Certificate of Incorporation of the Health Care Auth. for Baptist Health, an Affiliate of UAB Health Sys. 2.

[33] Id. Ex. A.

[34] See Health Care Auth. for Baptist Health v. Davis, No. 1090084, 2011 WL 118268 (Ala. Jan. 14, 2011), *withdrawn and superseded on reh'g by* Health Care Auth. for Baptist Health, 158 So. 3d at 397.

[35] Baptist Health Financials, supra note 1, at 13.

[36] Health Care Auth. for Baptist Health v. Cent. Ala. Radiation Oncology, LLC, 292 So. 3d 623, 630–31 (Ala. 2019).

[37] Ala. Code § 22-21-318(c)(2) (1975).

corporation."[38] As a result, these "public entities have certain responsibilities" and their employees are "public officer[s]."[39]

Yet, governance of the public Baptist Health Care Authority is split between state and religious entities. As required by Alabama law, the UA Board of Trustees selects the majority of the Authority's directors. The remainder, however, are chosen by the original religious owner, Baptist Health.[40] This version of shared governance makes the state the majority member but gives the religious minority member a veto over some decisions. Baptist Health retains a right to approve certain actions of the Authority and the right and obligation to resume ownership and debt of the hospitals if the affiliation agreement is terminated.[41]

The public Authority also explicitly claims a religious identity and mission. It describes itself as a "faith-based health system" with "nearly 60% inpatient market share in its primary service area."[42] Its website is "baptistfirst.org."[43] The Authority's outpatient facilities include those branded as University of Alabama Birmingham and others branded Baptist.[44] The mission ascribed to all these facilities is to "witness to the love of God through Jesus Christ."[45] In Alabama, state entities thus own, operate, and manage facilities with religious messages, religious goals, and religious shared governance. And they are not alone.

The University of Maryland St. Joseph Medical Center provides another example. Here, the hospital is an officially designated Catholic

[38] *Cent. Ala. Radiation Oncology*, 292 So. 3d at 630–31; see also Health Care Auth. for Baptist Health, 158 So. 3d at 402–16 (concluding that the Baptist Health Authority does not enjoy state immunity just like a number of other governmental entities, such as municipalities, counties, and public corporations).

[39] *Cent. Ala. Radiation Oncology*, 292 So. 3d at 631–32 (concluding that the Health Care Authority for Baptist Health is subject to the state Open Records Act). Under the Open Records Act, "A public officer or servant, as used in this article, is intended to and shall include, in addition to the ordinary public offices, departments, commissions, bureaus and boards of the state and the public officers and servants of counties and municipalities, all persons whatsoever occupying positions in state institutions." Ala. Code § 36-12-1 (1975).

[40] See Ala. Code § 22-21-316(a) (1975) ("[N]o fewer than a majority of the directors shall be elected by the governing body or bodies of one or more of the authorizing subdivisions.").

[41] Baptist Health Financials, supra note 1, at 13.

[42] Id. at 3.

[43] Baptist Health, https://www.baptistfirst.org [https://perma.cc/F32Y-N4AT] (last visited Oct. 15, 2022).

[44] Locations, Baptist Health, https://www.baptistfirst.org/locations/ [https://perma.cc/7E2Z-2RRJ] (last visited Oct. 15, 2022).

[45] Spiritual Care, Baptist Health, https://www.baptistfirst.org/patients-and-visitors/spiritual-care/ [https://perma.cc/9BVQ-UXWM] (last visited Oct. 15, 2022).

hospital, with a sponsoring order of nuns and an identity under canon law as an "extension . . . of the Roman Catholic Church."[46] The owner is the University of Maryland Medical System ("UMMS").[47] With a board appointed by the governor and assets that revert to the state, UMMS is plainly part of the state, "tethered to State government and subject to State oversight in important ways."[48] Yet, for a decade, it has owned and operated UM St. Joseph as a Catholic hospital, subject to sectarian restrictions on care and oversight from the Catholic Church.[49]

Like the Baptist Health Authority, UMMS is a corporate entity that functions as an instrumentality of the state. In 1984, the Maryland General Assembly created UMMS by statute, granted it the assets and liabilities of the public university's medical center, and required it to serve "the highest public interest."[50] Among UMMS's public responsibilities are to provide "comprehensive services for patient populations naturally served by University Hospital, including uncompensated care and outpatient care," and to furnish "specialty care services . . . to meet the needs of the State and region."[51] UMMS was created as an independent corporation, rather than a state agency, with the proviso that it "is not subject to any provisions of law affecting only governmental or public entities."[52] But

[46] J. Stuart Showalter & John L. Miles, Restructuring Health Care Organizations While Retaining Recognition as a Catholic Institution, 32 St. Louis U. L.J. 1111, 1125 (1988).

[47] The Maryland Supreme Court has held that "UMMS is an instrumentality of the State." Napata v. Univ. of Md. Med. Sys. Corp., 12 A.3d 144, 151 (Md. 2011). UMMS appears to satisfy the Supreme Court's requirements for applying the Constitution to ostensibly private corporations created by government: "the Government creates a corporation by special law, for the furtherance of governmental objectives, and retains for itself permanent authority to appoint a majority of the directors of that corporation." Lebron v. Nat'l R.R. Passenger Corp., 513 U.S. 374, 400 (1995).

[48] Hammons v. Univ. of Md. Med. Sys. Corp., 551 F. Supp. 3d 567, 587 (D. Md. 2021).

[49] UMMS owns the hospital through two wholly owned subsidiaries, UMSJ Health System, LLC and University of Maryland St. Joseph Medical Center, LLC, which have identical directors, and both claim ownership of UM St. Joseph. UMMS is entitled to elect board members of the governing body of both entities, UMMS's Chief Financial Officer maintains the hospital's financial records, and all corporate decisions "must be approved by UMMS." See Complaint at 12–13, *Hammons*, No. 20-cv-02088-ELH (D. Md. July 16, 2020) (quoting UMSJ Health System LLC, Form 8879-EO, 2017, https://hscrc.maryland.gov/Documents/public-interest/IRS%20990%20-%202017/FY18_UMSJHS_FORM%20990.pdf [https://perma.cc/AT5H-JGBR]).

[50] Md. Code Educ. § 13-302(4).

[51] Id. § 13-303(c).

[52] Id. § 13-303(a)(2).

as the state explains, "the General Assembly ensured that the State would continue to play a prominent role in the System's governance."[53]

Today, the State of Maryland continues to be intertwined in UMMS. By statute, UMMS's entire board of directors must be appointed by the governor of Maryland.[54] State oversight of operations is rigorous. Each year, UMMS has to file audited financial statements with the governor and the University of Maryland Board of Regents.[55] That same board, along with the Maryland Board of Public Works, may decide to dissolve UMMS, in which case its assets "revert to the State."[56] As a result, in several cases, courts have deemed UMMS to be part of the state government.[57]

Nevertheless, UM St. Joseph advertises itself as a Catholic acute care hospital as well as an "[i]ntegral member of the University of Maryland Medical System."[58] When visiting the UMMS website, patients see the state university logo and name over "St. Joseph Medical Center."[59] Until recently, if they clicked further, they would find that the mission of the hospital is "guided by our Catholic heritage" and core values that include "[r]espect for all people as God's loved children."[60] The local board of the hospital includes three Catholic priests out of eighteen directors.[61]

UM St. Joseph also abides by the Ethical and Religious Directives for Catholic Health Care Services ("ERDs").[62] These directives require that healthcare "must be animated by the Gospel of Jesus Christ and guided

[53] Origin & Functions, Univ. of Md. Med. Sys. Corp., https://msa.maryland.gov/msa/mdmanual/25ind/priv/html/medf.html [https://perma.cc/3UV3-FJ3S] (last visited Oct. 15, 2022).

[54] Hammons v. Univ. of Md. Med. Sys. Corp., 551 F. Supp. 3d 567, 584 (D. Md. 2021).

[55] Napata v. Univ. of Md. Med. Sys., 12 A.3d 144, 147 (Md. 2011).

[56] Id. at 151.

[57] See id. (holding that UMMS is an instrumentality of the state for purposes of Maryland's Public Information Act); *Hammons*, 551 F. Supp. 3d at 587 (holding that UMMS is entitled to state sovereign immunity).

[58] The Joint Comm'n, Self-Study Handbook for Univ. of Md. St. Joseph Med. Ctr. 3 (revised Aug. 1, 2019).

[59] Univ. of Md. St. Joseph Med. Ctr., https://www.umms.org/sjmc [https://perma.cc/327Q-9ADY] (last visited Sept. 21, 2022).

[60] About UM SJMC, Univ. of Md. St. Joseph Med. Ctr., https://web.archive.org/web/20211201124656/https://www.umms.org/sjmc/about [https://perma.cc/6X5J-4RSZ] (last visited Sept. 21, 2022). UMMS describes UM St. Joseph as having "[i]ts Catholic heritage ever-present." Univ. of Md. Med., 2018 Ann. Rep. 43 (Anne Haddad ed., 2018).

[61] UM SJMC Board of Directors, Univ. of Md. St. Joseph Med. Ctr., https://www.umms.org/sjmc/about/board-of-directors [https://perma.cc/66A2-DLBP] (last visited Oct. 17, 2022).

[62] See A Tradition of Passionate Care, Univ. of Md. St. Joseph Med. Ctr., https://jobs.umms.org/sjmc/ [https://perma.cc/3CRU-3VSG] (last visited Oct. 15, 2022).

by the moral tradition of the Church."[63] They restrict healthcare based on the views of the U.S. Conference of Catholic Bishops on reproduction, end-of-life care, gender, and family formation.[64] As a result, UM St. Joseph has, for example, denied transgender patients treatment for gender dysphoria by invoking religion.[65] Where ethical issues arise, a committee resolves them according to Catholic doctrine.[66]

On a continuum of state-religious fusion, institutions owned by the state sit at an extreme. But they are not the only form of government-religious hospitals.

B. Joint Ventures

Government-religious hospitals may be structured as joint ventures between public and religious entities. In joint ventures, the state and religious actors pool their resources for the purpose of creating a new entity while maintaining their respective corporate identities. The central difference from our previous examples lies in the joint government-religious, rather than sole governmental, ownership of the hospital.

The University of Michigan and Trinity Health–Michigan's joint venture provides a case study. Together, state and religious entities own and operate St. Joseph Mercy Chelsea Hospital.[67] They share governance. Their brands are displayed side-by-side. And public and private employees practice in the hospital.

Before its acquisition by Catholic-affiliated St. Joseph Mercy Health System in 2009, Chelsea Hospital was a secular community hospital.[68] While it did not perform abortions, it did offer tubal ligations, vasectomies, and contraceptives.[69] After the acquisition, Chelsea became an officially designated Catholic hospital, adopted the ERDs, and ceased

[63] See ERDs, supra note 26, at 8.

[64] See generally id. (describing restrictions on healthcare dictated by Church directives).

[65] See Complaint at 2–3, Hammons v. Univ. of Md. Med. Sys. Corp., No. 1:20-cv-02088 (D. Md. July 16, 2020).

[66] The Joint Comm'n, Self-Study Handbook for Univ. of Md. St. Joseph Med. Ctr. 7–8 (revised Dec. 1, 2012).

[67] Lynn Monson, Merger Complete Between Chelsea Community Hospital and the Saint Joseph Mercy Health System, M Live (May 3, 2009), https://www.mlive.com/news/ann-arbor/2009/05/merger_complete_between_chelse.html [https://perma.cc/ECX7-DCNV].

[68] See id.; Vickie Elmer, The Sale of Chelsea Hospital, Ann Arbor Observer (Jan. 17, 2009), https://annarborobserver.com/the-sale-of-chelsea-hospital/ [https://perma.cc/L9AY-A92J].

[69] Elmer, supra note 68.

providing these services.[70] In 2018, consistent with a trend toward industry concentration, St. Joseph Mercy Health System was acquired by Trinity Health,[71] a nationwide Catholic system with annual revenues of $20.2 billion.[72] In short order, Trinity formed a joint venture to own St. Joseph Chelsea Hospital with Michigan Medicine, the academic medical center and clinical enterprise of the University of Michigan.[73]

Unlike the arrangements described in Section I.A, the religious and public entities here share both ownership and governance of the hospital. St. Joseph Mercy Chelsea, Inc., a Michigan non-profit corporation formed for purposes of the joint venture, holds the assets and liabilities of Chelsea Hospital.[74] Trinity Health–Michigan is the fifty-one percent majority member, the Regents of the University of Michigan the forty-nine percent member.[75] Both members have reserved powers to approve "the strategic plan, mission, vision and values; annual budget and unbudgeted capital or operating expenditures; modifications of governing documents; incurred or guaranteed debt; merger/acquisition transactions; and the admission of new members."[76] They jointly have the power to initiate or implement any proposed hospital governance decision, including the "[a]doption, amendment, modification, or repeal of any statement of philosophy, mission, mission integration, or values."[77]

Trinity Health, however, has the sole authority to decide matters of institutional mission and values to the extent they implicate Catholic identity. It also has exclusive power "to implement actions it reasonably and in good faith deems necessary to ensure the Corporation's and

[70] Id. In addition, employee health plans exclude birth control coverage for religious reasons. Id.

[71] See Contribution and Sale Agreement by and Among Regents of the University of Michigan, Trinity Health–Michigan, and St. Joseph Mercy Chelsea, Inc. 1 (2018).

[72] About Us, Trinity Health, https://www.trinity-health.org/about-us/ [https://perma.cc/2HBB-57YK] (last visited Oct. 9, 2022).

[73] See Letter from Marschall S. Runge, Exec. Vice President for Med. Affs. and Dean of the Med. Sch., and Kevin P. Hegarty, Exec. Vice President and Chief Fin. Officer, Univ. of Mich., to Univ. of Mich. Bd. of Regents (approved by Regents Feb. 15, 2018), https://regents.umich.edu/files/meetings/02-18/2018-02-X-1-Supplemental.pdf [https://perma.cc/CUQ8-SNVX] [hereinafter UM Regents Letter].

[74] Id.

[75] Id. The Regents are separate and independent of the state but enjoy a constitutional grant of authority and have general powers to control and supervise the University. See Mich. Comp. Laws Ann. §§ 390.1–11. The Supreme Court of Michigan has held that the Regents perform state functions. See People v. Brooks, 194 N.W. 602, 603 (Mich. 1923).

[76] UM Regents Letter, supra note 73.

[77] Amended and Restated Bylaws, supra note 3, art. II, § 3(a)(ii).

Hospital's continued compliance with canon law" and "decide other matters that could adversely impact the Catholic identity" of the venture.[78] The Regents have no equivalent unilateral authority.[79]

The governance of the joint venture and the hospital requires ongoing cooperation between the public entity and its religious partners. Both members take an active role in appointing directors to the board of the joint venture, with Trinity Health allotted five seats and the Regents four.[80] Both must approve the president/chair and vice chair positions, which alternate between Trinity Health- and UM-appointed directors.[81] The board of Chelsea St. Joseph Hospital likewise is largely non-self-perpetuating, requiring mutual engagement in the appointment process. It too includes a mix of public and private appointees and calls for participation from a public employee in the person of the UM Executive Vice President for Medical Affairs (currently the Dean of the Medical School).[82]

The day-to-day administration of Chelsea Hospital also intertwines religion and state. UM and Trinity Health must approve the president of the hospital.[83] And the chair and vice chair of the Board—appointed by UM and Trinity Health, respectively—set performance standards for the president.[84]

Chelsea bears outward markers of governmental identity. It holds itself out as part of Michigan Medicine. Under a license from the Regents, the University of Michigan brand is displayed next to St. Joseph's logo in Chelsea's internet presence and healthcare operations.[85] Michigan Medicine

[78] Id. § 3(c).

[79] Id. § 3(b). UM must approve the use of its legal or trade name other than when set forth in a licensing agreement. Id.

[80] Id. art. III, § 3.

[81] Id. art. V, § 2.

[82] Id. art. VII, § 2; Executive Vice President for Medical Affairs and Dean U-M Medical School, Mich. Med., http://evpma.med.umich.edu/about-us/index.html [https://perma.cc/HXC2-4YR4] (last visited Oct. 9, 2022); Univ. of Mich., 2019 Ann. Rep. 88 (2019).

[83] Amended and Restated Bylaws, supra note 3, art. V, § 2.

[84] Id. art. VI.

[85] See UM License Agreement 1 (July 1, 2018) (on file with authors) (stating that "Healthcare Operations" consist of "(i) the clinical and directly-related business operations of Chelsea in support of the Chelsea Collaboration; (ii) the provision of healthcare services by Chelsea; and (iii) the education of patients and physicians by Chelsea"); Chelsea Hospital Location Information, Trinity Health, https://www.stjoeshealth.org/location/st-joseph-mercy-chelsea-hospital [https://perma.cc/P639-883K] (last visited Oct. 9, 2022); Chelsea Hospital, Facebook, https://www.facebook.com/ChelseaHospitalMI (last visited Oct. 9, 2022).

hospitalists also practice in Chelsea Hospital, caring for patients alongside St. Joseph's employees.[86]

Yet, Chelsea also claims a meaningful religious identity and mission. The joint venture with the state explicitly maintains the hospital's Catholic identity and adherence to the ERDs.[87] And the public entity agreed that Chelsea must carry out its activities "in a manner consistent with the teachings of the Roman Catholic Church" and subject to the religious sponsorship of Catholic Health Ministries.[88]

The only nod to the government's role appears in an amendment to Chelsea's corporate purpose. Prior to formation of the joint venture, the hospital's corporate purpose was, among other things, to "further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States."[89] Pursuant to the venture with the University of Michigan, its statement of corporate purpose did away with mention of the Church.[90] Nonetheless, Chelsea retains many markers of religiosity—Catholic mission, Church sponsorship, restricted healthcare services, and majority religious board membership. And it does so even as the state labels it with a public brand, provides public employees, and governs it jointly.

Michigan is not the only academic medical center to consider sharing ownership with a religious joint venturer. The University of Arkansas likewise proposed uniting public and Catholic health systems. St. Vincent's—a Catholic hospital system—and the University of Arkansas for Medical Sciences ("UAMS")—the only adult Level One Trauma Center in Arkansas and the state's largest public employer—entered negotiations to establish financial alignment and clinical integration

[86] Michigan Hospitalists at Chelsea & Michigan St. Joe's Services, Mich. Med., https://medicine.umich.edu/dept/intmed/divisions/hospital-medicine/patient-care-service-lines/michigan-hospitalists-chelsea-michigan-st-joes-services [https://perma.cc/VG2V-KXW7] (last visited Oct. 9, 2022).

[87] See Amended and Restated Articles of Incorporation of St. Joseph Mercy Chelsea, Inc., art. VI (June 27, 2018) (on file with authors) [hereinafter Amended and Restated Articles of Incorporation].

[88] Amended and Restated Bylaws, supra note 3, art. I, § 3.

