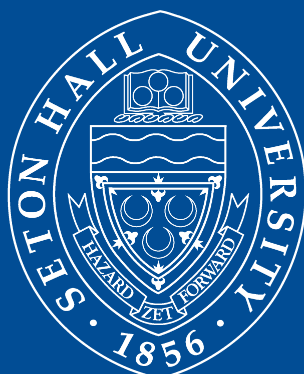
PROCEEDINGS OF THE SYMPOSIUM

Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry?



SETON HALL **LAW**

Center for Religiously Affiliated Nonprofit Corporations
Center for Health & Pharmaceutical Law & Policy

In collaboration with

UNIVERSITY *of* ST. THOMAS

John A. Ryan Institute for Catholic Social Thought
Terrence J. Murphy Institute for Catholic Thought, Law and Public Policy
Veritas Institute

Kathleen M. Boozang, J.D., LL.M., Editor

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Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry?

March 26-27, 2012

Seton Hall University School of Law
Newark, NJ

Hosted by

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The Symposium Story

In September 2010, Robert Galloway, Jerry Mansmann and David Vandewater visited the Seton Center for Religiously Affiliated Nonprofit Corporations and the Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law in Newark, New Jersey, and requested a study of the issues relevant to the potential use of a for-profit structure in the context of Catholic hospitals.

The recommendation of the Seton Center as a resource to study this question grew out of previous professional relationships. Sister Melanie DiPietro and Mr. Mansmann represented Catholic hospitals when they were practicing law together, and Mr. Galloway was employed by several Catholic health care systems and later became an independent consultant. Mr. Galloway remembered that in 1994, when a for-profit transaction was an interest of a client, Sister Melanie wrote a proposal suggesting that the compatibility of a for-profit structure with ministry should be studied. Mr. Galloway, thus, recommended that the Center now study the question.

Sister Melanie, on behalf of the Seton Center, and Professor Kathleen M. Boozang, on behalf of the Center for Health & Pharmaceutical Law & Policy, agreed to do the study if there was adequate funding equally coming from nonprofit and for-profit contributors. Further, the Centers retained all rights to choose presenters and to develop the program of the Symposium. The Centers developed a proposal, which was sent to Catholic health care systems, other nonprofits and for-profit organizations.

All donors have respected the independence of the Centers. The University of St. Thomas' John A. Ryan Institute for Catholic Social Thought; the Murphy Institute for Catholic Thought, Law and Policy; and the Veritas Institute of the Opus College of Business made a contribution to the Symposium and agreed to collaborate in the planning and in the presentations. Sister Melanie ultimately selected the presenters after independent research and recommendations from advisors and presenters.

The Symposium contributors and advisors are listed below and recognized for their financial and/or intellectual contributions to the Symposium:

Contributors
Alvarez & Marsal, New York City
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Ernst & Young LLP, Nashville
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The University of St. Thomas:
- John A. Ryan Institute for Catholic Social Thought
- Terrence J. Murphy Institute for Catholic Thought, Law and Policy
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Advisors: Ethicists
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Ron Hamel, Senior Director, Ethics, Catholic Health Association
Daniel O'Brien, Vice President, Ethics, Ascension Health
Michael Panicola, Corporate Vice President, Ethics and Social Responsibility, SSM Health Care

A special thanks is due to Denise Pinney, whose tireless work made this Symposium a reality—and a success. We would also like to thank Gwen Davis, Janet LeMonnier, Rosa Alves, Michael Ricciardelli, Gregory Corcoran, Brian Jacek, Catherine Finizio and the rest of the team at the Center for Health & Pharmaceutical Law & Policy for all their efforts on behalf of this Symposium.

Introduction

The ultimate question raised by this Symposium is a theological one: how is the apostolate of health care, commonly referred to as a ministry, performed historically under the auspices of a religious congregation acting in the name of the Church, sustained in an increasingly complex socio-political and economic environment? Simply put, the issue is one of stewardship. That is, how do current ministers best preserve the traditions and ministry of Catholic health care in the United States? What is the path that ensures that this healing ministry continues as a revelation of God's presence?[1] Catholic health care has been a significant and unique presence in the United States since the revolutionary period. It has survived numerous challenges, creatively turning transformational moments into opportunities from which it emerged thriving: the Civil War, the Depression, the multiple wars of the twentieth century, Vatican II, the enactment of Medicare and Medicaid, the proliferation of guns and drugs, the sexual revolution and civil rights movement, the managed care experiment, AIDS, and the continued growth of vulnerable populations of immigrants, uninsured and poor, especially among children and seniors. And through it all, the congregations dedicated to Catholic health care embraced the most vulnerable of its patients and the most unpopular causes, and soldiered on, as daily witnesses to Jesus' healing ministry: "And Jesus went about all the cities and villages, teaching in their synagogues and preaching the gospel of the kingdom, and healing every disease and every infirmity." (*Mt* 9:35).

Importantly, the health care ministry of the Catholic Church has also been an essential voice in the political discourse about openness to life and the dignity of every human life in all of its stages, universal access to health care, and the benefits communities can and should expect from the nonprofit health care provider. Catholic facilities remained in urban and rural communities long after other private community providers left; the Church sponsors Medicaid managed care in communities of greatest need.

This has all been accomplished through the intelligence of the

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[1] *See* U.S. Conference of Catholic Bishops, Health and Health Care: A Pastoral Letter of the American Catholic Bishops (1981); *see generally*, Juliana Casey, Food for the Journey: Theological Foundations of the Catholic Healthcare Ministry 86 *et seq.* (1991).

many sisters, clergy and laity who have labored for decades to identify creative business, financial and legal models that enable the continued existence of Catholic health care in a manner consistent with the Church's structures, teaching and mission. New challenges face Catholic health care, brought on by the combined changes to the health care delivery and financing systems inspired by spiraling health care costs and the enactment of the Patient Protection and Affordable Care Act. Consolidation, horizontal and vertical integration, and access to capital are the bywords of the health system executive suite. These drivers have led to the pressing question of whether Catholic institutions should convert to the for-profit corporate form to facilitate access to capital. More specifically, should Catholic institutions collaborate with private equity firms in the for-profit enterprise? Is the for-profit setting an appropriate vehicle for the continued vitality of the healing ministry of Jesus? Is the for-profit structure appropriately identified as Catholic?

This Symposium sought to accomplish two goals: to understand the primary for-profit options being presented to Catholic health care systems, and to raise the issues required for an analysis of for-profit conversions as identified by the various disciplines that have contributed to sustaining Catholic health care in the United States for over two centuries. Keith Pitts of Vanguard, David Vandewater of Ardent, and Leo Brideau of Ascension were amazing colleagues throughout this enterprise. They were forthcoming prior to and during the symposium about their respective for-profit models. They answered innumerable questions with grace and patience. Rev. Robert Beaulieu was called upon spontaneously a few times to speak to the St. Vincent (Worcester, Ma.) experience since its acquisition by Vanguard, which enlightened the conversation as well.

The contributors did not seek to answer the questions, or express a preference for the outcome of the conversation. Rather, they struggled together over several months to understand the proposition of for-profit Catholic health care, to learn the language and issues of each other's disciplines, and to come together with a cohesive analytical framework that will aid decision-makers as they seek to discover the right path for the future of health care ministry in the United States.