[89] St. Joseph Mercy Chelsea, Inc., Articles of Incorporation 2 (Jan. 31, 2018); see also UM Regents Letter, supra note 73 (noting that hospital "will retain a Catholic identity").

[90] The Amended and Restated Articles of Incorporation, supra note 87, art. II § A, use the language of the Internal Revenue Code, allowing the hospital to pursue purposes that "are exclusively religious, charitable, educational, and scientific within the meaning of Section 501(c)(3)."

across their hospitals.[91] Under the proposal, a newly created entity would have overseen the collaboration and would have been governed fifty-fifty by public and Catholic systems.[92] At least one representative of the Church likely would have served on this body.[93]

UAMS and St. Vincent's insisted that their affiliation would impact neither St. Vincent's Catholic identity nor UAMS's ability to offer comprehensive secular care.[94] But the language of the proposal's term sheet seemed to suggest that Catholic doctrine would apply across the network.[95] Pressed for answers, the Bishop of Little Rock wrote, "I will not allow any affiliation that implicates St. Vincent in any jointly governed institution that would result in our material cooperation with any of the immoral medical practices." "[The] 'devil' (so to speak) is always in the details."[96] Unable to agree on those details, the parties did not consummate the deal.[97]

Other co-ownership arrangements involve public entities outside the academic medical context. For example, in a now-defunct partnership, Baptist Health Systems of Alabama (no relation to Baptist Health Authority) shared ownership of Cullman Regional Medical Center fifty-fifty with the county Health Care Authority.[98] An existing secular public hospital became jointly owned by a religious entity.

These organizational forms put religion and government into sustained, day-to-day contact. Sometimes, their venture is co-equal. At other times, one is subordinate to the other.

[91] See Leslie Newell Peacock, UAMS, St. Vincent Collaboration, Ark. Times (Apr. 11, 2013), https://arktimes.com/news/arkansas-reporter/2013/04/11/uams-st-vincent-collaboration [https://perma.cc/UG9D-RKGB]; Jon Parham, UAMS & St. Vincent Sign Letter of Intent to Explore Affiliation Opportunities, UAMS News (Aug. 30, 2012), https://news.uams.edu/2012/08/30/uams-st-vincent-sign-letter-of-intent-to-explore-affiliation-opportunities/ [https://perma.cc/PZA6-NGC8].

[92] Peacock, supra note 91.

[93] Id.

[94] Id.

[95] Id. (noting that the collaboration will provide care "in a manner that is accessible, responsive, and respectful of the dignity of the individual human being").

[96] Id.; Bishop Anthony B. Taylor, Diocese of Little Rock, https://www.dolr.org/clergy/anthony-b-taylor [https://perma.cc/KLV5-2CNT] (last visited Oct. 9, 2022).

[97] UAMS, St. Vincent Call Off Talks for Strategic Alliance, KUAR (July 26, 2013, 4:37 PM), https://www.ualrpublicradio.org/local-regional-news/2013-07-26/uams-st-vincent-call-off-talks-for-strategic-alliance [https://perma.cc/5NNX-DYPT].

[98] Michael Romano, Healthcare Hath No Fury, Mod. Healthcare, July 21, 2003, at 16.

C. Joint Operations

Joint operating agreements sit one step removed from joint public-private ownership. These agreements sometimes result from failed mergers of public and private. Under their terms, a religious entity typically operates a public facility, but no public assets transfer to the religious system.

The history of University Medical Center ("UMC") of the University of Louisville illuminates. In 2011, a merger was proposed between Jewish Hospital & St. Mary's HealthCare, St. Joseph Health System, and UMC, the region's safety-net hospital and the primary teaching affiliate of the public university's medical school.[99] The merger would have combined the three entities as part of Catholic Health Initiatives. All hospitals in the merged system would have had to follow Catholic directives.[100] But the Kentucky attorney general and governor rejected the merger.[101] The two religious institutions subsequently merged into KentuckyOne Health and complied with Catholic restrictions.[102]

Within two years, however, KentuckyOne came to operate the public UMC. Under a joint operating agreement with UMC, KentuckyOne took over most day-to-day operations.[103] But UMC did not transfer ownership of its state assets and retained a role in governance. Indeed, the attorney general approved the deal partly because it differed from the earlier merger proposal in ensuring that "the executive branch of the Commonwealth of Kentucky retains authority to oversee the new agreement."[104]

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[99] See Off. of the Att'y Gen. of Ky., Proposed Consolidation of Jewish Hospital Healthcare Services Inc., 1, 3, 14 (2011), http://www.khpi.org/dwnlds/ag-merger-report.pdf [https://perma.cc/CK5T-N4PD].

[100] See Libby A. Nelson, Church, State and a University Hospital, Inside Higher Ed (Aug. 9, 2011), https://www.insidehighered.com/news/2011/08/09/church-state-and-university-hospital [https://perma.cc/76PR-VQBY].

[101] See Hospitals with Different Religious Backings Can Still Partner, but Some Challenges Await, Becker's Hosp. Rev. (July 15, 2013), https://www.beckershospitalreview.com/hospital-transactions-and-valuation/hospitals-with-different-religious-backings-can-still-partner-but-some-challenges-await.html [https://perma.cc/99UA-HRCR].

[102] For further elaboration, see Sepper, supra note 23, at 970–71.

[103] See UofL, University Medical Center Partners with KentuckyOne Health, The Lane Rep. (Nov. 14, 2012), https://www.lanereport.com/15242/2012/11/kentuckyone-health-and-uofl/ [https://perma.cc/JX4Q-F9ZV].

[104] Kathy Keadle, University Medical Center, UofL Announce Partnership with KentuckyOne Health, UofL News (Nov. 14, 2012), https://www.uoflnews.com/post/uofltoday/university-medical-center-uofl-announce-partnership-with-kentuckyone-health/ [https://perma.cc/BD7N-NSV6].

The deal closely involved the state entity in a joint operational structure with Jewish and Catholic sponsors. Three UMC directors were added to the KentuckyOne board.[105] The KentuckyOne CEO and UMC President had joint authority to decide how to allocate KentuckyOne's investments in the public institution.[106] Public officials crowed, "[t]his likely will become immediately a model that is viewed on the national stage as something that other people will want to embark on."[107]

But concerns about religious restrictions on healthcare surfaced again. To bolster patient access, the deal included work-arounds of religious restrictions. The University of Louisville maintained control and operation of the Center for Women and Infants, which became a "hospital within a hospital" (that is, a secular hospital able to provide care, unfettered by religion, within a hospital operated by a religious entity).[108] Employees of the University of Louisville, however, found their health benefits limited by religious doctrine. KentuckyOne terminated insurance coverage of vasectomies to reflect Catholic beliefs. And it appeared to exclude employees' domestic partners and married same-sex spouses from insurance plans.[109] Even in the absence of co-ownership, joint operations deeply entangled the state with religion.

D. Collaborations and Affiliations

For decades, public and religious healthcare entities have also collaborated, affiliated, and contracted to increase access to care and promote efficiency of healthcare delivery.[110] Their arrangements range from short- to long-term, regular to occasional. They manifest varying degrees of overlap and intensity. They include agreements related to

[105] Ashok Selvam, CHI Deal Revived in Kentucky, Mod. Healthcare, Nov. 19, 2012, at 18.
[106] Id. at 19.
[107] Id. at 18.
[108] See Ralph K.M. Haurwitz, Critics Wary of Catholic Teaching Hospital for New UT Medical School, Austin Am.-Statesman (Dec. 8, 2012), https://www.statesman.com/story/news/local/2012/12/09/critics-wary-catholic-teaching-hospital/6677407007/ [https://perma.cc/R7BT-Y97R] (describing "hospital within a hospital" arrangement); see also Nelson, supra note 100 (same).
[109] See Laura Ungar, University of Louisville Hospital Pushing Catholic Beliefs Through Health Insurance Changes, Critics Argue, Courier-J. (Nov. 23, 2013), https://www.courier-journal.com/story/news/local/2013/11/23/university-of-louisville-hospital-pushing-catholic-beliefs-through-health-insurance-changes-critics-argue/3685883/ [https://perma.cc/5LT2-GZD9].
[110] See, e.g., Keadle, supra note 104 (noting sixty years of research and clinical collaborations with Jewish Hospital, St. Mary's, and the University of Louisville).

billing, referral networks, and transfers. Many avoid the degree of religious and public intermixing present in fully state-owned religious hospitals and in joint ventures and operations. Often, more entwined and prolonged collaborations grow out of earlier, less sustained interactions.[111]

A common arrangement sees public employees delivering care in religious facilities and hosting religious institution employees. For example, the University of California system offers specialized services in Catholic hospitals across the state.[112] Healthcare education also provides opportunity for cooperation. Public hospitals train interns from religious medical schools, and vice versa.[113]

Management of public hospitals is often delegated to religiously affiliated systems. For example, since 2014, a succession of Catholic healthcare systems has managed the Oklahoma State University Medical Center, Tulsa's safety-net hospital and the public academic medical center.[114] Under these arrangements, the hospital's assets and liabilities

[111] The joint venture of the Regents and Trinity Health–Michigan in Chelsea resulted from earlier cooperation under a 2012 master affiliation agreement between University of Michigan, Saint Joseph Mercy Health System, and Trinity Health to work together to "create health care solutions in communities each mutually serves across the state." See Mary Masson, Saint Joseph Mercy, U-M Proceed with Chelsea Joint Venture, U. Rec. (Feb. 15, 2018), https://record.umich.edu/articles/saint-joseph-mercy-u-m-proceeding-chelsea-joint-venture/ [https://perma.cc/6HQU-49KG].

[112] See Frequently Asked Questions on Partnerships Between California's Catholic Health Care and Secular Providers, All. of Cath. Healthcare 2–3 (2021), https://thealliance.net/sites/default/files/partnerships_alliance_faqs_finalv2_2.24.211.pdf [https://perma.cc/2H6V-734B] (compiling examples across California). UC Davis and Mercy Medical CenterMerced jointly run a cancer center that serves 12,000 patients each year. Id. St. Mary's Medical Center in San Francisco operates the city's only in-patient adolescent psychiatry program with UC San Francisco. Id. at 3.

[113] See, e.g., Carol M. Ostrom, Ties Between UW, PeaceHealth Worry Medical Trainees, Grad Students, Seattle Times (July 6, 2014), https://www.seattletimes.com/seattle-news/ties-between-uw-peacehealth-worry-medical-trainees-grad-students/ [https://perma.cc/Y6BE-S95J]; Catholic Health Ass'n of the United States, LSU, Our Lady of the Lake in Baton Rouge, La., Complete Transition, Cath. Health World (May 15, 2013), https://www.chausa.org/publications/catholic-health-world/archives/issues/may-15-2013/lsu-our-lady-of-the-lake-in-baton-rouge-la.-complete-transition [https://perma.cc/82VS-W2AZ] (reporting that after closure of a state-owned hospital, an agreement was established between LSU and Catholic Our Lady of the Lake to maintain healthcare access for Baton Rouge residents and continue graduate medical education).

[114] See Shannon Muchmore, Mercy Health System Chosen to Manage OSU Medical Center, Tulsa World (Apr. 1, 2014), http://www.tulsaworld.com/news/health/mercy-health-system-chosen-to-manage-osu-medicalcenter/article_ec04df9d-75bb-5db6-ad83-a1a89376fb9f.html [https://perma.cc/5TFD-3Q2S]. In 2016, Saint Francis took over management. See Saint Francis Health System and Oklahoma State University Medical Authority (OSUMA) Enter a

remain publicly owned. Hospital management, however, is transferred to a religious healthcare system for a (typically lengthy) fixed term. Occasionally, these agreements give rise to "creative solutions" that ensure a hospital meets community needs for reproductive healthcare despite management's religious objections.[115]

Several public health districts similarly partner with Catholic systems. In San Juan County, Washington, one such district replaced the public clinic and hospital with a new facility run under contract by Catholic PeaceHealth.[116] Although the public district covered one-third of its construction costs and uses property taxes to subsidize its operations, Peace Island Medical Center restricts services according to religious doctrine.[117]

Another example of extended public-religious collaboration comes from Austin, Texas. In 1995, Seton, a Catholic hospital system, entered into a lease and management contract with Brackenridge, the public hospital primarily responsible for the city's indigent care.[118] The contract made clear that Brackenridge would retain ownership and the facility would not be identified as Catholic.[119] Initially, with the exception of abortion, religious restrictions on care did not apply.[120] But the Vatican later objected, requiring the creation of a hospital within a hospital—a reproductive health floor run by the University of Texas Medical Branch with a separate patient elevator.[121]

Management Contract for Downtown Tulsa Hospital, OSU Headlines News & Media (Oct. 5, 2016), https://news.okstate.edu/articles/communications/2016/saint-francis-health-system-and-oklahoma-state-university-medical-authority-osuma-enter.html [https://perma.cc/CT76-BWHN].

[115] See infra note 121 and accompanying text.

[116] See Aaron Corvin, ACLU Says Faith-Based Hospitals Jeopardize Reproductive, End-of-Life Care, The Columbian (Mar. 23, 2013), http://www.columbian.com/news/2013/mar/24/ACLU-faith-based-hospitals-jeopardize-care/ [https://perma.cc/3GNG-DRSQ].

[117] See id. For another example, see Uttley & Khaikin, supra note 24, at 13 (discussing Natchitoches Regional Medical Center, owned by the Natchitoches Parish Hospital District and governed by a board of commissioners appointed by the parish council and managed by CHRISTUS Health, a Catholic non-profit hospital system).

[118] Barbra Mann Wall, Conflict and Compromise: Catholic and Public Hospital Partnerships, 18 Nursing Hist. Rev. 100, 100 (2010).

[119] Id. at 101.

[120] Mary Tuma, Questions of Church-State Separation at Dell Seton Medical Center, Austin Chron. (Jan. 20, 2017), https://www.austinchronicle.com/news/2017-01-20/questions-of-church-state-separation-at-dell-seton-medical-center/ [https://perma.cc/92CX-4TU6].

[121] Wall, supra note 118, at 109–11; Tuma, supra note 120.

When the county decided to close the 150-year-old public hospital and establish a teaching hospital for a new medical school at UT Austin, Seton was the obvious partner. Seton agreed to build and operate the facility and to maintain public safety-net services.[122] Under the agreement, the county health district ("Central Health") retains ownership of the hospital land and the right to buy back the hospital if Seton defaults or materially breaches the agreement.[123] Funding for the hospital and affiliated medical school came from the UT system, Seton, private donations, and a voter-approved property tax increase.[124] Central Health also pays for Seton's safety-net services through public funds.[125]

Under various agreements, the new Dell Seton Medical Center at the University of Texas became the exclusive site for county healthcare and public medical education. Central Health committed not to compete with Dell Seton and to "encourage the use" of other Seton healthcare facilities.[126] Likewise, UT Austin promised not to open its own facility for fifteen years.[127] UT-affiliated providers must work and teach at Dell Seton.

The public entities agreed on compliance with religious directives. Inside Seton facilities, UT-affiliated physicians and students must abide by the Catholic ERDs.[128] As a result, a range of reproductive health services is transferred outside the teaching hospital. For example, Seton denies emergency contraception to survivors of sexual assault if they are ovulating.[129] So, the area's EMT protocols require transport of sexual assault victims to a facility that is not operated by Seton.[130] The county

[122] See Master Agreement Between Travis County Healthcare District D/B/A Central Health and Seton Healthcare Family 25–26 (June 1, 2013) [hereinafter Master Agreement] (on file with authors).

[123] Id. at attach. E.

[124] Tuma, supra note 120.

[125] Master Agreement, supra note 122, at 2, 8, 13–16, Annex B.

[126] Lease Agreement Between Travis County Healthcare District D/B/A Central Health and Seton Family of Hospitals 20 (June 1, 2013) [hereinafter Lease Agreement] (on file with authors).

[127] Affiliation Agreement Between and Among the Board of Regents of the University of Texas System and the University of Texas at Austin and Seton Healthcare Family 47, 107 (Oct. 16, 2014) [hereinafter Affiliation Agreement] (on file with authors).

[128] Id. at 101 ("UT Austin/UT Austin Dell Medical School, UT System Institutions, and [Dell Medical School] Faculty, Residents, and Fellows are not bound by the ERDs and are not prohibited from performing ERD Non-Compliant Procedures outside of Seton facilities without involvement, participation, or support of Seton.").

[129] Tuma, supra note 120.

[130] See id.

Central Health district, moreover, assumed responsibility to protect against violations of religious doctrine at Seton facilities.[131] Seton has the unilateral right to terminate the agreement if it decides religious doctrine has been violated or Central Health has otherwise endangered Seton's status as a "Catholic healthcare organization" in ways that may affect the direction of the hospital's operation and management.[132]

* * *

Government-owned, -operated, and -administered institutions combine economic power with religious domination and then add the authority of the state. In the United States, governments are not supposed to own or be subject to control by religious institutions. Religious entities are not expected to fly the banner of government or to grant state bureaucrats decision-making authority. Yet the entities we describe uniformly defy these expectations, even as they differ in their particulars.

Instead of neutrality toward citizens, the state manifests preference for certain religions. As one reader suggested, our account might more appropriately be titled Government's Christian Hospitals.[133] Members of non-Christian or non-Catholic religions stand in disfavor before the state. Religious actors invoke state authority, and the government asserts religious doctrine.[134]

The next two Parts argue that simultaneous (and ongoing) shifts in healthcare's political economy and in religion law doctrine enabled this phenomenon.

II. ASCENDANCE OF THE NEOLIBERAL POLITICAL ECONOMY

This Part explains that neoliberal policies of austerity and privatization facilitated church-state fusion in healthcare.[135] Cities and counties were once expected to play the role of safety-net providers of hospital care. But over the last few decades, states starved the public sector. Governments

[131] See Master Agreement, supra note 122, at 25.

[132] Id. at 33.

[133] Thank you to Nikolas Guggenberger for this point.

[134] Douglas Laycock, The Underlying Unity of Separation and Neutrality, 46 Emory L.J. 43, 46 (1997) (describing such a pattern as prohibited by constitutional guarantees of equal treatment of religion in public life).

[135] See Grewal & Purdy, supra note 5, at 19. For historical work on neoliberalism, see Angus Burgin, The Great Persuasion: Reinventing Free Markets Since the Depression (2012), Daniel Stedman Jones, Masters of the Universe: Hayek, Friedman, and the Birth of Neoliberal Politics (2012), and David Harvey, A Brief History of Neoliberalism (2005).

chose to divest from hospitals, closing or privatizing public facilities. Meanwhile, private hospitals rushed to consolidate, undermining competition.

By the early 2000s, cities, counties, and public universities would have found few options in their search for partners to deliver healthcare services and academic medical research. Most markets had few competitors. In many instances, an economically successful religious institution was the obvious choice. Not infrequently, Catholic-affiliated healthcare systems—among the largest and longest-standing—enjoyed this position of market dominance.[136] The secular options often assumed by constitutional doctrine and political actors were no longer easily available.