In no sense can it be said that these essays and exchanges,

contained in this monograph, capture every issue to be addressed in making these decisions. Not really touched upon is the question of why—are the anticipated changes for which immediate access to capital is desired going to improve the access, quality or cost of health care to those whom the Catholic Church serves? Is bigger better? Are these changes essential for survival? Will Catholic health care be irrevocably disadvantaged if it does not take advantage of the benefits of for-profit conversion? These are the questions to be answered by the business strategists. The focus of the Symposium was descriptive on comparative differences between for-profit and nonprofit forms that the planners deemed relevant to the religious and canonical issues—and that could be addressed in a day and a half.

And so we invited theologians, financial analysts, canon lawyers, corporate lawyers, public interest lawyers, First Amendment lawyers and even the vice president for mission from Johnson & Johnson to identify the implications of for-profit conversion. As you read the resultant papers, Catholic health care boards and their Members will find the questions not helpful merely to those considering a for-profit conversion, but also as a means for introspection about your current ministry. Dr. Kennedy asks why we are engaged in health care ministry and are we doing it well? Professor Maines and Dr. Naughton ask what it is that we do that is uniquely Catholic; they identify "Essential Principles for Catholic Health Care" which they commend to facilitate conversation by every Catholic health care entity board. Sister Doris Gottemoeller engages in a rigorous analysis of the distinctions and content of mission and identity, providing her own list of ten essential characteristics of Catholic health care which, when married to superior quality, honest and transparent business arrangements and compliance with the law, should embody the qualifications for an organization to call itself Catholic. Several participants decried the possibility that a for-profit entity that is Catholic by contract might be reduced to mere adherence to the *Ethical and Religious Directives for Catholic Health Care Services*—a moral minimalism. Consensus seemed to reflect a desire for institutions where Catholic Social Teaching penetrates every aspect of an entity that claims a Catholic identity.

Sister Sharon Holland continued the conversation that began with the realization that congregations are shrinking, and the ac-

knowledgement that their historic work must necessarily be continued by the laity: how do we ensure that future leadership will be imbued with Catholic social teaching and moral tradition? In the context of the current conversation, the question becomes how do we ensure that for-profit boards and investors desire leadership who are committed to carrying out a ministry grounded in Catholic social teaching and moral tradition? Sister Holland emphasized the heightened importance of formation programs, but she and others wondered whether they could be sustained in the second and later generations of leadership in the for-profit environment.

Sister Sharon Holland and Sister Melanie DiPietro raised innumerable canon law questions, including what the relationship of the public juridic person would be, if any, to the for-profit civil corporation— especially if it is no longer possible to reserve powers to the public juridic person. This conversation inevitably leads to questions about enforceable remedies if the anticipated expectations of either the Bishop or the public juridic person are not satisifed, and what happens if the private equity firm that initially enters into this relationship pulls out in three to five years. Professors Greaney and Glynn, both corporate lawyers, reinforced the notion that the public juridic persons are likely to have less power in the new corporate structures, as they will no longer be Members with reserved powers. However, they also emphasized the flexibility of corporate law to create arrangements that reflect the goals of the involved parties.

Two participants raised meta-issues about the future of the for-profit Catholic provider: What will the place of a for-profit Catholic health care ministry be in the public life of the United States; will the lobbying positions of for-profit hospital groups reflect the issues important to Catholic providers? First Amendment scholar Angela Carmella conducted a thorough review of the law to determine whether for-profit status would affect First Amendment free exercise protections or statutory religious exemptions, and concluded that for the most part, it is an open question. Public interest lawyer John Jacobi viewed the questions through the prism of whether health care is a public or private good, and indicated that the real difference between for-profit and nonprofit models will likely emerge at the margins: will a for-profit Catholic health care provider invest in a non-remunerative but necessary pediatric facility, for example?

Numerous audience members with decades of experience as officers, directors, ethicists and lawyers for Catholic health care facilities also contributed importantly to the conversation, asking challenging questions and adding perspectives from their own experiences that unquestionably enriched our experience. The papers contained here are better as a result of their shared perspectives.

Sister Melanie DiPietro must be acknowledged as the intellectual force and dedicated planner behind this conference, for which we thank her. That being said, all of the participants in this symposium literally spent months aiding in the construction of the questions, of the panel topics, and of each other's presentations. The hours of back and forth conversation, the two days of exchange, and this monograph would not have been possible without the generous support and open-mindedness of our supporters: equally from the for-profit and nonprofit sectors. We extend a special thanks to David Vandewater, who brought the question to the Seton Hall Law Center for Religiously Affiliated Nonprofit Corporations. It is important to thank both the for-profit and nonprofit contributors for the freedom given to select the topics and speakers.

Melanie DiPietro, Program Co-Chair
Founding Director of the Center for Religiously Affiliated Nonprofit Corporations, Seton Hall Law School*

Kathleen M. Boozang, Program Co-Chair and Editor
Professor of Law, Associate Dean for Academic Advancement and Director, Center for Religiously Affiliated Nonprofit Corporations, Seton Hall Law School

* Sister Melanie DiPietro currently serves as Special Legal Advisor & Counsel to Catholic Charities USA.

Symposium Overview

This Symposium begins in the *Setonian* spirit, as conveyed by our motto, rooted in the words of St. Elizabeth Ann Seton to her son in 1812, "*Hazard yet Forward.*" Which is to say, "despite the difficulties, let's proceed; despite the hazards, let's move forward." And so we shall, with gratitude to all of those who accepted the challenge to finance, plan, and examine a sensitive and novel question from interdisciplinary perspectives. A special thank you needs to be extended to the financial supporters of this Symposium, each of whom trusted the Centers at Seton Hall Law and made a contribution with no preconditions or interference in the planning of the program. We hope that this Symposium meets their expectations.

Mother Elizabeth Ann Seton (1774-1821), the first native-born citizen of the United States to be canonized by the Roman Catholic Church, for whom Seton Hall University is named.

The real, practical value of this Symposium to the exploration of the topic ultimately rests with you, who have committed your own time and energy to come to Seton Hall Law School to enter into a dialogue on an issue so important to the Church, and, ultimately, to health care itself.

The Symposium has two goals. The primary goal of the Symposium is a dialogue that in a good faith, honest and exploratory manner "drills down" in a way that will enrich both the for-profit and nonprofit parties' analysis of their individual transactions. Through our open dialogue, both presenters and you—practitioners, Members, executive management leaders, board members, academics, religious leaders and public juridic persons—are hazarding forward, sharing insights.

Each presenter is moving outside the single perspective of his or her area to apply the principles of a given discipline to this

unique conversation and question: "Is the For-Profit Structure a Viable Alternative for Catholic Health Care Ministry?" The presenters from outside the Catholic community and those coming from the financial and consulting community as well as other for-profit organizations enrich the potential of the exploration of this Ministry question. Ironically, it is their unfamiliarity with the content of Ministry that may best assist those of us who enter the dialogue with good faith predispositions to suspend our predispositions.