A. Privatization and Austerity

Our story of the ascendance of neoliberalism begins approximately forty years ago. Post-World War II prosperity had come to a halt, replaced in the 1970s by economic maladies including runaway inflation. Medical costs experienced a particularly steep rise, prompting declarations of a healthcare crisis.[137] Meanwhile, political failures from Watergate to Vietnam punctured public confidence in government.[138]

Ronald Reagan's election as President harnessed this sense of disillusionment in political institutions. As Reagan famously quipped, "The nine most terrifying words in the English language are: I'm from the Government, and I'm here to help."[139] Rather than look to government, policies would depend on the rationality and efficiency of markets to solve the ills of the American economy.[140]

[136] Solomon et al., supra note 24, at 15–17 (describing growth in sole community Catholic hospitals and noting the large number of states where Catholic healthcare holds thirty percent or more of the hospital market).

[137] See Paul Starr, The Social Transformation of American Medicine 379–92 (1982); Simpson, supra note 7, at 122 ("[B]etween 1960 and 1980, national health expenditures rose from 5.0 to 8.9 percent of gross domestic product, while the cost for employers grew by 700 percent between 1970 and 1982.").

[138] See generally Kevin M. Kruse & Julian E. Zelizer, Fault Lines: A History of the United States Since 1974 (2019) (examining political, economic, and cultural divisions emerging in 1970s).

[139] News Conference, Reagan Quotes and Speeches: August 12, 1986, Ronald Reagan Presidential Found. & Inst., https://www.reaganfoundation.org/ronald-reagan/reagan-quotes-speeches/news-conference-1/ [https://perma.cc/VJ7T-SUNP] (last visited Nov. 18, 2022).

[140] See Grewal & Purdy, supra note 5, at 7; Corinne Blalock, Neoliberalism and the Crisis of Legal Theory, 77 Law & Contemp. Probs. 71, 88–89 (2014); see also John D. Donahue,

The conservative movement mobilized with the goals of privatizing public services and of bringing a business-like ethos to government. Wholesale abdication of social services proved impracticable, because despite their skepticism of government, Americans remained attached to the social services it provided.[141] So, governments instead moved to privatize public services on the prevailing assumption that private enterprise would lower costs.[142] Privatization took myriad forms: "load shedding," where government simply stopped providing the service; deregulating industry; allowing private organizations to compete for contracts to deliver services previously performed by public agencies; issuing vouchers to permit social service recipients to choose private instead of public providers; and selling government-owned assets.[143]

This preference for the private sector found a natural home in healthcare. As historian Rosemary Stevens explains, since the Civil War, American medicine has reflected a general expectation that "the role of government is necessary but should be limited to filling in gaps in medical care," primarily through funding.[144] For much of U.S. history, that gap-filling function belonged to cities and states, which subsidized private hospitals even as they operated public facilities.[145] With the passage of the Hill–Burton Act of 1946, the federal government began to play this role as well, funding the construction of one-third of all hospitals by

The Privatization Decision: Public Ends, Private Means 3 (1989) (describing the "renewed cultural enthusiasm for private enterprise"); Monica Prasad, The Politics of Free Markets: The Rise of Neoliberal Economic Policies in Britain, France, Germany, and the United States 55–60 (2006) (arguing that this focus on the market began under Reagan).

[141] See Jon D. Michaels, Constitutional Coup: Privatization's Threat to the American Republic 97 (2017).

[142] See Jamie Peck, Constructions of Neoliberal Reason 6–24 (2010) (discussing public-private partnerships as a neoliberal response to problems created by deregulation); see also Jody Freeman & Martha Minow, Introduction: Reframing the Outsourcing Debates, *in* Government by Contract: Outsourcing and American Democracy 1, 8 (Jody Freeman & Martha Minow eds., 2009) ("[T]he purported efficiencies of private service provision tend to be assumed . . . .").

[143] See Edna Wells Handy, Privatizing Municipal Hospitals: Crisis and Opportunity, 3 Kan. J.L. & Pub. Pol'y 119, 119 (1994).

[144] Rosemary Stevens, The Public-Private Health Care State: Essays on the History of American Health Care Policy 320 (2007).

[145] Id. at 53–77.

1975.[146] Medicare and Medicaid further cemented federal and state governments "as a consumer rather than supplier of health care."[147]

Even before politicians adopted neoliberal positions, public hospitals found themselves in a precarious fiscal position. Financing reforms initially expected to aid public hospitals—from the post-World War II expansion of private insurance to the 1965 enactment of Medicare and Medicaid—had produced the unintended consequence of sending the newly insured elderly and working class elsewhere.[148] Medicaid in particular resulted in state and local government health dollars being diverted to private hospitals, draining public institutions of resources to care for the uninsured.[149]

In the 1970s, local governments—which typically owned and operated public hospitals—became crunched for cash. White flight and a declining tax base took a punishing toll on local budgets,[150] even as cities and counties retained their traditional legal obligations of indigent care.[151] State deficits resulted in dumping responsibilities and debts on local governments—what Jamie Peck calls the "hallmark of austerity urbanism, US style."[152]

[146] See John Henning Schumann, A Bygone Era: When Bipartisanship Led to Health Care Transformation, NPR (Oct. 2, 2016, 6:00 AM), https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation [https://perma.cc/4T8W-LS47].

[147] Gabriel Winant, The Next Shift: The Fall of Industry and the Rise of Health Care in Rust Belt America 12 (2021).

[148] See Starr, supra note 137, at 387. See generally Jennifer Mittelstadt, From Welfare to Workfare: The Unintended Consequences of Liberal Reform, 1945–1965 (2005) (tracing the history and effects of postwar welfare reform).

[149] See Starr, supra note 137, at 387.

[150] See William Shonick, The Public Hospital and Its Local Ecology in the United States: Some Relationships Between the "Plight of the Public Hospital" and the "Plight of the Cities", 9 Int'l J. Health Servs. 359, 361 (1979); Thomas J. Sugrue, The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit 3–14 (1996). Rural hospitals, most of which were public, experienced similar pressures driven by population loss, although they moved more slowly to privatize. Phyllis E. Bernard, Privatization of Rural Public Hospitals: Implications for Access and Indigent Care, 47 Mercer L. Rev. 991, 1013–14 (1996).

[151] See, e.g., Daniel R. Berg, A History of Health Care for the Indigent in St. Louis: 1904–2001, 48 St. Louis U. L.J. 191, 191 (2003) (citing city charter requiring indigent care); Shaun Ossei-Owusu, The State Giveth and Taketh Away: Race, Class, and Urban Hospital Closings, 92 Chi.-Kent L. Rev. 1037, 1043–44 (2017) (noting state legal obligation on counties to provide indigent care).

[152] Jamie Peck, Austerity Urbanism: American Cities Under Extreme Economy, 16 City 626, 650 (2012); see also Kim Phillips-Fein, Fear City: New York's Fiscal Crisis and the Rise of Austerity Politics 5–8 (2017) (arguing that the transformation of New York City from a

The application of market rationality put public hospitals at a significant disadvantage. Unlike their private sector counterparts, these hospitals delivered a great deal of indigent and uncompensated care,[153] with half their patients on Medicaid or uninsured.[154] And when recession hit in the early 1980s, the number of uninsured people began to grow—a trend that would continue as manufacturing and union jobs were replaced by service industry positions unlikely to offer health insurance.[155] States tightened Medicaid eligibility requirements; from 1975 to 1986 the proportion of low income persons covered by Medicaid fell from sixty-three percent to thirty-eight percent.[156] With healthcare costs rising ever upward, the widely recognized "plight of the public hospital"[157] seemed to provide further proof of government inefficiency.

Private hospitals, by contrast, could embrace the ideal of competition unencumbered by equivalent responsibilities. From the 1980s onward, non-profit hospitals enthusiastically adopted a new model inspired by the for-profit sector that made financial considerations the "primary driver of change."[158] One cause of this shift was the transition from passive fee-for-service health insurance to active managed care, which pushed hospitals to reduce costs and join systems with greater resources.[159] Managed care would be picky about providers.

Private hospitals also began to consolidate dramatically. Driven to protect capital, these hospitals pursued an "urge to merge" that drew on

postwar "island of social democracy" to a neoliberal city was not inevitable but the result of contested political decisions in favor of austerity).

[153] See Ron J. Anderson, Paul J. Boumbulian & S. Sue Pickens, The Role of U.S. Public Hospitals in Urban Health, 79 Acad. Med. 1162, 1163–64 (2004); see also Randall R. Bovbjerg & William G. Kopit, Coverage and Care for the Medically Indigent: Public and Private Options, 19 Ind. L. Rev. 857, 866 (1986) (reporting that in 1986 "[p]ublic hospitals provide[d] a vastly disproportionate amount of uncompensated care (40.1% of uncompensated charges, double their 19.0% share of total charges), as do major teaching hospitals").

[154] See Mike King, A Spirit of Charity: Restoring the Bond Between America and Its Public Hospitals 26 (2016).

[155] See Bovbjerg & Kopit, supra note 153, at 861–62; Jerome P. Kassirer, Our Ailing Public Hospitals: Cure Them or Close Them?, 333 New Eng. J. Med. 1348, 1349 (1995) (observing that the number of uninsured Americans then stood at forty-one million and was increasing by 100,000 per month).

[156] Barry R. Furrow, Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients, 3 Health Matrix 31, 31 (1993).

[157] For early recognition, see, for example, Symposium, The Plight of the Public Hospital, 44 J. Am. Hosp. Ass'n 40, 40–92 (1970).

[158] Simpson, supra note 7, at 120–21.

[159] See Stevens, supra note 144, at 324.

"prevailing beliefs about managerial and competitive advantage in the market."[160] Through economies of scale, hospital systems, it was thought, would bring down costs and improve quality.[161] The Reagan administration effectively issued "an invitation to [corporate America] to merge with anyone"—setting off a long cycle of permissive antitrust enforcement and market consolidation.[162]

Cost-cutting initiatives in private hospitals put pressure on their public competitors in two ways. First, private hospitals strategically eliminated and reduced unprofitable service lines.[163] These services then fell to public hospitals, increasing their costs and disadvantaging them in competition for managed care contracts. Second, cost pressures increased patient dumping, whereby private hospitals sent poor, uninsured, or medically demanding patients to public hospitals. This practice both cut costs from private hospitals' budgets and saddled their competitor public hospitals with new burdens.[164] Passage of the Emergency Medical Treatment and Labor Act in 1986 ("EMTALA"), which requires all emergency rooms to screen patients, aimed to prevent this practice.[165] But in response, some private hospitals pulled out of local trauma networks or closed their emergency rooms, leaving public facilities to treat emergency cases and the uninsured.[166]

Commitments to efficiency and preference for nongovernmental actors then called for divestment from public hospitals. In the early 1980s, one healthcare executive explained that, "Where historically government officials felt it was improper to sell their hospitals, many now feel that it's

[160] Id. at 329–30.

[161] See Simpson, supra note 7, at 123–24.

[162] Sandeep Vaheesan, Merger Policy for a Fair Economy, LPE Blog (Apr. 5, 2022), https://lpeproject.org/blog/merger-policy-for-a-fair-economy/ [https://perma.cc/YK2N-HEB8].

[163] See Michael S. Jacobs, When Antitrust Fails: Public Health, Public Hospitals, and Public Values, 71 Wash. L. Rev. 899, 902 (1996).

[164] See Lewis R. Goldfrank, The Public Hospital, 24 Fordham Urb. L.J. 703, 708–09 (1997).

[165] See Robert L. Schiff & David Ansell, Federal Anti-Patient-Dumping Provisions: The First Decade, 28 Annals Emergency Med. 77, 77 (1996) (discussing the history of EMTALA's enactment and enforcement); Sara Rosenbaum, Lara Cartwright-Smith, Joel Hirsh & Philip S. Mehler, Case Studies at Denver Health: "Patient Dumping" in the Emergency Department Despite EMTALA, The Law that Banned It, 31 Health Affs. 1749, 1749 (2012) (showing continuation of the problem).

[166] See Ossei-Owusu, supra note 151, at 1046–47 (describing this phenomenon and that the public hospitals in Los Angeles provided 55.5% of uncompensated care after EMTALA).

inappropriate for government to be in the business of operating them."[167] In the 1990s, large operating deficits led even more cities and counties to close, sell, or substantially reduce the services of their public hospitals.[168] Today, approximately half of the nearly 1,800 public hospitals open in the 1980s have privatized or closed their doors.[169] These closures disproportionately impacted people of color, stripping entire communities of healthcare services and jobs.[170]

Various degrees of privatization also crept into those public facilities that remained open. Special agencies or health authorities, created by statute, often were granted formal ownership, separating the hospital from city government but empowering it to issue bonds or engage in other governmental acts.[171] The aim was to avoid the perceived ills of civil service protections for workers and government processes of procurement.[172] Today, most public hospitals adopt this quasi-governmental form.[173] Another form of privatization involved turning

[167] Starr, supra note 137, at 435. There were, of course, some public hospital closures that predate this trend, which tended to prompt community opposition. See Jeffrey A. Alexander & Thomas G. Rundall, Public Hospitals Under Contract Management: An Assessment of Operating Performance, 23 Med. Care 209, 210 (1985); Dan Ermann & Remy Aronoff, A Study of Central-City Hospital Changes, 18 Med. Care 745, 752–53 (1980).

[168] See, e.g., Kevin Sack, Hard Cases at the Hospital Door, N.Y. Times, Sept. 17, 1995, at E5; Randall R. Bovbjerg, Jill A. Marsteller & Frank C. Ullman, The Urban Inst., Health Care for the Poor and Uninsured After a Public Hospital's Closure or Conversion 9–10 (2000), https://www.urban.org/sites/default/files/publication/62266/309647-Health-Care-for-the-Poor-and-Uninsured-After-a-Public-Hospital-s-Closure-or-Conversion.PDF [https://perma.cc/58HY-R9QM].

[169] Fast Facts on U.S. Hospitals, 2021, Am. Hosp. Ass'n, https://www.aha.org/system/files/media/file/2021/01/Fast-Facts-2021-table-FY19-data-14jan21.pdf [https://perma.cc/KX5A-5JBY] (last visited Feb. 4, 2022); see also Am. Hosp. Ass'n, Hospital Statistics: The AHA Profile of United States Hospitals 7 (1994) (showing downward trend from the 1980s).

[170] See Brietta R. Clark, Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare, 9 DePaul J. Health Care L. 1023, 1028–29, 1031 (2005); Aumoithe, supra note 6, at 1–2, 4. Studies of rural hospitals showed that, once privatized, hospitals were far more likely to close permanently. Bernard, supra note 150, at 997–98.

[171] See Handy, supra note 143, at 122.

[172] See Berg, supra note 151, at 208–10 (discussing St. Louis public hospital taking this step); King, supra note 154, at 97 (noting transfer of Atlanta's Grady Hospital to a hospital authority with the hope of distancing it from city politics).

[173] See King, supra note 154, at 49.

over management of public hospitals to private for-profit or not-for-profit hospital systems.[174]

Outsourcing the day-to-day operation of hospitals transferred significant decision-making authority and vast public resources away from the government. Proponents often rationalized cutting back the public role with predictions that private actors would fill gaps in care for the indigent and uninsured.[175] Instead, private management typically cut services to achieve the efficiency that privatization promised.[176] And the poor suffered.

B. Public-Religious Partnerships

By the turn of the twenty-first century, commentators began to observe a "revolution" ushering in a new style of collaborative governance in public-private arrangements.[177] Private parties no longer merely executed the government's projects, but rather were beneficiaries of devolution in decision-making, even on fundamental questions of public interest.[178]

[174] See Shonick, supra note 150, at 360; Handy, supra note 143, at 122. Already by 1980, approximately ten percent of public hospitals contracted out their management services. Alexander & Rundall, supra note 167, at 210 (finding approximately 225 public hospitals managed under contract in 1980); Jack Needleman & Michelle Ko, The Declining Public Hospital Sector, *in* The Health Care "Safety Net" in a Post-Reform World 200, 201 (Mark A. Hall & Sara Rosenbaum eds., 2012) (finding 1,801 total public hospitals in the same year).

[175] See Armando Lara-Millán, Redistributing the Poor: Jails, Hospitals, and the Crisis of Law and Fiscal Austerity 120, 122, 127–28 (2021) (describing downsizing of Los Angeles public hospital based on an unfounded belief that contracts with private providers would deliver better care and noting county sent out 25,000 letters soliciting private providers but found no takers); Needleman & Ko, supra note 174, at 200 (discussing public hospitals' pressures from the 2008 financial crisis).

[176] See Alexander & Rundall, supra note 167, at 212 ("[R]educing the level of the public hospital's participation in these federal/state programs [Medicaid and other programs for the poor] may be a cost-cutting strategy commonly observed under contract management.").

[177] See Matthew Diller, The Revolution in Welfare Administration: Rules, Discretion, and Entrepreneurial Government, 75 N.Y.U. L. Rev. 1121, 1127 (2000). On the proliferation of public-private hybrids around 2000, see Jody Freeman, The Private Role in Public Governance, 75 N.Y.U. L. Rev. 543, 554–55 (2000), and Freeman & Minow, supra note 142, at 1–2.

[178] See Michaels, supra note 141, at 111 (referring to permitting private organizations to make sensitive discretionary policy decisions as "deep service contracting"). Public-private partnerships were not new but ceding the "public trust" was. See William J. Novak, Public-Private Governance: A Historical Introduction, *in* Government by Contract: Outsourcing and American Democracy, supra note 142, at 23, 25.

Critics sounded alarms about transparency, democracy, and accountability.[179]

The embrace of religious institutions became a distinctive feature of public-private initiatives in healthcare and beyond. During the Reagan administration, the Moral Majority forged "an enduring alliance between religious conservatives and free-market neoliberals."[180] In this period, governments began to expect religious organizations long involved in the welfare state "to *substitute* for services that were being eroded or starved of funding."[181] Privatization came to be defended in religious terms.[182] A turning point arrived with President Bill Clinton's welfare reform of 1996, itself a massive move toward privatization.[183] A provision known as Charitable Choice fostered the recruitment of deeply sectarian organizations to provide the social services that states owed the public.[184] And President George W. Bush expanded on these initiatives, creating for religious institutions an "infrastructure designed to entrench their position in the social services" like nothing before seen.[185]

As Martha Minow described in her book *Partners, Not Rivals*, the use of religious entities to achieve public ends became commonplace in the push to privatize.[186] Minow seemed optimistic about such government-religious partnerships, assuming compliance with conditions that would preserve public values of equality, pluralism, and democracy.[187] Others

[179] See, e.g., Diller, supra note 177, at 1127–28; Gillian E. Metzger, Privatization as Delegation, 103 Colum. L. Rev. 1367, 1373 (2003); Michele Estrin Gilman, Legal Accountability in an Era of Privatized Welfare, 89 Calif. L. Rev. 571, 596–97 (2001).