Even more courageous is the willingness of the presenters to share their "research of first impression" to enable all of us to engage in public dialogue for a common good. Each presenter will endeavor to be objective and offer no suggestion for a definitive answer to the question. Rather, we hope that the presentations provide information to assist decision makers in their analysis and in reaching their own conclusions within their own facts and circumstances.

The second goal of this Symposium is that it provides a model for cooperation among the Catholic Academy represented here by Seton Hall Law School, the University of St. Thomas and St. Louis University; that the Catholic Academy may be a think tank for the Church in Service to address the complex issues that are certain to arise for all Church-related institutions that serve the public.

Structure of the Symposium Dialogue

Theology, Catholic Social Teaching and Canon law are normative disciplines. There is a long history of applying these disciplines in the context of the public charitable corporate status of health care. There is a comfort level with the "fit" of Ministry to the public charitable corporate form for the provider of services. In fact, many public charitable corporations use both for-profit and non-profit corporations to support the delivery of their primary service. The new issue of a for-profit, *religiously affiliated* provider, however, requires us to educate ourselves before reaching conclusions. The goal of Monday's presentation is to "level the playing field" and create, as much as possible, objective comparative legal and financial descriptions of the differences or similarities between the for-profit and not-for-profit public charitable status of the corporation. The discussion on Monday provides the frame of reference for

Tuesday's discussion of the for-profit structure from theological, Catholic Social Teaching and Canon law perspectives.

THE PRESENTATIONS FOCUS ON A SELECT NUMBER OF THEMES, MODELS AND PERSPECTIVES

1. The opening session presents the essential principles of Catholic health care in the corporate provider context. The focus on the corporate level centers the discussion on the effect of the corporate form on the elements of Ministry. For example, the corporation may only influence the availability of universal health care through its ability to lobby, and the rules governing lobbying are very different for for-profits and nonprofits.
2. We are privileged to have the creators and operators of three models that address issues thought to be relevant to Catholic identity tell their own story and dialogue with the audience.
3. The legal presentation is based on the assumption that the Ministry question is fundamentally related to the governance and management of the corporation, both in the identification of the persons and the legal rights among them. Therefore, this presentation is simply a comparative description based on the default provisions of the law governing public charitable corporations and for-profit corporations. This general information is relevant (but not necessarily dispositive!) to the essential principles of Catholic health care as well as the canonical issues and the managerial issues focusing on Communion with the Church that will be developed on Tuesday.
4. The financial topics focus on where "the rubber hits the road." Is access to equity a preference, or a compelling need for survival, to create a "margin for mission"? Does the external market use the same criteria to measure financial success? Is legal form a factor or *the* factor in financial sustainability and competitive success? Does culture dictate the means and ends of financial success, or do financial criteria determine culture? These questions will interface with the discussion on Tuesday morning concerning animating a Catholic health care system and managerial organizations.

5. There are two presentations that are meant to provide a broader context for the discussion. The presentation focusing on the *Credo* of Johnson and Johnson was chosen because the language of the Credo reflects many of the interests of Catholic Social Teaching, but does not raise the standard to Ministry. And the opening presentation on Tuesday is meant to transition the discussion to another, more expansive, assumption: does either corporate model determine health care as a private commodity or a public good?
6. The remaining presentations on Tuesday explore the Symposium question from the three disciplines related to Catholic Identity and Ministry: Theology, Canon Law and Catholic Social Teaching. We end with what we expect to be an engaging and facilitated lunch conversation.

Identifying Essential Principles for Catholic Health Care

*T. Dean Maines**
*Michael J. Naughton***

Since 2007, the Veritas Institute has had the privilege of working with several Catholic health care systems. Using a tool called the *Catholic Identity Matrix*, which we developed jointly with Ascension Health, our work has focused upon helping these organizations assess the degree or extent to which principles for Catholic health care have been operationalized within their hospitals—that is, the extent to which these principles have been embedded within the operating policies, processes, and practices that guide how Catholic hospitals deliver care. Our remarks emerge from reflection upon this work. They capture some of the lessons we have learned about Catholic health care's distinctive nature, about the principles that animate this nature, and about how these principles can be brought to life within organizations.

The title and question for this Symposium, *Is for-profit Catholic health care a viable alternative for ministry?*, challenge us to exercise the virtue of practical wisdom (prudence). They call us to be wise in the practical affairs of Catholic health care. Among the virtues, far-sighted practical wisdom holds a primary place. This is especially true for the professional leader. The challenge to practical wisdom before us can be formulated in a three-part question:

Can a for-profit institution, with its unique legal and financial structures and forms, serve as

- *an effective means*
- *to achieve the end of Catholic health care*
- *in constantly changing circumstances?*

First, *effective means*: Is a for-profit structure an effective institutional form to achieve or realize the essential principles of a Catholic health care organization? Throughout the Church's history,

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** Michael J. Naughton, Ph.D., Director, John A. Ryan Institute for Catholic Social Thought, University of St. Thomas.

people have created and adapted new institutional forms to help them live a life of faithful Christian discipleship. Today is no different. Monasteries, religious orders, oratories, guilds, mutual benefit societies, cooperatives, credit organizations, universities, and charities are all different institutional forms the Catholic Church has used to evangelize the culture, to bring the good news to the world. Practically wise leaders are precisely that, "practical": They employ great competency, insight, and creativity to invent new forms of organizational life and to make these institutions effective and sustainable. If one is not competent, skillful, and creative, one cannot be prudent.

Second, *a good end*: We need to keep before us the real heart of the matter, namely, the end, the *telos*, the purpose of Catholic health care. What are the underlying first principles that describe more concretely the institutional goods that Catholic health care promotes? As Stephen Covey has noted, we need the habit of beginning with the end in mind.[1] Or, as John Henry Newman put it, the practically wise person "discerns the end in every beginning."[2] As we discern the beginnings of Catholic health care within a for-profit structure, can we see the end? What problems or issues might a for-profit structure pose for Catholic health care? Does the for-profit form itself compromise that end? Conversely, what opportunities might this form offer Catholic health care?

Third, *constantly changing circumstances*: What are the unique circumstances and situations in which we find ourselves? As our former colleague Peter Vaill has wisely pointed out, we live in "permanent whitewater."[3] The rapidity of change within health care is widely recognized and commented on. Change is a fact of life; however, authentic development and growth in the midst of change is not. Future changes could present extraordinary opportunities for Catholic health care. They also could raise significant risks, specifically the loss or diminishment of Catholic health care's mission and distinctive identity.

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[1] STEPHEN R. COVEY, THE SEVEN HABITS OF HIGHLY EFFECTIVE PEOPLE: RESTORING THE CHARACTER ETHIC (1989).

[2] JOHN HENRY CARDINAL NEWMAN, THE IDEA OF A UNIVERSITY DEFINED AND ILLUSTRATED: I. IN NINE DISCOURSES DELIVERED TO THE CATHOLICS OF DUBLIN; II. IN OCCASIONAL LECTURES AND ESSAYS ADDRESSED TO THE MEMBERS OF THE CATHOLIC UNIVERSITY (BiblioLife 2009) (1858).