[180] Cooper, supra note 16, at 281; see also Jason Hackworth, Faith Based: Religious Neoliberalism and the Politics of Welfare in the United States 19–21 (2012) (exploring union of neoliberal and religiously conservative politics).

[181] Cooper, supra note 16, at 294; see also Hackworth, supra note 180, at 9 ("According to neoliberal thought, charities were 'crowded out' by the rise of the welfare state and would grow again . . . and represent an improved replacement if government were to reduce its profile . . . ."); Chiara Cordelli, Privatization Without Profit?, 60 NOMOS 113, 114–15 (2019) (describing nonprofits' participation in the drive to privatization).

[182] See Linda C. McClain, Unleashing or Harnessing "Armies of Compassion"?: Reflections on the Faith-Based Initiative, 39 Loy. U. Chi. L.J. 361, 367 (2008).

[183] Cooper, supra note 16, at 267.

[184] See Steven K. Green, "A Legacy of Discrimination"? The Rhetoric and Reality of the Faith-Based Initiative: Oregon as a Case Study, 84 Or. L. Rev. 725, 725–26 (2005) ("Charitable Choice was an important component of the movement to restructure, reduce, and privatize welfare . . . ." (internal quotation marks omitted)).

[185] Cooper, supra note 16, at 271.

[186] Martha Minow, Partners, Not Rivals: Privatization and the Public Good 6 (2002).

[187] Id. at 103–05.

were less sanguine.[188] David Saperstein, for example, argued that, for some key participants, the thrust of public-religious partnerships was "to undo the social welfare state per se or to erode the wall separating church and state."[189] Kathleen Sullivan warned of the risk that some faiths could "become entrenched and dangerous allies of government, emboldened to engage in sectarian dominance and oppression."[190]

Healthcare was no exception. Religious healthcare systems came to manage public hospitals. Others were granted leases and handed operation of public facilities. Some public-religious arrangements resulted from austerity and economic stress. For example, rural county health authorities turned over management to or merged with religious healthcare.[191] There, defunding the public sector played a leading role. In other cases, premier public academic medical centers sought to maintain or extend their market dominance through mergers and joint ventures with religious systems.[192]

Across the board, governments had few options for partnership by the early 2000s. No longer was it common to find the public hospitals that once served—and in some markets still do serve—as the locus of academic medicine, due to their shared focus on medically complex patient populations, specialized clinical care, and safety-net services.[193] Trends toward consolidation, which escalated with each passing decade,

[188] See, e.g., Alex J. Luchenitser, Casting Aside the Constitution: The Trend Toward Government Funding of Religious Social Service Providers, 35 Clearinghouse Rev. 615, 615 (2002) (foreseeing significant constitutional violations).

[189] David Saperstein, Public Accountability and Faith-Based Organizations: A Problem Best Avoided, 116 Harv. L. Rev. 1353, 1361–62 (2003).

[190] Kathleen M. Sullivan, The New Religion and the Constitution, 116 Harv. L. Rev. 1397, 1412–20 (2003).

[191] See, e.g., John Green, Centura Health Takes Over Operations at Ulysses Hospital; Grant County Retains Ownership, Hutchinson News (Feb. 6, 2016, 5:00 PM), https://www.hutchnews.com/story/news/local/2016/02/06/centura-health-takes-over-operations/21009688007/ [https://perma.cc/6A4W-KQGM] (reporting that under an affiliation between Grant County and Centura, the Catholic chain would take over operation of its hospital while maintaining county ownership).

[192] See, e.g., Off. of the Att'y Gen. of Ky., supra note 99, at 1 (noting goal of proposed merger "to capture cost savings").

[193] See Roosa Sofia Tikkanen et al., Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York City, 47 Int'l J. Health Servs. 460, 461 (2017) (noting that academic medical centers are often the largest hospitals); Atul Grover, Peter L. Slavin & Peters Willson, The Economics of Academic Medical Centers, 370 New Eng. J. Med. 2360, 2360 (2014) ("Historically, AMCs have provided 37% of all charity care and 26% of all Medicaid hospitalizations . . . .").

left nearly all cities with highly concentrated hospital markets.[194] This consolidation also weakened the power of healthcare workers, especially the physicians who had sometimes resisted application of religion (or market efficiency) to medicine in the past.[195] And it did so during a period that decimated unions.[196]

In the absence of public hospitals, religious healthcare systems were often one of few potential joint venturers, subjects of merger, and sites for education and training. Most commonly, the dominant potential partner was Catholic (in some markets, Baptist and Seventh Day Adventist systems hold similar economic power). Due to its integrated organization, Catholic healthcare systems had proved well positioned to consolidate market power.[197] Catholic hospitals merged with each other in the 1980s and many systems then moved aggressively in the 1990s merger wave.[198] They often received discounted prices from other religious nonprofits during this decade, allowing the creation of economies of scale at a reduced price.[199] And so, when public officials sought to privatize their

[194] By 2018, ninety-five percent of metropolitan statistical areas had highly concentrated hospital markets. King et al., supra note 14, at 6.

[195] For economic research into merger effects on labor, see Elena Prager & Matt Schmitt, Employer Consolidation and Wages: Evidence from Hospitals, 111 Am. Econ. Rev. 397, 398–99 (2021).

[196] For comprehensive histories of the decline of labor, see generally Melvyn Dubofsky & Joseph A. McCartin, Labor in America: A History (9th ed. 2017) (describing rise and fall of labor organizing and unions), and Nelson Lichtenstein, State of the Union: A Century of American Labor (rev. & expanded ed. 2013) (narrating the historical relationship between trade unions and the labor movement). In hospitals, newly organized healthcare workers often found common cause with other community members and patients. See Nancy Tomes, Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers 259–60 (2016).

[197] Allison Roberts, Selling Salvation: Catholic Hospitals in the Healthcare Marketplace, Canopy Forum (Dec. 19, 2019), https://canopyforum.org/2019/12/19/selling-salvation-catholic-hospitals-in-the-healthcare-marketplace-by-allison-roberts/ [https://perma.cc/PKZ4-ZFDS].

[198] See Kathleen M. Boozang, Deciding the Fate of Religious Hospitals in the Emerging Health Care Market, 31 Hous. L. Rev. 1429, 1434 (1995) ("Although the 1980s witnessed many mergers among Catholic facilities, the realities of the 1990s have necessitated the consolidation of Catholic with non-Catholic facilities."); Stevens, supra note 144, at 331. In the 1990s, 171 mergers (and many affiliations) took place between Catholic and non-Catholic hospitals. See Rachel Benson Gold, Hierarchy Crackdown Clouds Future of Sterilization, EC Provision at Catholic Hospitals, 5 Guttmacher Pol'y Rev. 11, 11 (2002).

[199] See Paul Gertler & Jennifer Kuan, Does It Matter Who Your Buyer Is? The Role of Nonprofit Mission in the Market for Corporate Control of Hospitals, 52 J.L. & Econ. 295, 302 (2009) (finding that "religious nonprofits discount only to religious buyers" with a discount of about forty-eight percent and interpreting "this differential discounting to mission, where,

own hospital services or build facilities for medical education, Catholic healthcare frequently was the only or most economically appealing option.

The government-religious hospitals formed in this landscape reflect and refract concerns about privatization, consolidation, and access that cut across healthcare. Like the broader trend toward privatization, the transfer of decision-making and resources to religious entities de-democratized public institutions. As in other public-private partnerships, outsourcing day-to-day hospital operations took significant decisions and resources away from the government. Public obligations of transparency, access, democratic involvement, reason-giving, and respect for constitutional rights may apply with little force to private partners.[200]

Government-religious hospitals are also symptomatic of, and likely contributors to, rising religious consolidation in the healthcare marketplace. Through mergers and contracts, more and more facilities have become subject to sectarian identity and limitations.[201] And the imposition of religious doctrine in government facilities further limits the availability of reproductive, LGBTQ, and end-of-life care.[202]

* * *

Ultimately, the legacy of neoliberalism drove and continues to drive religious-public collaborations. But as the next Part demonstrates, seemingly unrelated changes in constitutional doctrine cleared the path.

for example, a Catholic hospital selling to another Catholic hospital can be confident that abortions will not be performed").

[200] See Kimberly N. Brown, "We the People," Constitutional Accountability, and Outsourcing Government, 88 Ind. L.J. 1347, 1349 (2013) (discussing the lack of and need for constitutional accountability of private partners of the state). The involvement of a religious entity heightens these concerns. For example, the organizational documents of government-religious hospitals explicitly grant religious entities the power to make decisions about patient care and worker restrictions by reference not to common goals of healthcare access, but to sectarian doctrine. For sophisticated work on the accessibility of religious reasons, see Jonathan Quong, Liberalism Without Perfection 266–73 (2010).

[201] See Sepper, supra note 23, at 937–47 (describing how Catholic systems have extended religious restrictions in facilities that are secular or affiliated with other religions).

[202] To the extent that restrictions come into new hospitals, these arrangements decrease overall access. When these arrangements preserve existing restrictions, they reduce availability indirectly by permitting the former religious owner to restrict care elsewhere.

III. REVOLUTION IN ESTABLISHMENT CLAUSE DOCTRINE

For much of the twentieth century, government-religious hospitals would have run headlong into the Establishment Clause, as Section III.A explains. Government officials, community members, and courts would have taken them as an obvious affront to disestablishment values, entangling church with state and risking corruption of both. But as Section III.B shows, by the twenty-first century, major reversals by the Supreme Court had significantly eroded the Establishment Clause and endorsed ever-greater government involvement in religious pursuits. States looking to develop healthcare ventures found themselves in constitutionally unsettled space. As Section III.C argues, the institutions constructed in that space destabilize equal citizenship and religious freedom far more than the public-religious partnerships that the Supreme Court has recently blessed.

A. The Erstwhile Wall Between Church and State

The Establishment Clause is commonly thought to erect "a wall of separation between church and state" in Thomas Jefferson's famed phrasing.[203] When rights were incorporated against the states in the twentieth century, the Supreme Court invoked Jefferson's wall.[204] Separationism, the Court emphasized, meant that "[n]either a state nor the Federal Government c[ould], openly or secretly, participate in the affairs of any religious organizations or groups, and *vice versa*."[205] Under what ultimately became known as the *Lemon* test, courts would evaluate whether governmental acts had a legitimate secular purpose, had an impermissible primary effect of either advancing or inhibiting religion, or resulted in an excessive entanglement of government and religion.[206]

Separationist doctrine imposed a variety of constitutional constraints on government funding of religious entities. Courts were to consider four factors: the character of a religious institution, its use of funds, the risk of political divisiveness, and, most importantly for our purposes, the state's

[203] Letter from Thomas Jefferson to the Danbury Baptists, supra note 12, at 258.

[204] See, e.g., Everson v. Bd. of Educ., 330 U.S. 1, 16 (1947) (citing Reynolds v. United States, 98 U.S. 145, 164 (1878)).

[205] Id. Before *Everson*, legal contests were fought in the states. For research on the closest corollary to government-religious hospitals, see Sarah Barringer Gordon, "Free" Religion and "Captive" Schools: Protestants, Catholics, and Education, 1945–1965, 56 DePaul L. Rev. 1177, 1178 (2007) (discussing the founding of Catholic-public schools between wars).

[206] Lemon v. Kurtzman, 403 U.S. 602, 612–13 (1971).

relationship with the religious actor.[207] Deploying these factors, courts would probe the state's responsibility for—or authorship of—religious messages and acts.[208]

The first factor, the character of the institution, mattered because Establishment Clause doctrine entirely barred funding of sectarian institutions. Under tests developed mostly in disputes involving religious schools, courts looked to the organization's stated purpose, personnel, governing board, financial relationship with a church, inclusion of religion in its operations, and image in the community.[209] These characteristics distinguished sectarian institutions from religious entities with secular characteristics, which could permissibly receive funding.

From the 1950s to '70s, as state financing of religious hospitals faced Establishment Clause challenges, courts and litigants emphasized the secular nature of healthcare services. From this point of view, the government merely paid religious hospitals for their secular services to the public—a burden that the government might otherwise have to carry itself.[210] While this delegatory view of hospital financing had begun to fade,[211] courts into the mid-twentieth century continued to invoke religious hospitals' public service function to authorize state funding.[212] By contrast, sectarian social welfare or worship would be outside the constitutionally proper role of the state.

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[207] See, e.g., Roemer v. Bd. of Pub. Works, 426 U.S. 736, 762–66 (1976) (enumerating and elaborating these factors).

[208] See Ira C. Lupu & Robert W. Tuttle, Secular Government, Religious People 89 (2014).

[209] See, e.g., Horace Mann League v. Bd. of Pub. Works, 220 A.2d 51, 65–66 (Md. 1966) (distilling factors from Supreme Court doctrine); see also *Lemon*, 403 U.S. at 617–18 (noting sectarianism of an institution "under the general supervision" of a church official with "ultimate financial responsibility" for it, church-appointed administrators, religion "perva[ded]" in the institution, and employees followed a religious handbook).

[210] See Rosemary Stevens, "A Poor Sort of Memory": Voluntary Hospitals and Government before the Depression, 60 Milbank Mem'l Fund Q. 551, 555–56 (1982) (observing that charitable hospitals were considered more "public" than "private" in their functions and that their service to the public justified government subsidy).

[211] See id. at 569.

[212] See, e.g., Finan v. Mayor of Cumberland, 141 A. 269, 269–71 (Md. 1928) (holding that funding of a religious hospital was justified because it was "performing services to the community which were public in nature" and that the program was "accomplish[ing] public purposes indirectly by such means"); Truitt v. Bd. of Pub. Works, 221 A.2d 370, 386–87 (Md. 1966) (observing that religious hospitals are eligible for government loans "because they are, or will be, parts of the State's hospital resources"); see also Jonathan Levy, From Fiscal Triangle to Passing Through: Rise of the Nonprofit Corporation, *in* Corporations and American Democracy 216 (Naomi R. Lamoureux & William J. Novak eds., 2017) (noting that at mid-century, nonprofits were considered "institutions for carrying out public tasks").

It became fairly standard for courts to categorize hospitals not only as nonsectarian but also as "pervasively secular."[213] They saw the religious character of hospitals as a remnant of the past, rather than a reflection of ongoing practice.[214] For example, analogizing to Sunday closing laws then-recently upheld by the Supreme Court, the Maryland Supreme Court determined that although church-affiliated hospitals may once have been connected to religion, "the use of the hospitals as a conduit for the treatment of Maryland patients [was] devoid of religious connotation."[215] Hospitals likewise disclaimed or downplayed religious affinities.[216]

Across cases, a key indicator of non-sectarianism was a commitment to nondiscrimination in employment and patient care. For example, in upholding a state lease of a local hospital (then still under construction) to a religious order, one court warned that any future allegation that the religious lessor favored a particular sect, proselytized, or "operate[d] the hospital under a sectarian code of ethics" would be taken seriously.[217] Discrimination based on religious doctrine would signal sectarianism and bar state aid.

Closely related to questions of sectarian character were concerns about diversion of funds to religious uses—the second constitutional limitation of the time. Courts typically saw few opportunities for religious uses in hospitals, given their secular pursuits. Nevertheless, courts looked for explicit assurances in the underlying statutes and agreements that state dollars would not fund religious use.[218]

The prospect of political divisiveness, our third factor, could also doom programs. If funding outlays flowed primarily to religious institutions, it

[213] See, e.g., St. Elizabeth Cmty. Hosp. v. NLRB, 708 F.2d 1436, 1442 (9th Cir. 1983); see also Tressler Lutheran Home for Child. v. NLRB, 677 F.2d 302, 305 (3d Cir. 1982) (noting that in a church-affiliated nursing home, direct patient care predominated over "religious atmosphere" and no religious qualification was required of patients or employees).

[214] See, e.g., Comm'n v. Effron, 220 S.W.2d 836, 838 (Ky. 1949) (given the openness of the hospital, the state constitution would not bar aid "merely because it was originally founded by a certain denomination whose members now serve on its board of trustees").

[215] *Truitt*, 221 A.2d at 388 (citing McGowan v. Maryland, 366 U.S. 420, 445 (1961)).

[216] See, e.g., Christopher J. Kauffman, Ministry and Meaning: A Religious History of Catholic Health Care in the United States 104, 149, 151 (1995) (noting early examples of Catholic hospitals emphasizing secular service and non-sectarian identity).

[217] Lien v. City of Ketchikan, 383 P.2d 721, 724–25 (Alaska 1963).

[218] See, e.g., State ex rel. Wis. Health Facilities Auth. v. Lindner, 280 N.W.2d 773, 775–76 (Wis. 1979) (noting prohibition on religious use in lease and in statutory authority to convey after lease term); Hunt v. McNair, 413 U.S. 734, 744 (1973) ("[E]very lease agreement must contain a clause forbidding religious use . . . .").

would seem that the program's primary effect was to advance religion.[219] In challenging aid to religious hospitals, parties advanced this line of argument. But courts tended to conclude that hospital financing presented no such worries, as it was usually open to all non-profits in a marketplace with ample secular participation.[220]

While hospital financing could typically withstand inquiries into institutional character, funding use, and political division, its primary hurdle was the fourth factor of church-state entanglement. Throughout the twentieth century, the Supreme Court insisted that the Constitution barred a state from having "such an intimate relationship with religious authority that it appears either to be sponsoring or to be excessively interfering with that authority."[221] Its doctrine policed against "the interference of religious authorities with secular affairs and secular authorities in religious affairs."[222]

This relational question often turned on the form of state aid. Tax exemptions or one-off grants were unlikely to prove problematic. Indeed, courts saw tax exemption as putting distance between church and state, thereby "avoiding persistent and potentially frictional contact."[223] Likewise, "one-time, single-purpose" grants implied "no continuing financial relationships or dependencies, no annual audits, and no government analysis of an institution's expenditures."[224] Annual grants could survive scrutiny, but only if they involved occasional "quick and non-judgmental" audits.[225] The Court was particularly keen to avoid situations where a state authority would be "deeply involved in the day-to-day financial and policy decisions" of a religious institution.[226]

[219] Compare Roemer v. Bd. of Pub. Works, 426 U.S. 736, 765 (1976) (where more than two-thirds of recipients had no religious affiliation), with Comm. for Pub. Educ. v. Nyquist, 413 U.S. 756, 768 n.23 (1973) (where the supermajority of recipients was Catholic).

[220] See, e.g., *Lindner*, 280 N.W.2d at 776.

[221] *Roemer*, 426 U.S. at 747–48.

[222] Cammack v. Waihee, 932 F.2d 765, 780 (9th Cir. 1991); see also *Lindner*, 280 N.W.2d at 781 (noting "[t]he most difficult question" for a hospital leaseback construction financing mechanism was whether it involved impermissible church-state interaction).

[223] *Roemer*, 426 U.S. at 748 n.15 (citing Walz v. Tax Comm'n, 397 U.S. 664, 674–75 (1970)).

[224] Tilton v. Richardson, 403 U.S. 672, 688 (1971).