[3] PETER B. VAILL, LEARNING AS A WAY OF BEING: STRATEGIES FOR SURVIVAL IN A WORLD OF PERMANENT WHITE WATER (1996).

We are here focused on the ends, the *telos,* and in particular the principles of Catholic health care. It is helpful to offer a balcony perspective before we move to the complicated terrain of law, finance, and leadership in relation to a for-profit structure. A balcony perspective is needed to gain a deepened understanding of the end, our *telos*, and principles. Of course, there is a danger that our formulations of Catholic health care's ends and principles can become rote, abstract, formulaic, and flat. If so, they will only distance us from the concrete realties before us. But this only reinforces the need for deeper insights on the end of Catholic health care—what Catholic health care is all about. Barbara Ward, a Catholic British economist and social commentator, captured this point well when she stated:

> The most important change that people can make is to change their way of looking at the world. We can change studies, jobs, neighborhoods, even countries and continents and still remain as we always were. But change our fundamental angle of vision and everything changes—our priorities, our values, our judgments, our pursuits. Again and again, in the history of religion, this total upheaval in the imagination has marked the beginning of a new life. . . a turning of the heart, a '*metanoia*' by which men see with new eyes and understand with new minds and turn their energies to new ways of living.[4]

This "metanoia," this new way of seeing and living, is very important in terms of how we see and think about institutions generally and in particular the institution we call Catholic health care. One way to frame our thinking about organizations in light of our topic is to place them on an institutional continuum that ranges from a "society of individuals" at one end to a "community of persons" at the other.[5] No organization perfectly embodies either pole; however, the continuum helps us to see more clearly the risks and opportunities different organizational forms may pose.

Does a for-profit system with its specific structures and forms necessarily move Catholic health care toward a "society of individuals"? This is an impersonal construct where there is little loyalty or connection to a transcendent good; where procedures and

[4] Barbara Ward, Address to the Pontifical Commission on Justice and Peace (1971).

[5] For further development on this distinction, see MICHAEL NAUGHTON, THE LOGIC OF GIFT: RETHINKING BUSINESS AS A COMMUNITY OF PERSONS—PERE MARQUETTE LECTURE (2012).

processes dominate the institutional landscape to such an extent that they replace practically wise judgment as the basis of decisions; where virtue and trust are displaced by the logic of contracts and the mechanics of the law; and where profit maximization reduces relationships to mere exchanges based on margins. The profit motive, in particular, can create or intensify what some have called the *financialisation* of health care, i.e., the reduction of health care to an impersonal commodity through the draconian application of financial ratios. In other words, does a for-profit structure in health care make it more difficult to have a "shared common good," and does it move us to a negotiation of individual interests and stakes with focus on survival, security, and individual success?

Or can a for-profit Catholic health care institution incline toward a "community of persons"? This term that has been increasingly used within the Catholic social tradition to describe an institutional life where a theological motive and an ecclesial relationship enable an organization to live out the gospel and humanize the world; where exchanges are not just about individual interests, but meaningful relationships, reciprocity, and even non-equivalence; where trust is developed through moral character and the exercise of virtue by those in the organization, and not primarily through legal contracts; where people are ready to make sacrifices; and where organizational rewards are shared equitably and where people develop integrally. In other words, can a for-profit Catholic health care organization participate in the deepest reality of its purpose, namely, "to continue the healing ministry of Jesus Christ"?

This purpose points us to the ultimate end of Catholic health care; as the French put it, the organization's *raison d'être*, its reason for being. Most organizations don't make this *raison d'être* explicit, but Catholic health care must and does. The end or *telos* of Catholic health care cannot be simply growth, healthy margins, survival or even a generic commitment to treating its patients well. These ends just are not good enough for an organization called to enflesh Christ's healing work. Yet, to institutionalize this purpose and to engage the question of whether this purpose can be achieved within a for-profit form, we need to "progressively articulate" the institutional goods that are necessary to incarnate this purpose.[6]

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[6] Kenneth E. Goodpaster, T. Dean Maines & Michelle D. Rovang, *Stakeholder Thinking: Beyond Paradox to Practicality*, 7 J. CORP. CITIZENSHIP 93 (2002).

In order to move toward this articulation, we must address two important organizational realities. First of all, we must articulate a *model of institutional life*. What model of institutional life comes to mind when we think of Catholic health care? Does this institutional model help us to see things whole or only in parts? Does it help us see the long-term implications of our decisions or simply their immediate effects? Do we have a model that is capable of describing or depicting all that we mean by the healing ministry of Jesus? The prototypical models of accounting and finance include balance sheets, income statements, and cash-flow statements. Prototypical models for law are contracts, a bundle of contracts, and for some, a social contract. For Catholic health care, these financial and legal formulas or metaphors are necessary and important. However, they fail to capture adequately how a Catholic health care organization can reflect the fuller meaning of a "community of persons."

In considering a Catholic health care system or hospital, we specifically should think about three interdependent objectives or dimensions of institutional life.[7] These dimensions are:

- *Mission*: the impact or effect an organization has on the world, especially in light of the service or product it provides;
- *Identity*: the organization's inner life, its culture and the kind of work that should be done in the organization; and
- *Stewardship*: the strength and viability of the institution, its ability to carry on its identity and mission into the future.

These three institutional objectives map with what people want from their work. Alasdair MacIntyre explains that:

> Most productive work is and cannot but be tedious, arduous, and fatiguing much of the time. What makes it worthwhile to work and to work well is threefold: that the work that we do has a point and purpose, is productive of genuine goods [mission]; that the work that we do is and is recognized to be *our* work, *our* contribution, in which we are given and take responsibility for

[7] *See* Pontifical Council for Justice and Peace, Vocation of the Business Leader: A Reflection (2012), *available at* http://www.stthomas.edu/cathstudies/cst/VocationBusinessLead/; *see also* David Specht & Richard Broholm, Three-fold Model of Organizational Life (2009) *at* http://www.seeingthingswhole.org/uploads/Watermark-Three-Fold-Model-of-Organ-Life_729153.pdf (last viewed Dec. 21, 2012).

> doing it and for doing it well [identity]; and that we are rewarded for doing it in a way that enables us to achieve the goods of family and community [stewardship].[8]

Second, while these three dimensions help us to see an institution whole, what essential principles should inform and guide Catholic health care within each dimension? Without principles, a model of institutional life is morally blind. That is, its purpose or *telos* is unclear and it can serve any number of ends, some of which may be morally problematic. Conversely, lacking an adequate, capable model of institutional life, moral principles are impotent. In other words, they function as moral abstractions. They struggle to gain traction within the concrete realities of life. Locating moral principles within an institutional model helps us to see their practical implications more clearly.

For these reasons, we want to do more than provide a laundry list of moral standards for organizations to follow. We want to think about moral principles within the context of institutional life—that is, in relation to mission, identity, or stewardship—so that we can identify more readily what they call a Catholic organization to do and to become. Our proposed framework integrates the threefold model with seven principles for Catholic health care in the following manner:

Mission

- Holistic Care
- Respect for Human Life
- Solidarity with the Poor

Identity

- Dignity and Subjective Dimension of Work
- Subsidiarity

Stewardship

- Creation and Just Distribution of Wealth
- Act in Communion with the Church

The seven principles above are grounded in the broad Catholic moral tradition. More specifically, they draw upon the *Ethical and*

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[8] Alasdair MacIntyre, *How Aristotelianism Can Become Revolutionary: Ethics, Resistance and Utopia*, *in* VIRTUE AND POLITICS 323 (Paul Blackledge & Kelvin Knight eds., 2011).

Religious Directives for Catholic Health Care Services[9] and the Catholic social tradition. They also are rooted within the experience of Catholic health care leaders, as articulated within the Catholic Health Association's "Living Our Promises, Acting on Faith" project[10] and its *Shared Statement of Identity for the Catholic Health Ministry.*[11]

Mission

The term "mission" comes from the Latin *missio,* meaning "to send out." Thus, the mission dimension of the threefold model is externally focused. It considers the organization's effect upon the external world, and upon those in the world who are helped or served by the organization.

The mission dimension recognizes that the work of institutions has tremendous significance for humanity. Institutions produce products and deliver services, and many of these are essential to human flourishing—for example, food, clothing, transportation, education, and healing. Within the mission dimension, a moral litmus test is whether an organization is delivering "goods that are truly good, and services that truly serve."[12]

Considering Catholic health care institutions, the mission dimension raises two critical questions. First, who is Catholic health care called to serve? Second, what impact should Catholic health care have upon these individuals or groups? More specifically, what kind of healing should Catholic health systems or hospitals provide?

Three principles help to answer these questions. The principle of *holistic care* calls for health services to be provided in a way that recognizes that patients are not merely bodies, but persons.

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9 U.S. Catholic Conference of Bishops, Ethical and Religious Directives for Catholic Health Care Services (5th ed. 2009), *available at* http://www.usccb.org/about/doctrine/ethical-and-religious-directives/.

10 This project was initiated by the CHA board of trustees in 2002 to "identify and measure the ways in which Catholic health care organizations are living out their Catholic identity." *See generally* Ed Giganti, *Living Our Promises, Acting on Faith: Year Two Update of CHA's Performance Improvement Project in Health Ministry*, 82–1 Health Progress at 32 (Jan.–Feb. 2001).

11 Catholic Health Ass'n of U.S., Shared Statement of Identity for the Catholic Health Ministry, *at* http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=802.

12 Kenneth E. Goodpaster, *Goods That Are Truly Good and Services that Truly Serve: Reflections on "Caritas in Veritate,"* 100 J. Bus. Ethics 9, 9–16 (2011).

Patients are multifaceted beings who have a physical, social, psychological, and spiritual dimension to their existence. Holistic care calls for all those dimensions to be attended to in the healing process. Jesus healed people radically. That is, he healed them physically and psychologically, but his healing touched their innermost being, it penetrated to their spiritual core. Carrying forward the healing ministry of Jesus into the contemporary world, Catholic health care is concerned with the radical healing of those it serves. It aspires to transform the experience of sickness and healing into an experience of God's saving love present in the midst of suffering, an experience of redemption that leads not only to restored health but also to greater wholeness.[13]

Practically, holistic care requires advanced medical expertise to be integrated with the ministrations of other professions within particular settings—for example, an emergency department, a cancer center, a hospice. Thus, Catholic health care's characteristic approach is interdisciplinary. It unites the insights of clinicians with those of social workers, psychologists, and chaplains, to promote healing in body, mind, and spirit through caring, compassionate relations.

A second principle relevant to mission is *respect for life*. At the heart of the broad Catholic moral tradition is the conviction that each human being is made in God's image and likeness, and thus possesses intrinsic worth simply by virtue of his or her existence. The English word "respect" is drawn from the Latin *respectare*, to re-look, to look a second time. Respect for human dignity calls us to move beyond first impressions, to look again, to seek and recognize the unique value of each individual as an unrepeatable, irreplaceable personal reality.[14]

Respect for human dignity makes multiple moral demands upon us. Taken as a whole, the principles for Catholic health care highlight the range and varied nature of these demands. Among other things, respect for human dignity requires us to demonstrate a profound respect for all human life, throughout the entire cycle of human existence, from conception through birth, through childhood, adolescence and maturity, all the way to natural death. Showing respect for human life in its most vulnerable stages—that

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13 BENEDICT M. ASHLEY & KEVIN D. O'ROURKE, HEALTH CARE ETHICS: A THEOLOGICAL ANALYSIS 135 (4th ed. 1997).

14 We are indebted to our colleague Ken Goodpaster for this insight.

is, at the beginning of life and the end of life—is a fundamental and essential way in which we manifest respect for human dignity.

The third principle, *solidarity with the poor*, further develops the themes of respect for human dignity and concern for the vulnerable. The general principle of solidarity emphasizes the unity of all humans and our interdependence. It calls us to serve as our brothers' and sisters' keeper, regardless of their distance from us, whether we measure that distance socially, culturally, or economically. Catholic health care institutions act upon this general call by being places that welcome all community members who seek healing.

But while we are called to exercise solidarity in our relations with all people, in the Christian tradition, as well as other religious traditions, the poor and vulnerable, those who live at society's margins, are recognized as having the most urgent claim upon our attention and conscience. Both Jewish and Christian Scriptures underscore this point, revealing God's special concern for the poor. Solidarity with the poor emphasizes the duty of Catholic health care institutions to act for the good of the poor who live within the communities they serve. They must attend to their health care needs, but they also are called to be with the poor in their plight, to listen to them, and to advocate on their behalf. Attention to and service of the poor should be a hallmark of every Catholic health system and hospital.

Identity

In contrast to mission, the identity dimension of the threefold model is internally focused. It centers upon an institution's inner life, the unique character or distinctive personality of its culture. It pays particular attention to how employees interact with one another.

While employees or associates are the principal stakeholder here, this dimension has particular salience for an institution's leaders. In his book, *Leadership in Administration*, Philip Selznick examined the process by which an organization acquires a distinctive culture or identity. This process entails the inculcation and maintenance of moral values, of moral principles. Indeed, Selznick identifies the leader's role primarily with this task of promot-

ing, integrating, and sustaining moral principles.[15] Embedding moral principles within an organization's operations fosters a unity of intention and action that gives that organization its distinctive character. It also transforms the organization from a collection or "society of individuals" into a "community of persons"—in the case of Catholic health care, a community focused on the healing ministry of Jesus Christ.

For Selznick, the moral principles in question here focus especially upon relations inside the organization, without losing sight of the moral principles that guide its relations with external parties. So the critical question for the identity dimension is, "who are we?" in the sense of "how do we work together to serve the needs of others?" What kind of relationships and structures should we form inside the institution, to carry our mission out to the world?