[225] *Roemer*, 426 U.S. at 764.

[226] Hunt v. McNair, 413 U.S. 734, 747 (1973).

Government "surveillance" and "controls" were important signals of impermissible entanglement.[227]

Public employees working in sectarian settings also risked hopelessly entangling church and state. In a series of (now-defunct) cases, the Court struck down state programs that enlisted public employees to deliver services in religious schools.[228] According to the Court, these programs created a "substantial risk" that public employees would "conform" to the religious environment.[229] Moreover, their presence formed a "graphic symbol of the 'concert or union or dependency' of church and state."[230]

Focusing on entanglement, courts usually, though not always, upheld government funding for religious hospitals. Cases involved two principal financing mechanisms: (1) low-interest construction loans or grants and (2) leases of publicly constructed hospital facilities to religious entities for operation and management.[231] The former category could be designed to avoid religious uses, require nondiscrimination, and offer something like a one-off grant with little monitoring or operational oversight. The latter proved trickier. Leases proposed a long-term relationship, but also tended to be arm's length with the state as lessor and payor and the religious organization as lessee and supplier of services.

Judicial review of these arrangements reflected emerging awareness of the inadequacies of existing facilities. The draft for World War II had revealed that thirty percent of young men were medically unfit for service—a wake-up call as to the dire state of American healthcare.[232] The federal government responded by devoting massive funding to states and localities to build hospitals and clinics.[233] Adjudicating Establishment Clause claims, courts typically confronted a governmental entity that had

[227] Lemon v. Kurtzman, 403 U.S 602, 616 (1971); see also 2 Kent Greenawalt, Religion and the Constitution 405–14 (2008) (discussing substantial limits on government funding for religious purposes).

[228] Sch. Dist. v. Ball, 473 U.S. 373, 388 (1985); Meek v. Pittenger, 421 U.S. 349, 350 (1975).

[229] *Ball*, 473 U.S. at 388.

[230] Id. at 391 (quoting Zorach v. Clauson, 343 U.S. 306, 312 (1952)).

[231] For examples in the first category, see *Finan v. City of Cumberland*, 141 A. 269, 270–71 (Md. 1928); *Truitt v. Board of Public Works*, 221 A.2d 370, 374, 391–92 (Md. 1966); and *Kentucky Building Commission v. Effron*, 220 S.W.2d 836, 837–39 (Ky. 1949). For examples in the second, see *Lien v. City of Ketchikan*, 383 P.2d 721, 722–23 (Alaska 1963), and *State ex rel. Wisconsin Health Facilities Authority v. Lindner*, 280 N.W.2d 773, 781–83 (Wis. 1979).

[232] See Marcus S. Goldstein, Physical Status of Men Examined Through Selective Service in World War II, 66 Pub. Health Rep. 587, 593 (1951).

[233] See Hill-Burton Act, 42 U.S.C. § 291 (2020).

leased a public hospital to a religious group as a last resort. In a repeated fact pattern, the government had constructed the facility, only to find itself in fiscal straits and unable to afford to run it.[234]

Driven by exigent healthcare needs and marketplace realities, courts often stretched and strained to avoid separationist concerns. For example, in upholding an act that offered low-interest loans for hospital construction, one state supreme court emphasized that the state could not attain its goals without the inclusion of church-affiliated hospitals, because they accounted for one out of six hospitals and admitted over one-fourth of patients.[235] The need for hospital facilities was "evident and immediate."[236] A plan that excluded religious hospitals—the court held—was inherently inefficient given the important place of those hospitals "in the State hospital structure."[237] Political economic concerns shaped Establishment Clause analysis.

Although the financing mechanisms and lease agreements of the twentieth century usually survived constitutional scrutiny, courts saw that they raised serious constitutional concerns and responded by installing guardrails against advancement of religion and entanglement of church and state. Bids to build more intimate partnerships between public and religious hospitals met with serious opposition, including objections from medical staff and community members.[238] But separationism's guardrails did not endure.

B. The Erosion of Separation

Starting in the mid-1980s, cracks began to appear in the separationist wall, as courts moved toward a more permissive stance on church-state

[234] See, e.g., *Effron*, 220 S.W.2d at 838 (noting statutes meant "to let the governments assume the burden of operating hospitals as a public service from the State to its citizens"); *Lien*, 383 P.2d at 724–25 (noting need to lease the hospital to the Sisters of St. Joseph of Newark to operate after funds ran out and voters approved).

[235] See *Truitt*, 221 A.2d at 387. St. Joseph, a government-religious hospital we describe in Part I, was constructed with this state funding. Id. at 386.

[236] Id. at 391.

[237] Id.; see also *Effron*, 220 S.W.2d at 838 ("Recognizing that these institutions were in existence and were being operated efficiently through their own boards, the Federal and State Governments have thought it more practical to aid them rather than to build new ones.").

[238] See, e.g., Simpson, supra note 7, at 33 (citing complaints from the 1950s onward that allowing medical staff from Baylor University, a Baptist medical school, to provide care at the public hospital violated church-state separation); id. at 129–30 (discussing proposed 1990s merger between public Hermann and Sisters of Charity Health System thwarted by Establishment Clause concerns, among others).

relations. By the first years of the twenty-first century, commentators agreed that the *Lemon* test was "essentially moribund."[239] Today, the Supreme Court no longer feels compelled to ask whether government action has a secular purpose or whether it advances or inhibits religion. Programs that funnel money primarily to religious institutions—once rejected as politically divisive—flourish. Just last year, the Court weakened the prohibition on religious uses of government monies.[240]

That the revolution in Establishment Clause doctrine coincided with the ascendance of austerity and privatization was no coincidence. By the 1970s, neoliberals and social conservatives had joined cause in a "realignment of American democracy."[241] The Reagan-Bush years saw "an assault on separationism in every respect: in its history, its doctrinal structure, and its core premises concerning the role of religion in public life."[242] Religious groups' access to public spaces, funds, and collaboration gained steam.

During this period, the Court began to emphasize the mechanisms of state funding rather than the character of the recipient institution. In *Mueller v. Allen*, for example, the Court said that a program channeling funds to religious schools through individual parents "reduced the Establishment Clause objections."[243] Similarly, in *Witters v. Washington Department of Services for the Blind*, the Court upheld a state subsidy for a student's ministerial training at a Christian college, likening it to state employees using their paychecks to support a church.[244] In both cases, the Court allowed state aid to go towards pervasively sectarian institutions

[239] Noah Feldman, From Liberty to Equality: The Transformation of the Establishment Clause, 90 Calif. L. Rev. 673, 693 (2002).

[240] Carson v. Makin, 142 S. Ct. 1987, 2002 (2022) (requiring the State of Maine to fund sectarian schools engaged in religious instruction equally to secular and non-sectarian religious schools on the ground that the Free Exercise Clause bans discrimination based on the religious use of state funds).

[241] Robert Self, All in the Family: The Realignment of American Democracy Since the 1960s, at 327, 368, 399 (2012); see also Darren E. Grem, The Blessings of Business: How Corporations Shaped Conservative Christianity 6–9 (2016) (discussing how conservative evangelicals adopted the neoliberal approach to big business, thereby redefining religious politics); Darren Dochuk, From Bible Belt to Sunbelt: Plain-Folk Religion, Grassroots Politics, and the Rise of Evangelical Conservatism, at xviii–xxi (2011).

[242] Ira C. Lupu, The Lingering Death of Separationism, 62 Geo. Wash. L. Rev. 230, 237 (1994); Steven K. Green, The Third Disestablishment: Church, State, and American Culture, 1940–1975, at 354–59 (2019) (discussing the ways in which separationism started falling apart and left the Court struggling over funding).

[243] 463 U.S. 388, 399 (1983).

[244] 474 U.S. 481, 486–87, 489 (1986).

once precluded from funding. In the Court's view, the "genuinely independent and private choices of aid recipients" cut off state responsibility.[245]

For a period of time, the political divisiveness inquiry still cabined governmental aid. The *Witters* Court, for example, insisted that most recipients would use the grants at secular schools.[246] Similarly, in *Bowen v. Kendrick*, the Court explained that one "relevant factor" in determining constitutional permissibility remained whether "the statute directs government aid to pervasively sectarian institutions."[247] To pass muster under the Establishment Clause, funding schemes had to benefit a "wide spectrum of public and private organizations."[248]

But in 2002, in *Zelman v. Simmons-Harris*, the Court jettisoned the requirement that state aid not primarily benefit religious institutions.[249] It upheld a school voucher program that, in practice, sent the overwhelming majority of resources to religious schools. In doing so, the Court replaced "no aid" with neutrality, permitting state funding for religious organizations on "neutral" terms.[250] Political division no longer concerned the Court.

By the early 2000s, the Supreme Court also questioned limits on direct aid based on the sectarian character of the recipient. Justice Thomas's plurality opinion in *Mitchell v. Helms*, for example, explicitly rejected inquiry into whether an institution is "pervasively sectarian."[251] It insisted that "the religious nature of a recipient should not matter to the constitutional analysis, so long as the recipient adequately furthers the government's secular purpose."[252] The risk of state funds being diverted to religious uses held no water.

[245] Id. at 487–88.
[246] Id. at 488.
[247] 487 U.S. 589, 610 (1988).
[248] Id.
[249] 536 U.S. 639, 652–53 (2002).
[250] Id. at 652; see also id. at 688–90 (Souter, J., dissenting) (discussing "no aid" rule).
[251] 530 U.S. 793, 827–29 (2000) (denying an as-applied challenge to a federal law that, in providing school materials, mostly benefited religious schools); see also Good News Club v. Milford Cent. Sch., 533 U.S. 98, 98–100 (2001) (holding that a school could not exclude a Christian organization from its limited public forum on the grounds that the organization intended to use it for religious purposes). In later decades, the Court confirmed this view, holding that a program could not exclude entities based on their religious status. See Espinoza v. Mont. Dep't of Revenue, 140 S. Ct. 2246, 2246 (2020).
[252] *Mitchell*, 530 U.S. at 827.

The Court moved steadily from reliance on the *Lemon* test to a series of inquiries that proved less restrictive of governmental religious support and expression.[253] For example, as it reversed the line of cases barring public employees from working in religious schools, the Court concluded that "administrative cooperation" between religion and state and potential "political divisiveness" were present in many government programs and did not suffice to show excessive entanglement.[254] In "a true turning point," as Ira Lupu puts it, the *Lynch v. Donnelly* Court "simply shoved *Lemon* aside" and gave its blessing to a city's display of the Christian nativity scene.[255] The Court went on to permit prayer in legislative sessions, Christian holiday displays in government buildings, and the erection of crosses and exhibition of the Ten Commandments on public land.[256] Rejecting concerns about denominational favoritism, advancement of religion, and entanglement, the Court developed a presumption of constitutionality for traditional practices of public religion. And so, the institutional boundaries that once kept state and religion distinct became blurry or even suspect.

C. The End of Secular Government?

These shifts in Establishment Clause doctrine paved the way for public-religious partnerships imbued with ever-thicker sectarian identity and characterized by co-religionist discrimination. The second Bush Administration took up *Zelman* with enthusiasm and promulgated agency rules to send state dollars indirectly to sectarian social services.[257] These

[253] See, e.g., Capitol Square Rev. & Advisory Bd. v. Pinette, 515 U.S. 753, 780 (1995) (O'Connor, J., concurring) (describing the endorsement test); Lee v. Weisman, 505 U.S. 577, 594–95 (1992) (describing the coercion test); id. at 632–33 (Scalia, J., dissenting) (describing the originalist history-and-tradition test).

[254] See Agostini v. Felton, 521 U.S. 203, 233–34 (1997) (citing Aguilar v. Felton, 473 U.S. 402, 413–14 (1985)).

[255] Lupu, supra note 242, at 239 (discussing Lynch v. Donnelly, 465 U.S. 668 (1984)).

[256] See Marsh v. Chambers, 463 U.S. 783, 786 (1983) (reversing a lower court's holding that opening the state legislature with prayer violated all three prongs of *Lemon* because historical practice of legislative prayer immunized it from constitutional challenge); *Pinette*, 515 U.S. at 769–70 (holding that erection of a Latin cross on state capitol grounds does not violate the Establishment Clause); Van Orden v. Perry, 545 U.S. 677, 691–92 (2005) (upholding display of Ten Commandments on state capitol grounds).

[257] See Ira C. Lupu & Robert W. Tuttle, The Faith-Based Initiative and the Constitution, 55 DePaul L. Rev. 1, 66–67 (2005); Jill Goldenziel, Administratively Quirky, Constitutionally Murky: The Bush Faith-Based Initiative, 8 N.Y.U. J. Legis. & Pub. Pol'y 359, 361–63 (2005).

initiatives included, or even favored, "faith-infused" programs with strong sectarian identities.[258]

A longstanding church-state settlement took as a given that governments bear obligations of nondiscrimination and openness, whereas religious entities have some leeway to discriminate.[259] As a result, religious entities could use religion as a criterion in hiring for leadership or pastoral positions, but public institutions could not.[260] These commitments were also reflected in state funding programs that insisted on equal treatment for all patients (or, more broadly, social service beneficiaries).[261] This market-wide détente preserved some degree of freedom to select among secular and religious options. Charitable Choice undermined this settlement by no longer requiring public-funded programs to hire people of any faith (or no faith at all) as a condition of government contract.[262] As Melinda Cooper notes, these public-religious partnerships "implicitly endorsed the notion—long championed by Christian litigators—that religious organizations alone should be untouched by antidiscrimination laws, an innovation whose full consequences are only now beginning to be felt."[263]

And yet the "conventional political economy story" continued to predict that constitutional doctrine would follow public opinion, allowing state aid, but not state endorsement, of religion.[264] Across the ideological spectrum, there remained widespread agreement that there needs to be

[258] McClain, supra note 182, at 379 (exploring Bush's many faith-based initiatives).

[259] See Greenawalt, supra note 227, at 353–60.

[260] See, e.g., Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-1(a) (2020) (authorizing religious organizations to discriminate "with respect to the employment of individuals of a particular religion to perform work connected with . . . its activities").

[261] E.g., Greenawalt, supra note 21, at 68 (describing "a present consensus" that "[w]hen receiving federal funding for programs, religious organizations should not discriminate on the basis of religion in admitting applicants" and "[p]otential recipients should be able to choose an alternative secular provider").

[262] It prompted heated debate over whether the state could or should directly fund entities that discriminate. Compare Steven K. Green, Religious Discrimination, Public Funding, and Constitutional Values, 30 Hastings Const. L.Q. 1, 7–8 (2002) (recounting public and governmental debates about the legitimacy of funding sectarian entities that wished to discriminate in employment), with Carl H. Esbeck, Stanley W. Carlson-Theis & Ronald J. Sider, The Freedom of Faith-Based Organizations to Staff on a Religious Basis 10–12 (2004) (defending religious discrimination in hiring by government contractors).

[263] Cooper, supra note 16, at 267.

[264] See Richard Schragger & Micah Schwartzman, Religious Antiliberalism and the First Amendment, 104 Minn. L. Rev. 1341, 1349 (2020) (citing John C. Jeffries, Jr. & James E. Ryan, A Political History of the Establishment Clause, 100 Mich. L. Rev. 279, 282–83 (2001)).

some sphere of publicness that is not dominated by religious authority. Public, secular, and religious options were expected to continue to exist and compete, so that religious pluralism would flourish.[265] No one anticipated government-religious institutions.

In its search for hospital partners, however, governments discovered religious entities who increasingly disavowed their secular character and commitments to nondiscrimination. Consider Mercy Medical Center—a wholly controlled subsidiary of Trinity Health Michigan, the Catholic joint venturer of the University of Michigan. Adjudicating a claim of religious discrimination against Mercy, a federal district court described the hospital as follows: "Mercy's mission is to continue the healing ministry of the Catholic Church" through every facet of healthcare from its mission to "care for the sick, injured and disabled" to its "conduct [of] medically related research."[266] In the court's view, the Church's mission infused the hospital's ownership, operation, and employment practices and authorized discrimination.[267] This distinctly sectarian image of a modern hospital stands in stark contrast to the ecumenical account of hospitals in twentieth-century Establishment Clause cases.

Nor was this sectarian turn exceptional. Enormous healthcare systems, encompassing both religious and nonreligious hospitals, have converted employee pensions into "church plans" exempt from federal protections and then have defunded them.[268] Catholic hospitals have argued that their relationship with physicians is akin to that between churches and ministers and have asserted a constitutional right to fire medical staff for

[265] See, e.g., John J. DiIulio, Jr., Government by Proxy: A Faithful Overview, 116 Harv. L. Rev. 1271, 1278–82 (2003) (defending public-religious partnerships against antiestablishment criticisms); Christopher W. Eisgruber & Lawrence G. Sager, Religious Freedom and the Constitution 203 (2007) ("[W]hen electing to spend public resources or to receive public benefits, citizens must enjoy a meaningful secular alternative to available religious options.").

[266] Saeemodarae v. Mercy Health Servs., 456 F. Supp. 2d 1021, 1027 (N.D. Iowa 2006).

[267] Id. at 1036–38 (concluding that Mercy qualified as a religious organization and was thus entitled to an exemption from antidiscrimination law).

[268] See Rebecca Miller, God's (Pension) Plan: ERISA Church Plan Litigation in the Aftermath of Advocate Health Care Network v. Stapleton, Emp. Benefits Comm. Newsl. (ABA) Winter 2021, at 2, 5, 7.

any reason.[269] With some success, religious hospitals have insisted on a right to discriminate against women and LGBTQ patients.[270]

Even as compared to the controversial public-religious partnerships of Charitable Choice, however, government-religious hospitals dramatically escalate threats to disestablishment values of equal citizenship and religious freedom. At least in some instances, the state assumes a religious identity and the religious entity becomes a government functionary—the textbook definition of religious establishment. Even the looser collaborations and affiliations we describe put church and state in much closer proximity than in cases the Supreme Court has seen before. Merging, joint venturing, and contracting with religious healthcare, governments bind church and state together in active and ongoing cooperation. There is a sort of "intimate continuing relationship or dependency" that the Supreme Court repeatedly identified as the hallmark of unconstitutional entanglement.[271]

Government-religious institutions, moreover, directly involve the state in discrimination against employees and patients. The state explicitly commits to the application of religious teachings. And so, government employees are bound to treat patients differently based on religious doctrine, subject to interpretation by leaders of specific faiths. Litigation against the University of Maryland Medical System illustrates the point. There, Jesse Hammons, a transgender man, alleges that in 2020, the chief medical officer canceled a hysterectomy, because "according to University of Maryland St. Joseph Medical Center's religious beliefs, Mr. Hammons's gender dysphoria did not qualify as a sufficient medical reason to authorize the procedure" and the procedure would violate the

[269] See Order on Defendants' Motion for Judgment on the Pleadings at 2–4, 13–14, Morris v. Centura Health Corp., 2020 WL 6120134 (D. Colo. Sept. 30, 2020) (No. 2019 CV 31980) (discussing defendant's claim that religious autonomy precludes judicial review of religious hospital's firing a doctor for providing state-approved aid-in-dying to a patient with advanced-stage cancer).