The Catholic social tradition offers Catholic health care a rich tradition of reflection on work and organizational life. Two principles from the social tradition are vital to the identity dimension. The first principle, the *dignity of human work and the subjective dimension of work*, is foundational. This principle offers two insights. First, it recognizes that all work has dignity, whether it is performed by a chief executive officer, a physician, a nurse, a clerk, or a janitor. Our work expresses our distinctive personalities; it helps us provide for our needs; and it enables us to contribute to society—both the "small society" of our families and the broader community. Second, this principle recognizes that work has both an objective and subjective dimension. Objectively, our work affects the world around us—for example, material objects, social arrangements, and other people. It enables us to shape the world; it gives us an opportunity to participate in God's ongoing creative activity. Subjectively, work influences how we develop as persons, who we become. In the words of Pope John Paul II, "work is a good thing for man. . . because through work man not only transforms nature, adapting it to his own needs, but he also achieves fulfillment as a human being and indeed in a sense becomes 'more of a human being.'"[16] Work can help us develop our capacity for forming right relationships with others; it also can help us expand our skills, our

[15] PHILLIP SELZNICK, LEADERSHIP IN ADMINISTRATION: A SOCIOLOGICAL INTERPRETATION 62–63 (1957).

[16] Pope John Paul II, *Laborem Exercens*, *in* CATHOLIC SOCIAL THOUGHT: THE DOCUMENTARY HERITAGE 9 (David J. O'Brien & Thomas A. Shannon eds., 1999).

abilities, and our knowledge. Conversely, work can also stunt or distort our development as human persons. Commenting upon the industrial organizations of his day in *Quadragesimo Anno*, Pope Pius XI lamented this latter tendency. Pius noted that dead matter went into factories and came out ennobled—that is, transformed into useful goods—while workers would go into the same factories and come out degraded, having served for hours as mere cogs in rote, mechanistic production schemes, with little time to relax, no time to reflect, and no opportunity to contribute with their minds as well as their hands.[17]

Because work has dignity and influences human development, leaders of Catholic health care institutions must ensure work is organized so that it helps employees grow authentically through the use of their intelligence and freedom, to achieve shared goals and create morally good relationships with one another and those served by the institution. Doing this requires leaders to observe a second principle, *subsidiarity*. Subsidiarity guides the distribution of authority, autonomy, and accountability within the context of community. Subsidiarity directs leaders to place decision-making at the most appropriate organizational level, keeping in mind that those closest to the work often know the most about it. Thus, decisions that affect the entire institution should be made by those who carry responsibility for the organization as a whole, while decisions whose impact is primarily local should be made locally, for example, at the unit or departmental level. Subsidiarity also calls leaders to provide associates with the support, education, and resources they need to responsibly exercise decision-making. Furthermore, it requires them to establish a "line of sight" between the institution's mission and the work of each subgroup, so that local decisions align with the organization's overarching purpose.

Stewardship

The stewardship dimension of the threefold model concentrates upon the institution's sustainability, broadly understood. It focuses upon how the institution employs the resources entrusted to it, to strengthen the organization and assure its continued existence. Stewardship also concerns itself with issues of governance,

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17 Pope Pius XI, *Quadragesimo Anno*, *in* Catholic Social Thought: The Documentary Heritage, *supra* note 16, at 135.

with an eye toward sustaining the continuity and vibrancy of an institution's purpose. Stewardship has particular salience for an institution's leaders, including those charged with its governance, since these individuals are charged with maintaining the organization's well-being and integrity over the long haul.

Two interrelated standards from the Catholic social tradition guide the management and allocation of resources, namely, *wealth creation and just distribution.* Like the good stewards in the Gospel parable of the talents, Catholic health care institutions are called to produce wealth by creatively utilizing the resources at their disposal. They must steward these resources responsibly and find innovative ways to produce more from what they receive. Leaders of Catholic health care organizations are called to do this with respect to the various types of resources entrusted to their organization: the skills, knowledge, and abilities of employees; financial assets; and facilities, property, and equipment. Furthermore, Catholic health systems and hospitals must act as good stewards of the natural environment. Relevant to this principle are such topics as revenue growth, market share, margins and profitability, service quality, operational effectiveness, productivity, employee development, and environmental impact.

Wealth creation brings with it the concomitant task of wealth distribution. The principle of just distribution calls for wealth to be allocated in a way that renders to others what they are due. This principle raises a set of knotty and enduring moral challenges for leaders, challenges that touch upon fundamental questions of equity and fairness. In a sense, these issues are never solved once and for all. Rather, they must be revisited again and again, as the institution's circumstances change. Among other things, the principle of just distribution calls leaders to discern and account for the moral implications of how they set prices, compensate employees, manage payables and receivables, and allocate benefits and support within their service area. These decisions affect relationships with a number of stakeholders, including patients, payers, associates, suppliers, and the communities in which the institution operates. These decisions also impact the very viability of the organization.

The principle of *acting in communion with the Church* highlights the fact that Catholic health care institutions are not isolated entities. Rather, these institutions participate in a set of realities that

are communions, things that are held in common. These communions inform the activities of Catholic health institutions. Catholic health systems and hospitals are called to cultivate these communions to ensure the continuity and vitality of their purpose through time.

First, Catholic health care institutions participate in an incarnational or sacramental reality, Christ's salvific work, and his healing ministry in particular. This work is not an historical artifact, but an active, vivifying presence here and now. Catholic health care institutions enflesh, or incarnate, the healing ministry of Jesus Christ in today's world. Consequently, leaders in Catholic health care have a responsibility to ensure that their institutions are instruments that make present God's love in every healing encounter.

Second, Catholic health care institutions participate in an ecclesial reality. Christ's saving work is entrusted to the Church as a whole. As ministries of the Church, Catholic health care undertakes Christ's healing work on behalf of and as part of the broader Church. Catholic health care institutions, then, are in relationship with other groups within the Church. For example, many Catholic health care institutions are authorized to participate in the healing ministry of Jesus through their sponsoring religious orders or congregations. Thus, they have a responsibility to cultivate their relationships with these institutes, whose distinctive charisms inspired their founding and have animated their operations through the years. A Catholic health care institution also has a responsibility to cultivate its relationship with the bishop in whose diocese its facilities are located. These are not optional activities, but the necessary bonds of ecclesial communion that ground Catholic health care in the healing ministry of Jesus Christ.

Third, Catholic health care institutions participate in a moral reality, a tradition of teaching, scholarship, and reflection that articulates the moral implications of these incarnational and ecclesial realities. Concretely, this tradition is expressed within the *Ethical and Religious Directives for Catholic Health Care Services*,[18] additional teachings on biomedical questions, the Church's social teaching, and other magisterial pronouncements. Catholic institutions have a responsibility to follow those teachings, but also to contribute to

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[18] U.S. CATHOLIC CONFERENCE OF BISHOPS, *supra* note 9.

their ongoing development. The men and women who staff Catholic health systems and hospitals are uniquely positioned to help the broader Church discern the moral implications of emerging developments in medical science, as well as new approaches to clinical practice.

We think the experience of Christian universities highlights the importance of these communions, these vital connections, to the task of sustaining institutional purpose. In his book, *The Dying of the Light*, James Burtchaell examines how the original Christian mission and identity of 17 universities—Dartmouth College, Wake Forest University, and others—gradually weakened over time. Burtchaell's research suggests that one factor contributing to this attenuation was the severing of each school from its founding ecclesial community. With the loss of that link, each school's identity and mission moved from being distinctly Methodist, Lutheran, Presbyterian or Catholic to being generically Christian, to being spiritual or humanistic, to ultimately becoming secular, focused upon the faculty's professional goals or simply the school's survival. Broadly, this experience suggests that absent a conscious cultivation of these communions, an active participation and cooperation in these shared goods, the distinctive identity and purpose of a Christian institution is prone to deflation and loss.[19]

CONCLUSION

All of this brings us back to what we discussed at the presentation's beginning—practical wisdom. To be wise in the practical affairs, we must address many questions about the for-profit form, in light of the principles of Catholic health care as they are applied within the context of the three-fold model. These questions include the following:

Mission

- In light of the continuing pressures to reduce the value of health care services to a price (commoditization), do for-profit structures intensify the barriers to implement the principles of holistic care, respect for life, and solidarity with the poor?

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[19] JAMES TUNSTEAD BURTCHAELL, THE DYING OF THE LIGHT: THE DISENGAGEMENT OF COLLEGES AND UNIVERSITIES FROM THEIR CHRISTIAN CHURCHES 819–51 (1998).

- Are the demands of respect for life and solidarity with the poor at risk within an organization that must be principally responsive to investors?
- Does a for-profit legal status make it more difficult for a hospital to be distinctively Catholic in the care that it provides?

Identity

- Does a for-profit structure place burdensome restrictions on hiring and on the development of the kind of culture needed to maintain a Catholic health care system? Are there unintended secularizing consequences here?
- How might a for-profit structure affect the moral and spiritual formation programs offered within a Catholic health care system?
- Are we overly dependent on thinking that structures alone can carry Catholic identity? Are we guilty of "dreaming of systems so perfect that no one will need to be good"?[20]

Stewardship

- What implications does a for-profit structure have for the just allocation of wealth among stakeholders, including investors?
- Could a for-profit ownership structure impede "communion with the Church"? What unintended consequences of a "private" ownership system might impede the establishment of robust ecclesial relationships?

To address these and others questions raised by this Symposium, they have to be considered in a way that reflects the virtue of practical wisdom; three important qualities must inform our conversations:

1. *Memory*: We need to remember, to recall, be mindful of the best of what lies deep within the Church's tradition, our wider culture and each of us. That is, we need to exercise what Plato and (more recently) Pope Benedict XVI have called *anamnesis*.[21] In our desire to be practical, we must

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[20] T.S. Eliot, *Choruses from "The Rock," in* THE COMPLETE POEMS AND PLAYS 1909–1950 at 106 (1971).

[21] Joseph Cardinal Ratzinger, *Conscience and Truth, in* ON CONSCIENCE 30–36 (2007).

avoid the error of forgetting the moral and religious principles that must guide our deliberations.

2. *Counsel*: We need counsel. Sr. Melanie DiPietro has gathered experts in finance, civil and canon law, moral theology, and management. It will take a good deal of intelligent conversation, careful listening, and careful questioning for us to avail ourselves fully of the counsel available in this setting.

3. *Foresight*: Finally, we need foresight. Foresight challenges us to anticipate the consequences entailed by a shift toward for-profit structures, especially unintended consequences. We are not fortunetellers; nonetheless, we must anticipate and judge the outcomes that are likely to result from our decisions. Again, Burtchaell's *Dying of the Light* offers an important lesson: While the leaders of Christian universities did not intend to secularize their institutions, over the long-term their decisions had the cumulative effect of moving them in that direction.

So, *is a for-profit system an effective structure to achieve the principles of Catholic Health Care within our current, dynamic environment? Is it a viable alternative for this ministry?* If we can bring forth this virtue of practical wisdom grounded in the principles of the Catholic tradition, and resist the temptation of answering these questions based purely on expediency and ideology, the participants of this Symposium can make a vital contribution to the ongoing development of this most important ministry of the Church for the world.

Examples of For-Profit Health Care Models

*Leo P. Brideau**
*Keith B. Pitts***
*David T. Vandewater****

Leo P. Brideau

Well, good morning. I want to thank Sister Melanie for organizing this symposium. It should be a very stimulating couple of days addressing a very important question.

What I'd like to do today is to break my presentation into, essentially, four segments. First, I want to talk a bit about the creation of Ascension Health Care Network, describing who we are, how we came to be, and how we are structured. I want to spend some time then on our role as a ministry of the church. I want to talk specifically about sponsorship and elements of Catholic identity, and how we ensure that those elements are a core part of who we are and how we behave. I want to spend a bit of time reconciling this question of Catholic health care on the one hand and for-profit status on the other hand, which is, obviously, the core theme of the conference. I will then close, briefly, with the value proposition that we think Ascension Health Care Network brings.

So, I begin with Ascension Health. Ascension is the largest Catholic health care system in America and the largest not-for-profit system in America. Ascension Health Care Network is a joint venture between Ascension Health Alliance and Oak Hill Capital Partners, a prominent private-equity firm that has been around for 26 years and whose focus is on creating value. We spent a great deal of time in discerning who our partner would be in this endeavor. This, of course, brings us to answer the question: How do we reconcile the concerns about preserving community benefit, preserving the mission of service to the poor and vulnerable, with the requirements of investors who expect a certain return on their income? For Ascension Health, we come at this question from the

* Leo P. Brideau, FACHE, President and Chief Executive Officer, Ascension Health Care Network.
** Keith B. Pitts, Vice Chairman, Vanguard Health Systems.
*** David T. Vandewater, M.S., President, Chief Executive Officer, Ardent Health Services.

standpoint of our commitment to maintaining the core elements of Catholic identity; that mission is a key part of who we are and what we are about. Oak Hill comes at it from the standpoint of reputation and role in the community. It views service to and engagement with the community as good business practice. So, we end up in the same place.

One of the catalyzing events for us in Ascension Health was watching the trend in transactions involving Catholic hospitals. In the last three years there have been 44 Catholic hospitals involved in these transactions, only five of which have gone to Catholic entities. The rest have gone to secular organizations, largely for-profit. Many of these hospitals approached Ascension Health wanting to join Ascension Health. The challenge that we had is simply that with the 70-plus hospitals Ascension Health has across the country, the competition for capital is significant. The need for capital to ensure that those ministries remain in place and vibrant in those locations where we are already located simply didn't leave any excess capital to permit us to support new hospitals coming in. As you might imagine, most of the hospitals who knock on the door aren't knocking because they have excess capital. It is the reverse: they have unfunded pension liabilities and they have unmet capital needs. For its purposes, Ascension Health needed a different source of capital. The question we raised was if, in fact, we are seeing more and more of these hospitals move to for-profit organizations, can we create a Catholic equity-based, or for-profit, health care system? Our answer was, yes, we believe we can.

So the decision really came out of these hospitals having difficulty meeting their capital needs, meeting their pension needs. And it came out of the board and the sponsor of Ascension Health. Naturally, the dialogue was a lot more formal than this, but essentially we said, okay, we are the largest Catholic health care system in America, so what? What difference does that make? If we aren't being active enough in strengthening the Catholic health ministry, not just inside of Ascension Health, but across America, then what business do we have being proud of the fact that we are the largest health care system? It is what we do with our size and scale that matters, and our board and sponsors really encouraged leadership to create a different model to be able to continue to sponsor and to strengthen the Catholic health ministry in the United States.