[270] See, e.g., Franciscan All. v. Becerra, 553 F. Supp. 3d 361, 365–66, 376–77 (N.D. Tex. 2021) (holding that objecting religious hospitals cannot be required to perform and provide insurance coverage for gender-transition procedures and abortions but must be exempted from antidiscrimination law under the Religious Freedom Restoration Act); Religious Sisters of Mercy v. Azar, 513 F. Supp. 3d 1113, 1132, 1149 (D.N.D. 2021), *judgment entered sub nom.* Religious Sisters of Mercy v. Cochran, No. 3:16-cv-00386, 2021 WL 1574628, at *1 (D.N.D. Feb. 19, 2021) (same).

[271] See Hunt v. McNair, 413 U.S. 734, 746, 754 (1973); Tilton v. Richardson, 403 U.S. 672, 688 (1971).

hospital's avowed religious beliefs.[272] The state's medical system—a state actor, according to the district court—asserted religious reasons to deny care.[273] Members of other religions receive a message from government institutions that they are outsiders and not full and equal members of the political community.[274]

This joinder of the state in a religious mission strikes at the heart of the requirements of neutrality and equal treatment. The state both prefers a particular sect—adopting its teachings, mission, and message as true—and coerces its employees and patients to accept and conform to religious teachings that they likely do not share. The religious entity for its part shoulders state authority and obligations, for example, to identify and meet public health needs. In the law and religion field, some would bemoan the corrosive effects of religion on government. Others would see the state's involvement as a serious threat to religious autonomy. What is clear is that one need not be a strict separationist to draw the line at a state institution that proclaims a denominational identity, imposes religious tests, and uses religious reasons to exert power over people, often when they are at their most vulnerable.

* * *

In less than forty years, Establishment Clause doctrine moved from impeding to welcoming public-sectarian partnerships. The government-religious institutions we describe were spurred on by the erosion of Establishment Clause constraints, but they go well beyond the funding and cooperative arrangements that previously survived court review. Today, they imperil religious freedom and equal standing before the state.

IV. THE PROMISE OF POLITICAL ECONOMIC REFORMS

As this Article makes clear, we are at an inflection point for religion law and healthcare. Large majorities of Americans support the nation's fundamental commitment to separation of church and state.[275] And when

[272] See Hammons v. Univ. of Md. Med. Sys., 551 F. Supp. 3d 567, 574 (D. Md. 2021).

[273] Id. at 571–72.

[274] For this formulation of religious endorsement, see *Lynch v. Donnelly*, 465 U.S. 668, 688 (1984) (O'Connor, J., concurring). On the value of equal citizenship, see Lawrence G. Sager & Nelson Tebbe, The Reality Principle, 34 Const. Comment. 171, 171, 174 (2019); Nelson Tebbe, Religious Freedom in an Egalitarian Age 72–73, 78–79 (2017); and Eisgruber & Sager, supra note 265, at 52–56.

[275] See In U.S., Far More Support Than Oppose Separation of Church and State, Pew Rsch. Ctr. (Oct. 28, 2021), https://www.pewforum.org/2021/10/28/in-u-s-far-more-support-than-oppose-separation-of-church-and-state/ [https://perma.cc/HKP6-TWEY].

people seek care at hospitals, they anticipate a full array of professional medical care free of religious imposition.[276] Yet government-religious hospitals aggregate state authority, economic power, and religious dominance. In doing so, they pose a serious threat to religious freedom and equal citizenship.

Explaining the origins of these striking institutions required analysis of transformations in religion law and political economy. The larger project of law and political economy, however, also aims to be constructive. In this Part, we highlight several strategies, some more controversial than others, that might move us from religious domination toward pluralism and from religious preferentialism toward equality.

We set aside the pursuit of constitutional litigation through the courts. Claims under the Religion Clauses still might avert or undo some aspects of the church-state mergers, notwithstanding the precipitous erosion of Establishment Clause doctrine.[277] Government-owned and -operated religious institutions might be a bridge too far toward establishment even for this Supreme Court. And patients deprived of care, providers blocked from delivering services, and managers governed by religious doctrine could mount free exercise arguments as well. Such litigation could spark

[276] Patients expect unrestricted care even at religious hospitals. Debra Stulberg, Maryam Guiahi, Luciana E. Hebert & Lori R. Freedman, Women's Expectation of Receiving Reproductive Health Care at Catholic and Non-Catholic Hospitals, 51 Persp. Sexual Reprod. Health 135, 139–40 (2019).

[277] In future work, we plan to identify legal arguments to challenge mergers of church and state. Conservative courts might still be persuaded by evidence of entanglement, where a religious enterprise is administered by the state, out of concern not for political divisiveness but for religious institutional autonomy. See Stephanie H. Barclay, Untangling Entanglement, 97 Wash. U. L. Rev. 1701, 1722, 1727 (2020) (arguing that entanglement jurisprudence ought to remain good law in the context of protecting religious groups from government interference with autonomy, internal affairs, and administration). The originalist approach favored by some members of the Court could bolster Establishment Clause challenges to specific practices of the hospitals we describe. See Michael W. McConnell, Establishment and Disestablishment at the Founding, Part I: Establishment of Religion, 44 Wm. & Mary L. Rev. 2105, 2108–10 (2003) (setting forth examples of disestablishment at the founding, some of which closely relate to facets of the institutions we describe). For example, the reservation of public hospital board positions to certain sects might be analogized to religious tests for public office. See Torcaso v. Watkins, 367 U.S. 488, 496 (1961) (invalidating a state law requirement that notary publics affirm a belief in God). But see Caroline Mala Corbin, Opportunistic Originalism and the Establishment Clause, 54 Wake Forest L. Rev. 617, 619–20 (2019) (noting the Court's selective use of originalism in Establishment Clause opinions).

and support social movements in favor of religious pluralism and non-domination.[278]

But we would be naïve to think that the courts will comprehensively remedy the contemporary merger of government and religion. The federal courts' conservative trajectory is cemented for a generation. Even bracketing current political realities, in general, courts' institutional conservatism makes them unlikely catalysts of a more democratic political economy.[279]

Forestalling or undoing church-state mergers will instead require tackling consolidation, privatization, and religionization of the economy. Recent political economy scholarship proposes various strategies—antitrust enforcement, public options, and public utility regulation—to rebalance power within the economy.[280] This Part identifies how these tools could mitigate and prevent the harms of church-state fusion in hospital markets.

A. Antitrust

The first strategy would harness competition to counter religious domination. Governments seeking hospital partners for joint ventures or medical education currently have few choices. American healthcare markets have never been less competitive.[281] Over ninety percent of hospital markets are highly concentrated—and they are becoming more consolidated.[282] Frequently, Catholic healthcare mega-systems with extensive religious restrictions hold the dominant economic position.

[278] See Douglas NeJaime & Reva Siegel, Answering the *Lochner* Objection: Substantive Due Process and the Role of Courts in a Democracy, 96 N.Y.U. L. Rev. 1902, 1908 (2021) (exploring how constitutional litigation can serve as a catalyst for democratic reforms). But see Samuel Moyn, The Court Is Not Your Friend, Dissent Mag. (Winter 2020), https://www.dissentmagazine.org/article/the-court-is-not-your-friend [https://perma.cc/FB3A-KGSJ] (arguing that progressives should pursue wins through democratic processes rather than the courts).

[279] See, e.g., Joseph Fishkin & William E. Forbath, The Anti-Oligarchy Constitution: Reconstructing the Economic Foundations of American Democracy 2–3 (2022) (exploring how Americans for much of history saw constitutional issues as decided, not primarily through the courts, but through political economic struggles); see also Robert M. Cover, Justice Accused: Antislavery and the Judicial Process 259 (1975) ("If a man makes a good priest, we may be quite sure he will not be a great prophet.").

[280] On progressive ideas of social control over the economy, see William J. Novak, Institutional Economics and the Progressive Movement for the Social Control of American Business, 93 Bus. Hist. Rev. 665, 668, 671–75 (2019).

[281] See King et al., supra note 14, at 4.

[282] Id. at 6.

Sometimes, the government-religious hospital itself may exercise monopoly power.

Antitrust law offers a mechanism to mitigate this threat. Most straightforwardly, more competition would mean more choices for state healthcare partners and wider options for patients and providers. Rigorous pre-merger review of hospital transactions by federal and state regulators could help preserve competition.[283] This prophylactic antitrust enforcement would indirectly generate some measure of religious pluralism, ensure availability of necessary health services, and safeguard some secular (if not governmental) options.

Many states have some authority to approve or block healthcare transactions, although this power varies widely. Based on the state attorney general's duty to protect charitable assets, a state typically must receive notice of transactions involving nonprofit hospitals—a category into which nearly sixty percent of hospitals fall.[284] California's charitable trust law, for example, requires the AG's consent for any sale or transfer of a healthcare facility owned or operated by a nonprofit corporation and permits them to set conditions on approval.[285] In 2021, California, Florida, and Indiana considered pre-merger clearance laws that would require consent from the state attorney general for the consummation of most healthcare deals, avoiding the expense of litigating to block mergers.[286] And Oregon recently passed the ambitious Equal Access to

[283] Large transactions above a certain threshold are subject to mandatory notice and review by the U.S. Department of Justice and Federal Trade Commission. See Hart-Scott-Rodino Act, 15 U.S.C. § 18a(a) (2020).

[284] See State Health Facts: Hospitals by Ownership Type, Kaiser Fam. Found. (2020), https://www.kff.org/other/state-indicator/hospitals-by-ownership/?currentTimeframe=0&selectedDistributions=statelocal-government--non-profit--for-profit--total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/L7CY-VANR].

[285] Health Care Consolidation and Contracting Fairness Act of 2022, Cal. Health & Safety Code § 1255.4(b)–(d) (2022), https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220AB208# [https://perma.cc/UF3T-J5TU].

[286] Samantha Liss, 4 Healthcare Antitrust Issues to Watch, Healthcare Dive (Mar. 1, 2021), https://www.healthcaredive.com/news/4-healthcare-antitrust-issues-to-watch/595693/ [https://perma.cc/ZWZ5-XASD] (last visited Sep. 15, 2022) (predicting trend will continue). Both Oregon and Nevada passed bills to expand review. See Alexandra D. Montague, Katherine L. Gudisken & Jaime S. King, Issue Brief: State Action to Oversee Consolidation of Health Care Providers, Milbank Memorial Fund 3 (Aug. 2021), https://www.milbank.org/wp-content/uploads/2021/08/State-Action-to-Oversee-Consolidation_ib_V3.pdf [https://perma.cc/VYE9-PFBY]. These bills permit the AG to block mergers and acquisitions without having to expend the significant time and resources in litigating. See Health Care Consolidation and Contracting Fairness Act of 2022, Cal. Health & Safety Code § 1255.4(b)–(d) (2022),

Care Act, which represents a major effort to reduce hospital consolidation and its negative effects.[287] Hospitals in the state must show that any proposed material transaction will reduce rising patient costs, increase access in medically underserved areas, or improve health outcomes. Deals that affect essential services, including reproductive and maternal healthcare, trigger an in-depth review before a board that includes residents and consumer advocates.[288]

Beyond generally improving competition, antitrust review might block specific agreements between governments and their would-be religious healthcare partners. Typically, antitrust laws apply to transactions with government health institutions as they do to the anti-competitive conduct of private parties.[289] Some proposed government-religious hospitals raise run-of-the-mill antitrust concerns of increased market power and reduced price competition.[290] For example, when the University of Arkansas and St. Vincent's considered merging, St. Vincent's CEO announced that the combined entity would soon become one of two or three remaining healthcare systems in the entire state.[291] Such admissions should set off alarm bells for antitrust enforcers.

And across the government-religious hospitals we describe, consumer welfare suffers where consolidation with a religious healthcare facility or

https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220AB2080# [https://perma.cc/B4VJ-PCZX].

[287] H.B. 2362, 81st Leg. Assemb., Reg. Sess. (Or. 2021). For analysis, see Amy Littlefield, Oregon Will Protect Reproductive Health Care When Hospitals Merge, The Nation (July 19, 2021), https://www.thenation.com/article/society/oregon-catholic-hospitals/ [https://perma.cc/5MGW-BHR5].

[288] H.B. 2362, 81st Leg. Assemb., Reg. Sess. § 2(11)(a) (Or. 2021), https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2362/Introduced [https://perma.cc/ATW4-4EY5].

[289] State action doctrine protects against federal antitrust challenge only when the anticompetitive conduct of private entities is clearly contemplated and actively supervised by the state with a "clear articulation" of an intent to displace competition. See Fed. Trade Comm'n v. Phoebe Putney Health Sys., Inc., 568 U.S. 216, 220, 226 (2013) (unanimously holding that public hospitals could be subject to the same antitrust scrutiny as private corporations).

[290] See U.S. Dep't of Just. & Fed. Trade Comm'n, Horizonal Merger Guidelines 2 (Aug. 19, 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf [https://perma.cc/3UNW-3N4R] (defining a merger that increases market power as one that "raise[s] price, reduce[s] output, diminish[es] innovation, or otherwise harm[s] customers as a result of diminished competitive constraints or incentives").

[291] See Mark Friedman, St. Vincent, UAMS Talking Partnership, Ark. Bus. (Sept. 3, 2012, 12:00 AM), https://www.arkansasbusiness.com/article/86596/st-vincent-uams-talking-partnership [https://perma.cc/HU86-3ESQ].

system results in reduction or termination of secular services. In a traditional anti-competitive scenario, consumers are harmed when two entities that used to compete no longer do so, but instead provide the service—say, fertility treatments—through a single organization at higher cost or lower quality. By contrast, religious market domination means that some services become unavailable. Where a secular entity newly becomes subject to restrictions on care, the service line is discontinued. When a government buyer takes over a formerly religious hospital, it instead agrees to maintain restrictions and not to initiate competition for services that a public entity otherwise would be expected to provide.[292] This loss of a service can be a marker of anti-competitive effects in that the combination of two entities has driven out competitors.[293]

To avoid reduction in services sought by a religiously plural public, states could condition hospital transactions on maintaining vital secular care. In mergers between Catholic and secular hospitals, for example, state officials have required that secular hospitals continue delivering HIV- and reproductive-related services.[294] More recently, the California Attorney General conditioned the merger of Catholic and non-Catholic hospitals into healthcare mega-system Common Spirit Health on maintaining reproductive healthcare at pre-transaction levels for ten years.[295] More systematically, California law now prohibits hospitals from maintaining restrictions on treatments after the sale of a hospital.[296] In Washington state, where forty-one percent of hospitals are Catholic,

[292] In many states, public hospitals also limit access to abortion, a practice the Supreme Court upheld in *Doe v. Bolton*, 410 U.S. 179, 201 (1973), but they have offered therapeutic abortions, tubal ligations, contraception, and emergency contraception.

[293] 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, 27–28 (2001); see also Caitlin M. Durand, Who Blesses This Merger? Antitrust's Role in Maintaining Access to Reproductive Health Care in the Wake of Catholic Hospital Mergers, 61 B.C. L. Rev. 2595, 2636–38 (2020) (providing a more recent review). Reduction in availability of multiple service lines—reproductive, end-of-life, and LGBTQ-affirming care—makes the case for unilateral market power even more compelling. See Appelbaum & Morrison, supra note 293, at 27.

[294] See Appelbaum & Morrison, supra note 293, at 30 (noting Montana's approval of a merger conditioned on deeding a building to Planned Parenthood to fund expenses of abortion patients who had to travel outside of the geographic market).

[295] Durand, supra note 293, at 2641.

[296] Cal. Corp. Code § 5917.5 (2022).

the legislature similarly is seeking to stop mergers that limit reproductive, gender-affirming, and end-of life care.[297]

These healthcare market reforms align with recent efforts of antitrust scholars and enforcers to urge that beyond simply promoting efficiencies, antitrust policy should "disperse economic and political power and promote individual freedom."[298] On this view, concentrations of economic power not only inflate consumer prices but also threaten democracy and worker self-determination.[299] Within the highly consolidated healthcare market, in particular, some argue that antitrust enforcement should also aim to remedy unequal access to healthcare "both at the level of individual patient care and at the level of society."[300] And, as Barak Richman has pointed out in a different context, the Sherman Act shares as a common goal with the Religion Clauses to reduce entrenched power, with the effect of fostering "religious liberty against public and private authority alike."[301] In policing hospital markets, states might guard against the risk of religious preferentialism and the loss of equal citizenship status.[302]

[297] Melissa Santos, Democrats Seek to Stop Hospital Mergers that Limit Abortion Access, Axios (June 22, 2022), https://www.axios.com/local/seattle/2022/06/22/democrats-stop-hospital-mergers-limit-abortions [https://perma.cc/MR7M-GK25]; S.B. 5688, 67th Leg., Reg. Sess. (Wash. 2022), https://app.leg.wa.gov/billsummary?BillNumber=5688&Year=2021&Initiative=false [https://perma.cc/E4H4-2VX2]; S. 67-5688, Reg. Sess. (Wash. 2022); Tim Ford, Senate Bill Report: SB 5688, Senate Committee on Law & Justice (Jan. 18, 2022), https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/Senate/5688%20SBR%20LAW%20TA%2022.pdf?q=20220808113124 [https://perma.cc/4MFW-86TP].

[298] Maurice E. Stucke, Reconsidering Antitrust's Goals, 53 B.C. L. Rev. 551, 590 (2012).

[299] See, e.g., Tim Wu, The Curse of Bigness: Antitrust in the New Gilded Age 14–15 (2018); Sanjukta Paul, Recovering the Moral Economy Foundations of the Sherman Act, 131 Yale L.J. 175, 210 (2021); Lina M. Khan, The End of Antitrust History Revisited, 133 Harv. L. Rev. 1655, 1681–82 (2020) (reviewing Wu, supra); Zephyr Teachout & Lina Khan, Market Structure and Political Law: A Taxonomy of Power, 9 Duke J. Const. L. & Pub. Pol'y 37, 37 (2014); Thomas J. Horton, Fairness and Antitrust Reconsidered: An Evolutionary Perspective, 44 McGeorge L. Rev. 823, 838 (2013).

[300] See William M. Sage & Peter J. Hammer, A Copernican View of Health Care Antitrust, 65 Law & Contemp. Probs. 241, 288–89 (2002). See generally Jonathan B. Baker & Steven C. Salop, Antitrust, Competition Policy, and Inequality, 104 Geo. L.J. Online 1 (2015) (identifying antitrust and competition policies and reforms that could work to reduce inequality).

[301] Barak D. Richman, Religious Freedom Through Market Freedom: The Sherman Act and the Marketplace for Religion, 60 Wm. & Mary L. Rev. 1523, 1526 (2019).

[302] The potential for religious entities to accumulate wealth and economic power was also a major concern of state disestablishment. See Sarah Barringer Gordon, The First Disestablishment: Limits on Church Power and Property Before the Civil War, 162 U. Pa. L. Rev. 307, 311–12 (2014).

With regard to transactions entered into by state actors in particular, state attorneys general could review and condition deals on compliance not only with statutory law but also with constitutional principles. We saw something like this in Kentucky, where the attorney general rejected the merger of public hospitals with a Catholic healthcare system due to state constitutional constraints, including those against establishment and religious preference.[303] State and local officials and community groups also can harness public energy surrounding hospital transactions to promote responsiveness to citizens. Hospital transactions can generate "public awareness and political accountability regarding scarce resources and the rights and obligations of citizens."[304] In a highly salient way, they raise societal questions like what kind of community do we want to be? And what care should we demand from our healthcare institutions?[305]

These processes can empower local communities to demand a system responsive to a diverse public. There are numerous examples of compromises, defeated mergers, and alternatives secured through the activism of local citizens.[306] Take, for example, a proposal in upstate New York for the unification of two secular hospitals and one Catholic hospital into a single entity bound by Catholic doctrine.[307] Faced with loss of access to contraception, sterilization, and abortion—all of which had been available at the secular hospitals—the community organized. They held public rallies, wrote petitions, testified to regulators, and wrote op-eds.[308] Ultimately, they garnered the Federal Trade Commission's attention and presented unassailable evidence of the likely anti-competitive effects.[309]

There are some reasons for optimism about healthcare antitrust. To begin with, the Biden Administration has prioritized promoting competition across the American economy through ex ante measures and

[303] See supra note 101 and accompanying text.

[304] William M. Sage, Regulating Through Information: Disclosure Laws and American Health Care, 99 Colum. L. Rev. 1701, 1711 (1999).

[305] See Elizabeth Sepper, Making Religion Transparent: The Substance, Process, and Efficacy of Disclosing Religious Restrictions on Care, *in* Transparency in Health and Health Care 103, 103 (Holly Fernandez Lynch, I. Glenn Cohen, Carmel Shachar & Barbara J. Evans eds., 2019) (discussing the substance and aims of religion-based transparency).

[306] For additional examples, see Elena N. Cohen & Alison Sclater, Nat'l Women's L. Ctr., Truth or Consequences: Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care 32–35 (2003); Lisa C. Ikemoto, When a Hospital Becomes Catholic, 47 Mercer L. Rev. 1087, 1101–02 (1996).

[307] Appelbaum & Morrison, supra note 293, at 33–36.

[308] Id. at 34.

[309] See id. at 34–35.

backward-looking challenges to consummated transactions that violated antitrust law.[310] The Federal Trade Commission and state regulators are more closely scrutinizing hospital mergers than they did in past decades.[311] Some states have moved to address the crisis of consolidation by requiring a multi-agency healthcare approval process for all healthcare transactions, specific criteria related to access, and contractual terms designed to mitigate potential harms to the public.[312] Because traditional merger review takes place in already highly concentrated markets, policymakers will also need to "confront extant market power" and "stimulate lost or impeded competition."[313] There are some promising signs here too. The Department of Justice and the FTC—once unwilling to try and "unscramble the eggs"—increasingly seek to break up organizations that have already merged.[314]

There is also mounting enthusiasm for reforms to strengthen antitrust law and bolster agency enforcement. For example, commentators on the left and right tend to support increased funding for antitrust agencies and an expansion of the FTC's authority to challenge anti-competitive behavior by nonprofit entities (a power currently reserved to the DOJ).[315]

[310] Exec. Order No. 14036, 86 Fed. Reg. 36,987 (July 9, 2021).

[311] See Thomas L. Greaney & Barak D. Richman, Promoting Competition in Healthcare Enforcement and Policy: Framing an Active Competition Agenda (2019) (documenting recent efforts and healthcare antitrust enforcement successes).

[312] See King et al., supra note 281, at 4, 10, 23–24.

[313] Greaney & Richman, supra note 311, at 1.

[314] See President Biden Signs Executive Order on Promoting Competition, Davis Polk (July 21, 2021), https://www.davispolk.com/insights/client-update/president-biden-signs-executive-order-promoting-competition [https://perma.cc/53Q6-STSJ]; see also Remarks of Commissioner Rebecca Kelly Slaughter, Federal Trade Commission, Antitrust and Health Care Providers: Policies to Promote Competition and Protect Patients at the Center for American Progress 8 (May 14, 2019), https://www.ftc.gov/system/files/documents/public_statements/1520570/slaughter_-_hospital_speech_5-14-19.pdf [https://perma.cc/KMA8-MJA3] ("[T]he FTC should conduct a new round of retrospectives of healthcare provider mergers. Consistent with a recent Commission statement, the FTC should target some recently cleared, close-call hospital mergers, as well as hospital mergers that raised significant antitrust concerns . . . ."). For an overview of what it means to "unscramble eggs" and some examples of challenges to consummated deals, see John Kwoka & Tommaso Valletti, Unscrambling the Eggs: Breaking Up Consummated Mergers and Dominant Firms, 30 Indus. & Corp. Change 1286 (2021).

[315] Jaime S. King, Stop Playing Health Care Antitrust Whack-A-Mole, Bill of Health (May 17, 2021), https://blog.petrieflom.law.harvard.edu/2021/05/17/health-care-consolidation-antitrust-enforcement/ [https://perma.cc/K3QX-FGJL]; Alden F. Abbott, Lack of Resources and Lack of Authority Over Nonprofit Organizations Are the Biggest Hindrances to Antitrust Enforcement in Healthcare, Mercatus Ctr. (Apr. 29, 2021), https://www.mercatus.org/pu

A number of other proposals—such as no-fault monopolization rules that permit breakups without fault—would have the downstream effect of creating a more religiously plural market and increasing choice for government partners in healthcare.[316]

Dispersing market power has the benefits of mitigating religious domination, respecting institutional freedom, and preserving patient options. A more economically competitive market also would be a more religiously plural market.[317] And more competition between economic actors—religiously affiliated and not—could lead consumers and workers to be able to choose firms that best "align with their personal, religious, and ethical values"[318] as many conservative scholars urge.[319] Anti-trust therefore might present opportunities for alliances between progressives and conservatives.

B. Public Options

A second option would be to restore and expand the public provision of healthcare services. Political choices diverted public funding to private institutions and shuttered government hospitals. A more democratic, egalitarian, and religiously plural politics might turn to public options.

Like the remedies drawn from antitrust thinking, the public option is supported by considerations of economic efficiency as well as democratic values. As Ganesh Sitaraman and Anne Alstott explain, public options work to guarantee a floor of quality and affordability, avoid coercion, and

blications/antitrust-and-competition/lack-resources-and-lack-authority-over-nonprofit [https://perma.cc/C999-8CMT].

[316] See Robert H. Lande & Richard O. Zerbe, The Sherman Act is a No-Fault Monopolization Statute: A Textualist Demonstration, 70 Am. U. L. Rev. 497 (2020) (arguing that a textualist analysis of § 2 of the Sherman Act indicates that liability should apply to monopolies acquired or preserved regardless of anti-competitive conduct and contrary decisions should be overruled); see also Robert H. Lande & Sandeep Vaheesan, Preventing the Curse of Bigness Through Conglomerate Merger Legislation, 52 Ariz. St. L.J. 75, 86 (2020) (proposing model legislation that would block mergers that exceed specified asset thresholds).

[317] See Richman, supra note 301, at 1540–41 (compiling social science literature on the ways in which a more "competitive marketplace for religion" can foster greater and more vibrant religious participation).

[318] Stucke, supra note 298, at 602.

[319] See, e.g., Robert K. Vischer, Conscience and the Common Good: Reclaiming the Space Between Person and State 179–205 (2010); Ronald J. Colombo, The Naked Private Square, 51 Hous. L. Rev. 1 (2013).

put healthy competitive pressure on private providers.[320] On their account, public options have two central features: They "provide[] an important service at a reasonable cost" and "coexist[] . . . with one or more private options offering the same service."[321] In healthcare provision, a public option would ensure secular space as well as help address concerns about privatization, access, and (to some degree) consolidation.

What would a public option look like? Instead of contracting for government-religious hospitals, local governments (perhaps with the support of states) could form genuinely public hospital facilities—that is, facilities that deliver a baseline of care without regard to religious doctrine—as they once did. A public hospital would dilute the market power currently enjoyed by some religious healthcare systems. Public academic medicine could partner with and support these public institutions.

This strategy would go some distance in solving the problem of privatizing public arenas. Establishing public hospitals comes with the obvious downside of high start-up costs. But the investment of public dollars would ensure secular spaces with duties to all residents and welcoming of people of all faiths, or none. Because all levels of government are involved in hospital services, the public entity could take a variety of forms—ranging from revamping state hospitals (often dedicated to psychiatric care) to opening Veteran's Administration hospitals to the general public for services not offered at religious hospitals. And by providing an adequate baseline of secular care, a public option might also leave private religious entities with more latitude to deliver services consonant with their own religious identity.

The University of Louisville's experience offers an example. In 2019, due to persistent problems with KentuckyOne, the entire system became public.[322] The University of Louisville resumed operation of UMC and

[320] Ganesh Sitaraman & Anne Alstott, The Public Option: How to Expand Freedom, Increase Opportunity, and Promote Equality 3 (2019); cf. Jacob S. Hacker, The Case for Public Plan Choice in National Health Reform (2008), https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.522.2310&rep=rep1&type=pdf [https://perma.cc/R8EE-XC6T] (supporting a public option for health insurance).

[321] Sitaraman & Alstott, supra note 320 at 2, 27. For detailed exploration of public options in the context of banking, see Mehrsa Baradaran, How the Other Half Banks: Exclusion, Exploitation, and the Threat to Democracy 210–25 (2015).

[322] Chris Larson, U of L Lays Out $100M Plan to Turn Around Jewish Hospital, KentuckyOne, Louisville Bus. First (Aug. 14, 2019), https://www.bizjournals.com/louisville/news/2019/08/14/u-of-l-lays-out-100m-plan-to-turnaround-jewish.html [https://perma.cc/46KT-96GP].

purchased KentuckyOne Health's facilities from the Catholic health mega-system CommonSpirit through a state-funded loan.[323] With the legislature's approval, the newly acquired facilities became branded under the University of Louisville Health umbrella.[324] The Catholic facilities dropped their saint names (and likely their obligations to Catholic doctrine).[325] At least for the time being, the city and state emerged with a more robustly public healthcare system.

Another way to implement this strategy might be to create a hospital-within-a-hospital. Non-Catholic partners, including governments like the city of Austin and University of Louisville, used to offer secular medical care within a separate facility inside a hospital to accommodate the religious objections of the Catholic entity managing the rest of the space.[326] Sometimes, governments created totally separate spaces. For example, in 1996, when Petaluma Valley Hospital, a public facility in California, affiliated with a Catholic hospital, it built a taxpayer-funded outpatient surgical clinic primarily so that it could continue to provide abortions and tubal ligations.[327] Private law offers tools to enable such arrangements, allowing separate incorporation, governance, and staffing. These solutions, while perhaps nonideal, safeguard a (limited) realm of secular identity and services.[328]

Even where separate facilities have not been constructed, contract terms can mitigate the blurring of religion and state. For example, the Master Agreement for UT Seton specifies that the government health authority retains unilateral power over "approval, support, and funding of women's health projects . . . that Seton cannot participate in as a result of

[323] Id.

[324] Morgan Watkins, University of Louisville Renaming Jewish Hospital, Our Lady of Peace After Purchase, Courier-J. (Oct. 29, 2019), https://www.courier-journal.com/story/news/2019/10/29/u-l-rename-jewish-hospital-our-lady-peace-after-buys-them/2498063001/ [https://perma.cc/6GRW-ZC44].

[325] Id.

[326] See supra notes 108 and 121 and accompanying text. The latest version of the ERDs, released in 2018, is far more restrictive, limiting compromise and requiring that all entities "be operated in full accord with the moral teaching of the Catholic Church" regardless of whether the collaboration comes in the form of "acquisition, governance, or management." ERDs, supra note 26, at 26.

[327] See Ikemoto, supra note 306, at 1125.

[328] Cf. Shelly Welton, Revamping Public Energy, *in* Politics, Policy, and Public Options 134, 142 (Ganesh Sitaraman & Anne Alstott eds., 2021) ("[P]ublic options are proposed as gap-fillers, focused on expanding coverage to those currently underserved by the private market."); id. (explaining how the public sector could be the incubator for change and development in certain industries).

ERD restrictions."[329] Given the serious prospect that a religious body might cause the government to deny care based on theological principles, contractual language preserved some measure of public authority. Through careful contract drafting, governments might more thoroughly avoid delegating policy decisions—like assessment of community needs or allocation of public resources—to religious partners.[330]

States could also set guardrails on partnerships. One California law offers a model for states looking to prevent, rather than undo, public hospital mergers with religious entities. It requires that any deals with a private entity that involve more than fifty percent of a public hospital's assets be put to a referendum by the hospital district's voters.[331] In a more recent example, serial concerns about the inconsistency of religiously motivated discrimination and the values of a public university prompted students and faculty at the University of California to organize for reforms.[332] In response, in 2021, the Regents adopted an amendment that prohibits the university from affiliating with healthcare institutions that discriminate and requires terminating existing affiliations with organizations unwilling to comply with the state university's non-discrimination policy.[333] Such requirements may ultimately unwind government-religious hospitals.

States could also use tools of contract and corporate law to preserve equal citizenship and democratic control. Governments, for example, could leverage their majority ownership in some of the hospitals that we describe to dictate corporate policy.[334] Alternatively, they could enter into

[329] Master Agreement, supra note 127, at 14–15.

[330] On the dangers of delegating discretionary policy decisions to private actors, see Michaels, supra note 141, and Metzger, supra note 179.

[331] Cal. Health & Safety Code § 32121(p)(1) (2020); Ikemoto, supra note 306, at 1127 (describing the statute).

[332] The UC Academic Senate Non-Discrimination in Healthcare Task Force, Final Report 4 (July 24, 2019), https://senate.universityofcalifornia.edu/_files/reports/rm-jn-final-report-non-discrimination-healthcare-taskforce.pdf [https://perma.cc/U86C-DHRG]. One recommendation was that "[t]he University generally should retain sufficient capacity to fulfill its teaching and research mission within its own facilities, using its own personnel and equipment. Should there be a long-term need for additional hospitals, facilities or beds, the University generally should build or wholly acquire existing facilities." Id. at 13.

[333] See Rania Soetirto, UC Board of Regents Votes to End Affiliation with Restrictive Healthcare Institutions, Daily Bruin (June 27, 2021), https://dailybruin.com/2021/06/27/uc-board-of-regents-votes-to-end-affiliation-with-restrictive-healthcare-institutions [https://perma.cc/5XWA-5XGF].

[334] See Jon D. Michaels, We the Shareholders: Government Market Participation in the Postliberal U.S. Political Economy, 120 Colum. L. Rev. 465, 492 (2020).

long-term contracts with hospitals and other partners that insist on religious non-domination in provision of healthcare.

Finally, city, state, and federal governments might radically rethink what the public's health requires. William Sage, for example, has called for repurposing the enormous "wealth trapped within American health care," the vast majority of which is public dollars, toward collective health in patient groups and local communities—in turn, "[d]epopulating and reconstituting hospitals."[335] Governments could turn this moment of healthcare crisis into an opportunity to explore democratically engaged and accountable alternatives to the traditional doctors' offices and hospitals.[336] They could look to the Great Society community clinic models, which not only served low-income patients but also entrusted governance to patients and community members.[337] Cities already do creative work in this area, for example, entering into long-term, below-market contracts for healthcare providers to serve the poor.[338] Loosening the grip of expensive, high-tech hospitals on safety-net services might result in more responsive and accountable public health.

The time may be ripe for the exploration of such state entrepreneurship. Both market and government have failed to supply healthcare in an accessible and affordable way. After forty years of neoliberalism, Jon Michaels argues, a "routine course correction" may be underway—opening opportunities for, if not a return to a strong welfare state, new pathways of "public capitalism."[339] The state's best option may be "participating in the Market, alongside and in competition with private businesses," not in service of free enterprise but in support of market correction and redistribution.[340]

[335] William M. Sage, Fracking Health Care: How to Safely De-Medicalize America and Recover Trapped Value for Its People, 11 N.Y.U. J.L. & Liberty 635, 638, 664–71 (2017).

[336] See Tomes, supra note 196, at 262.

[337] Id. at 262–63 (noting that U.S. Office of Economic Opportunity-funded clinics had to have fifty-one percent of board members eligible for or receiving services offered, and free clinics often organized as collectives with patients, community volunteers, and medical staff).

[338] For example, the City of Austin has a long-term lease at a dollar per year to Planned Parenthood. See Chuck Lindell, Planned Parenthood Clinic to Stay Open, Austin American-Statesman (June 13, 2019), https://www.statesman.com/story/news/politics/state/2019/06/13/despite-new-law-austin-planned-parenthood-clinic-to-stay-open/4916035007/ [https://perma.cc/BNC6-6S7T].

[339] Michaels, supra note 334, at 472, 487.

[340] Id. at 501.

C. Public Utility Regulation

The flip side of antitrust enforcement is public utility regulation.[341] With regard to hospitals, we might think that consolidation has value for coordination of care delivery and recognize that many geographic regions can support only one hospital.[342] We might also be convinced that antitrust regulators may hesitate to take on already pervasively consolidated markets.[343] Rather than disperse market power, public utility regulation would take as given economies of scale in healthcare and then insist services be provided fairly and at reasonable cost. The government might not offer its own services but would oversee the hospital market to ensure a religiously plural people with different views on acceptable treatments could find a range of medical care.

Recent literature on political economy has given sustained attention to reviving public utility regulation of providers of critical goods and services.[344] Rather than a technical regulatory form, public utility aims "at harnessing the power of private enterprise and directing it toward public

[341] Sanjukta Paul argues that antitrust enforcement and regulation are not oppositional, but rather share a common goal of containing domination. She writes, "[R]ecognizing that both economic coordination and its regulation are pervasive and unavoidable, the key regulatory question is between forms of economic coordination (and competition), rather than between competition and coordination." Sanjukta Paul, The Dawn of Antitrust and the Egalitarian Roots of the Sherman Act, ProMarket (Jan. 11, 2022), https://promarket.org/2022/01/11/dawn-antitrust-sherman-act-egalitarian-roots/ [https://perma.cc/LAL5-742U] (emphasis omitted); see also Sanjukta Paul, Antitrust as Allocator of Coordination Rights, 67 UCLA L. Rev. 378 (2020) (elaborating).

[342] See, e.g., Nicole Huberfeld, Rural Health, Universality, and Legislative Targeting, 13 Harv. L. & Pol'y Rev. 241, 250–51 (2018) (describing the financial straits of rural hospitals and the impact on rural communities that depend on them); Dayna B. Matthew, Doing What Comes Naturally: Antitrust Law and Hospital Mergers, 31 Hous. L. Rev. 813, 824–26 (1994) (arguing that hospital services have many of the attributes of an industry with natural monopoly tendencies, including their dependence on expensive technology, regional monopolies, and production of the non-storable good of emergency care with fluctuating and variable demand).

[343] See, e.g., Timothy L. Greaney, Coping with Concentration, 36 Health Aff. 1564, 1565 (2017) ("Antitrust law has an important, constrained, role to play but is especially inept in dealing with extant market power."); see also Erin C. Fuse Brown, Resurrecting Health Care Rate Regulation, 67 Hastings L.J. 85, 138–40 (2015) (evaluating policy solutions to discipline healthcare prices and concluding that "only one solution—rate regulation—is capable of addressing the widespread and growing provider monopoly problem").

[344] See generally Baradaran, supra note 321, at 43–44 (discussing Brandeis's treatment of banks as public utilities); Ann M. Eisenberg, Economic Regulation and Rural America, 98 Wash. U. L. Rev. 737 (2021); K. Sabeel Rahman, Infrastructural Regulation and the New Utilities, 35 Yale J. on Reg. 911 (2018).

ends," including through modest forms of planning.[345] As Sabeel Rahman explains, Progressive Era thinkers adopted such regulation to secure democratic control over industries that provided goods or services necessary to well-being.[346] Today, he argues, "social infrastructure" defined by "necessity and vulnerability" equally calls out for regulation to ensure fair, affordable, and equitable access.[347]

There is a strong case for treating hospitals as public utilities. They meet basic human needs, hold economic power in a market that functions poorly, and have a stranglehold over vital services.[348] While most are nominally private, they bear important indicia of publicness. State and federal governments expend communal funds to build and sustain hospitals.[349] Communities rely on them for employment and financial wellbeing, so much so that rural hospital closures can have a direct negative impact on the economic health of entire counties.[350] Over decades, proponents of public utility regulation have argued that "[b]ecause service, cost, utilization, and quality decisions affect not only providers and users but also the wider social environment, it is necessary to make society privy to those decisions."[351] Indeed, the very term

[345] William Boyd, Public Utility and the Low-Carbon Future, 61 UCLA L. Rev. 1614, 1619, 1650 (2014).

[346] See K. Sabeel Rahman, The New Utilities: Private Power, Social Infrastructure, and the Revival of the Public Utility Concept, 39 Cardozo L. Rev. 1621, 1639 (2018). For a history of public utility's meaning in the Progressive Era, see William J. Novak, The Public Utility Idea and the Origins of Modern Business Regulation, *in* Corporations and American Democracy, supra note 212, at 145.

[347] Rahman, supra note 346, at 1625, 1643.

[348] See Nicholas Bagley, Medicine as a Public Calling, 114 Mich. L. Rev. 57, 65 (2015); Barry R. Furrow, Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients, 3 Health Matrix 31, 37 (1993).

[349] U.S. hospitals receive one out of every three dollars of the $1.3 trillion directly spent on healthcare. More than sixty percent of hospital costs are paid by public insurance programs. Andrea M. Sisko et al., National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth, 38 Health Affs. 491, 492 (2019). In 2011, nonprofit hospitals also received tax-exemptions worth $24.6 billion. Sara Rosenbaum, David A. Kindig, Jie Bao, Maureen K. Byrnes & Colin O'Laughlin, The Value of The Nonprofit Hospital Tax Exemption Was $24.6 Billion In 2011, 34 Health Affs. 1225 (2015).

[350] See George M. Holmes, Rebecca T. Slifkin, Randy K. Randolph & Stephanie Poley, The Effect of Rural Hospital Closures on Community Economic Health, 41 Health Servs. Rsch. 467, 477 (2006). For an urban story, see generally Winant, supra note 147 (exploring the collapse of industrialism in Pittsburgh and the rise of the healthcare system as central employer and exploiter of labor).

[351] William E. Corley, Hospitals as a Public Utility: or 'Work with Us Now or Work for Us Later', 2 J. Health Pol., Pol'y & L. 304, 304 (1977) (noting arguments from the 1950s); A.J.

"community hospital" evokes a sense of democratic ownership and institutional obligation to the people.[352]

Unlike a public option, the public utility approach does not necessarily require creation of new healthcare facilities. It instead would limit existing private power and treat healthcare as a public good in a social, if not economistic, sense.[353] As Nick Bagley has argued, to a limited extent, U.S. law has long followed such an approach.[354] Under federal and state laws, hospitals—public and private alike—have (some) obligation to meet public need, to serve all paying customers, to treat patients without discrimination, and to offer a fair price.[355] Non-profit hospitals—a category into which most hospitals fall—have made major employment, patient care, and governance reforms to maintain tax exemption.[356] "[W]here social needs are made explicit (for example, in civil rights legislation . . .), American hospitals are socially responsive institutions" willing to adapt quickly.[357] And religiously affiliated hospitals usually have been no exception.[358]

Public utility regulation could address the concrete harms of government-religious hospitals in a variety of ways. States could impose

Priest, Possible Adaptation of Public Utility Concepts in the Health Care Field, 35 Law & Contemp. Probs. 839, 840 (1970); Joshua A. Newberg, In Defense of *Aston Park*: The Case for State Substantive Due Process Review of Health Care Regulation, 68 N.C. L. Rev. 253, 257 (1990) (observing that in the 1960s and early 1970s many writers categorized hospitals as public utilities and there was a "widely-held expectation among health policy makers" that the United States would soon exercise more "centralized control of health services delivery").

[352] See Stevens, supra note 144, at 307–08, 315–19 (discussing the ambiguous rhetoric of "community"); Winant, supra note 147, at 141–50 (discussing communal claims on hospitals as institutions of significance).

[353] See K. Sabeel Rahman, Domination, Democracy, and Constitutional Political Economy in the New Gilded Age: Towards A Fourth Wave of Legal Realism?, 94 Tex. L. Rev. 1329, 1349–50 (2016).

[354] See Bagley, supra note 348, at 71.

[355] Id. at 72.

[356] See Michael J. DeBoer, Religious Hospitals and the Federal Community Benefit Standard—Counting Religious Purpose as a Tax-Exemption Factor for Hospitals, 42 Seton Hall L. Rev. 1549, 1569–70 (2012) (discussing the IRS's 1969 revenue ruling, which shifted analysis to consider whether hospitals maintained an open medical staff, used surpluses for patient care, were governed by a board composed of community members, and operated an emergency room open to all regardless of ability to pay).

[357] Stevens, supra note 144, at 320.

[358] See Donald H.J. Hermann, Religiously Affiliated Health Care Providers: Legal Structures and Transformations, *in* Religious Organizations in the United States: A Study of Identity, Liberty, and the Law 735–36 (James A. Serritella ed., 2006) (tracing shifts in Catholic hospitals in response to public incentives); Wall, supra note 16, at 73, 101–02 (describing desegregation of Catholic hospitals).

obligations to provide certain services as a condition of state licensure or funding. Many states have enacted statutes, for example, that ensure survivors of sexual assault receive emergency contraception in hospitals or require posting reproductive care policies.[359] State legislation was once proposed to require all hospitals to provide a full-range of reproductive health services—a proposal that advocates and legislators could take up again.[360]

More systematically, states could consider reinvigorating the certificate of need ("CON") processes used to plan allocation of healthcare services. Thirty-five states require government approval for the expansion, closure, or relocation of certain categories of health facilities.[361] Although the statutes vary, they may demand documentation of community need and police the impact on access, particularly in underserved areas. The CON process has long endured criticism as a politicized and inefficient rubber stamp,[362] but it can allow a measure of public control over hospital resources.[363] And such laws have been used effectively in many European countries, not only to refuse to build but also to develop more capacity when needed and to develop alternative patterns of care that make hospital beds unnecessary.[364] To stem the spread of care restrictions, states could explicitly prohibit expansion where the facility denies comprehensive reproductive or LGBTQ-affirming healthcare. Or the planning process might put a thumb on the scale for proposals that commit to offering comprehensive care. At least

[359] See Emergency Contraception, Guttmacher Inst. (Aug. 1, 2022), https://www.guttmacher.org/state-policy/explore/emergency-contraception [https://perma.cc/W9HB-YEF7].

[360] See Brietta R. Clark, When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict, 82 Or. L. Rev. 625, 646–47 (2003).

[361] See Emily Whelan Parento, Certificate of Need in the Post-Affordable Care Act Era, 105 Ky. L.J. 201, 205 (2017).

[362] See Tracy Yee, Lucy B. Stark, Amelia M. Bond & Emily Carrier, Healthcare Certificate-of-Need Laws: Policy or Politics? 3 (May 2011), http://nihcr.org/wp-content/uploads/2015/03/NIHCR_Research_Brief_No._4.pdf [https://perma.cc/4RBG-AABN] (noting that between eighty-eight and ninety-six percent of applications end up being approved).

[363] See Bagley, supra note 348, at 100 (proposing that states "reform their CON laws to more closely superintend provider consolidation, the construction of expensive facilities, or the acquisition of novel technologies"); Parento, supra note 361, at 237–54 (exploring modernization of CON laws in response to new health reform goals).

[364] Gerard R. Goulet, Certificate-of-Need Over Hospitals in Rhode Island: A Forty-Year Retrospective, 15 Roger Williams U. L. Rev. 127, 130 (2010).

in some states, interest in this form of public utility regulation is already gaining steam.[365]

Recognizing that healthcare privatization has placed many hospitals beyond the reach of accountability mechanisms available to ordinary citizens, states and cities might implement more stringent public and citizen oversight. Some jurisdictions, for example, have commissioned an independent public advocate to work on behalf of patients, healthcare workers, and the public.[366] These advocates could help avoid (or redress) wrongful denials of care, discriminatory treatment of patients and employees, or other abuses of hospital market power. They could coordinate citizen advocacy and mobilize political pressure for democratic healthcare reforms at the state and local levels.[367] And they could leverage a public mandate to ensure that hospitals respect constitutional norms such as religious freedom and secular government. If properly designed and employed, such participatory governance arrangements can shift power to communities, enhance local control over healthcare, surface political decisions about healthcare resources, and deliver tangible benefits.[368]

Although states and localities have historically led the way on public utility regulation, similar strategies may be available at the federal level. For example, Medicare has the financial leverage to obtain widespread provider compliance and participation. Healthcare scholars increasingly call for it to implement public utility style rate regulation.[369] And through

[365] Christine Khaikin, Lois Uttley & Aubree Winkler, When Hospitals Merge: Updating State Oversight to Protect Access to Care 8, 16–19, 21–23 (2016), https://www.hpae.org/wp-content/uploads/2016/10/WHM-CONreport_epub_1-42.pdf [https://perma.cc/U3S8-E9DP] (discussing state efforts and proposals).

[366] See Partners for Dignity & Rights, A Public Healthcare Advocate for Pennsylvania 32–33 (Aug. 2021), https://dignityandrights.org/wp-content/uploads/2021/09/PA-PHA-report.pdf [https://perma.cc/2E27-VEMA] (discussing public healthcare advocates in Nevada and Connecticut).

[367] On using law to support social movements, see Amna A. Akbar, Sameer M. Ashar & Jocelyn Simonson, Movement Law, 73 Stan. L. Rev. 821 (2021).

[368] Ben Palmquist, Equity, Participation and Power: Achieving Health Justice Through Deep Democracy, 48 J. L. Med. & Ethics 393, 397–405 (2020) (evaluating the failures and successes of federal programs calling for participatory community engagement in healthcare from the Economic Opportunity Act of 1964 to today).

[369] Erin C. Fuse Brown, Resurrecting Health Care Rate Regulation, 67 Hastings L.J. 85, 138–40 (2015); see also Bob Kocher & Donald M. Berwick, While Considering Medicare for All: Policies for Making Health Care in the United States Better, Health Affs. Blog (June 6, 2019), https://www.healthaffairs.org/do/10.1377/forefront.20190530.216896/full/ (proposing hospital price regulation).

its conditions of participation, Medicare already sets some bounds of public access to secular care. All hospitals, secular or sectarian, must respect patients' rights to spiritual and pastoral care consistent with their own needs.[370] In a similar vein, the conditions of participation establish that it is for patients to determine their own family structures and select their visitors consistent with their own commitments—prohibiting hospitals from, for example, denying access to same-sex partners.[371] Likewise, federal healthcare funding is conditioned on non-discrimination on the basis of race, national origin, age, disability, and sex.[372]

Notwithstanding its significant merits, public utility regulation, of all the reforms we discuss, would be most likely to see constitutional attack. It is not difficult to imagine religious hospitals invoking free exercise law against public obligations, including those prohibiting discrimination.[373] They might seek a religious exemption allowing denial of care to, for example, transgender patients—as several large Catholic-affiliated chains have sought to do.[374] Alternatively, they might assert religious autonomy against any interference with selection of employees, as an Adventist-Catholic chain has done.[375] They might find a receptive audience in a Supreme Court with newfound "special solicitude to the rights of religious organizations."[376] Indeed, efforts to separate church from state

[370] See Joint Commission on Accreditation of Healthcare Organizations, Hospital Accreditation Standards 11, 17 (2020). State laws often contain similar duties. Stacey A. Tovino, Hospital Chaplaincy Under the HIPAA Privacy Rule: Health Care or "Just Visiting the Sick?", 2 Ind. Health L. Rev. 49, 83 (2005).

[371] 42 C.F.R. § 482.13(h) (2021).

[372] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557(a), 124 Stat. 119, 260 (codified as amended in scattered sections of U.S.C.).

[373] See, e.g., Elizabeth B. Deutsch, Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate, 124 Yale L.J. 2470 (2015) (exploring potential religious liberty claims against the Affordable Care Act's prohibition on sex discrimination).

[374] Minton v. Dignity Health, 252 Cal. Rptr. 3d 616, 624 (Ct. App. 2019) (holding that free exercise objections under California's constitution do not permit healthcare chains to engage in sex discrimination), *cert. denied*, 142 S. Ct. 455 (2021).

[375] Order on Defendants' Motion for Judgment on the Pleadings at 4, Morris v. Centura Health Corp., 2020 WL 6120134 (D. Colo. Sept. 30, 2020) (No. 2019 CV 31980).

[376] Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC, 565 U.S. 171, 189 (2012).

or to promote disestablishment values might be seen as "hostility" toward religion, as the Supreme Court has put it in a handful of recent cases.[377]

* * *

Each of the strategies we have sketched is partial, imperfect, and non-exclusive. Some may not be appropriate to, or available in, all markets and jurisdictions. They operate, not at the level of constitutional litigation, but as small-c constitutionalism—the rules, norms, and statutes that shape who holds power and what limits apply to that power.

Across the country, Americans are grasping for a "new idea of freedom, one that is rooted in public programs that genuinely serve people and checking market dependency."[378] The strategies discussed here share a common aspiration to create or preserve spaces open to the public without regard to religious creed. They represent our initial attempt to grapple with how to defend the public institutions we still have and to make them more fully accessible and egalitarian. Where public institutions have disappeared, we instead ask how we can make private facilities and privatized functions meaningfully public.

CONCLUSION

Government-religious hospitals upend the conventional wisdom about the relationship between church and state in America. Across the political spectrum, religion law scholars assume the existence of secular options and the absence of religious domination in the marketplace. They broadly agree that equal membership in the political community cannot depend on one's religion and that the state cannot prefer any denomination. Government's institutions will be open to all, controlled by the people, and able to give public reasons for decisions.

Yet, in states across the country, government's religious hospitals have come to threaten religious freedom and equal citizenship. Church-state theorists will have to make room for them in their frameworks. Scholars of privatization and neoliberalism will need to grapple with their existence.

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[377] Am. Legion v. Am. Humanist Ass'n, 139 S. Ct. 2067, 2074 (2019); see also Espinoza v. Mont. Dep't of Revenue, 140 S. Ct. 2246, 2259 (2020) (deciding state constitution ban on aid to religious schools could only be explained by a "shameful pedigree" of anti-Catholicism "born of bigotry").

[378] Mike Konczal, Freedom from the Market 4–5 (2021) (exploring the long historical tradition of Americans resisting market dependency and asserting positive conceptions of rights).

These government-religious hospitals likely are a bellwether for larger political economy trends. Prison systems have dedicated faith-based units or even entire facilities.[379] State Medicaid contracts go to religiously affiliated insurers that refuse to cover reproductive healthcare for the many women of childbearing age covered by the public program.[380] In many cities, faith-based organizations are the sole providers of emergency shelter for unhoused people, a service funded by and often explicitly the duty of local governments.[381] School districts assign students to disciplinary schools that indoctrinate and discriminate.[382] Legislatures delegate public functions—ranging from policing to child welfare—to religious entities.[383]

As institutions combine state authority, economic power, and religious identity, it remains possible to preserve principles of secular government. Constitutional litigation under the Religion Clauses may offer a narrow path forward. But creative solutions—from fostering competition to developing public options—will be required to address the broader trends toward consolidation, privatization, and religionization of the economy.

[379] See generally Tanya Erzen, God in Captivity: The Rise of Faith-Based Prison Ministries in the Age of Mass Incarceration (2017) (describing experiences of religious minority prisoners in programs where evangelical Christians have a monopoly); Brad Stoddard, Spiritual Entrepreneurs: Florida's Faith-Based Prisons and the American Carceral State (2021) (analyzing prisons run by religious groups and ways in which states attempt to avoid constitutional challenges); Michael Hallett, Bryon Johnson, Joshua Hays, Sung Joon Jang & Grant Duwe, U.S. Prison Seminaries: Structural Charity, Religious Establishment, and Neoliberal Corrections, 99 Prison J. 150 (2019) (arguing that some programs run afoul of antiestablishment values).

[380] Susan Berke Fogel & Lourdes A. Rivera, Religious Beliefs and Healthcare Necessities: Can They Coexist?, Am. Bar Ass'n (Apr. 1, 2003), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/human_rights_vol30_2003/spring2003/hr_spring03_religiousbeliefs/ [https://perma.cc/N7ZV-WT5J] (discussing how the Balanced Budget Act of 1997 allows Medicaid managed care plans to opt out of covering a service "if the organization objects to the provision of such service on moral or religious grounds").

[381] Cooper, supra note 16, at 297–98.

[382] See, e.g., Smith v. Jefferson Cnty. Bd. of Sch. Comm'rs, 788 F.3d 580 (6th Cir. 2015) (upholding contract between a public school and a Christian school with Christian messages, mission, and approach to operate a disciplinary program to which students were assigned).

[383] In 2019, Alabama passed a bill giving Briarwood Presbyterian Church the right to set up its own law enforcement agency, over constitutional objections. Richard Gonzales, New Alabama Law Permits Church to Hire Its Own Police Force, NPR (June 20, 2019), https://www.npr.org/2019/06/20/734591147/new-alabama-law-permits-church-to-hire-its-own-police-force [https://perma.cc/G8XK-7PRN].