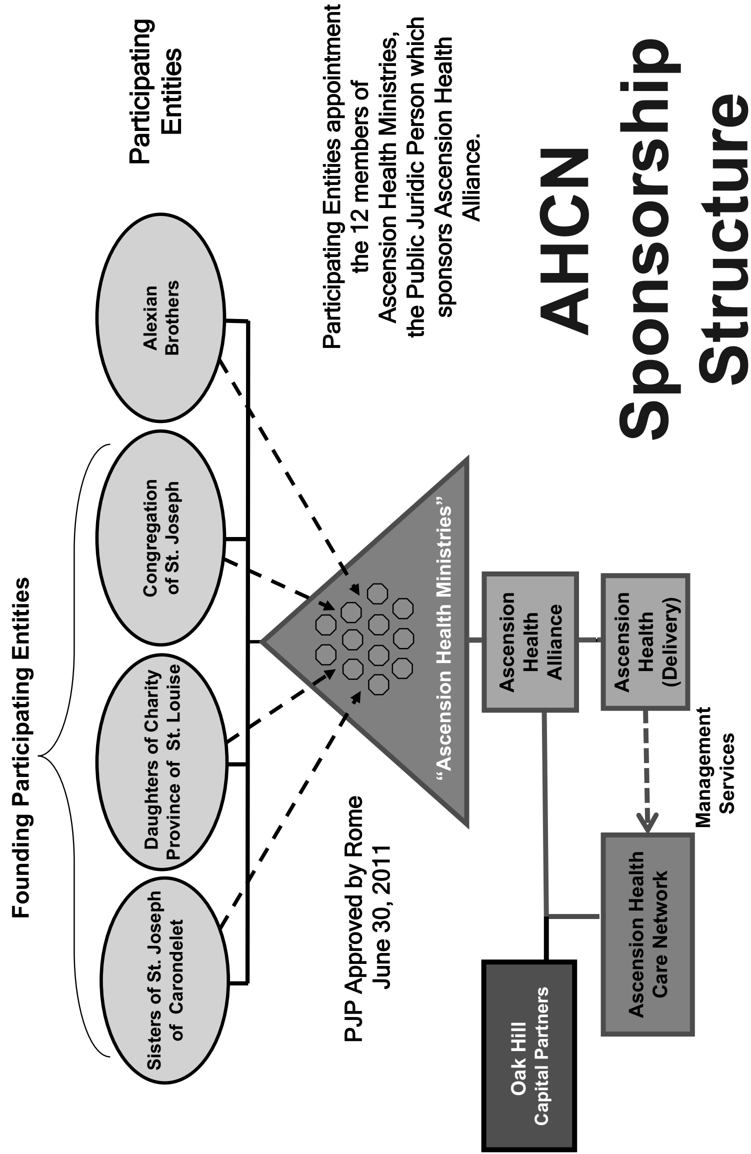
Ascension Health went through a careful discernment process

that involved theologians and ethicists, business people, lawyers and others. There was a lot of time spent seeking out and examining all of the documents written on this topic or commentary that could bear on the topic. In addition, as we evaluated private-equity firms as potential capital partners, we put them through our Values Compatibility Assessment Process. We do this for all partnerships in Ascension Health. And Oak Hill Capital Partners passed with flying colors. We also had prior experience with them. So this was not a quick decision. This took months and months to work through this discernment. It began with the fundamental understanding of who we are: that we are an active service done on behalf of the church in Jesus' name; a ministry of the church carrying on the healing mission of Jesus. That's the essence of who we are as an organization.

Ascension Health Care Network is sponsored by a Public Juridic Person, Ascension Health Ministries. The participating entities are the original founding sponsors of Ascension Health, and you can see the congregations represented here. Recently, we were very pleased to be joined by the Alexian Brothers. The Public Juridic Person then sponsors Ascension Health Alliance, which is the parent company of Ascension Health and it is also, together with Oak Hill Capital Partners, the parent company of Ascension Health Care Network. So that is how the sponsorship line runs for Ascension Health Care Network. All of the hospitals then that come into Ascension Health Care Network will be sponsored by Ascension Health Ministries, the Public Juridic Person.

The management contract between Ascension Health Alliance and Ascension Health Care Network is very important, because the intent here is that hospitals that come into Ascension Health Care Network, the for-profit component of the health care system, will be operated exactly as Ascension Health hospitals are, not just from a business standpoint, but also from the standpoint of Catholic identity in its fullness of expression in these hospitals. The structural elements include: it is a joint venture, 20 percent owned by Ascension Health Alliance, 80 percent by Oak Hill Capital. Ascension Health Alliance's minority rights live in perpetuity, which is a critical piece of this structure. We are a Delaware for-profit corporation. The board composition is six members appointed by Oak Hill, four by Ascension Health Alliance and the CEO of AHCN.

The key point that I want make here is that Ascension Health


AHCN
Sponsorship
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the 12 members of
Ascension Health Ministries,
the Public Juridic Person which
sponsors Ascension Health
Alliance.
Founding Participating Entities
Sisters of St. Joseph
of Carondelet
Daughters of Charity
Province of St. Louise
Congregation
of St. Joseph
Alexian
Brothers
PJP Approved by Rome
June 30, 2011
“Ascension Health Ministries”
Ascension
Health
Alliance
Ascension
Health
(Delivery)
Management
Services
Ascension Health
Care Network
Oak Hill
Capital Partners
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has sole authority in perpetuity over compliance with interpretation and application of the *Ethical and Religious Directives* (subject to the local Ordinary), as well as all other elements of Catholic identity—for example, charity care and community benefit. So if any private-equity partner were to put pressure on you to abandon the mission, to walk away from the poor, walk away from the vulnerable, the answer is Ascension Health has sole control within the partnership over every element of Catholic identity, including these key elements of Catholic identity shown in the graphic, in perpetuity. And so no ownership change in the company going forward can change that, even if we were to be unfortunate enough to have the wrong capital partner (and we don't think we do; we think we have right capital partner); nonetheless, that authority rests solely with Ascension Health.

The first paragraph in our materials available at this Symposium describes our vision, which in its essence is doing what is necessary to ensure a strong, vibrant Catholic health ministry in the country that is committed to the health and well-being of communities. That is the core of what we envision going forward. Our values will look pretty familiar to almost any Catholic health care ministry in the country. We care about them; we take them seriously. This is what we live by.

I talked about our sponsorship link: it's through the relationship with Ascension Health Ministries, the Public Juridic Person. Ascension Health Ministries is recognized by the Holy See as the sponsor of Ascension Health Alliance and all of its subsidiaries; so there is a direct linkage. And then, Ascension Health Ministries, as the sponsor, holds Ascension Health Alliance and through that holds the governance and management of Ascension Health Care Network accountable to make sure that these works are carried out consistent with the teachings and values of the Church, and are fully present in fulfillment of our mission.

We think that, as a ministry of the Church, Catholic identity goes way beyond agreeing to abide by the *Ethical and Religious Directives.* The team from St. Thomas University did a great job defining the core elements of Catholic identity. If you look at the way we express and define these seven elements here [shown in graphic #2], this ought to look very familiar. I want to say that these elements of Catholic identity, fully expressed (and this is about a seven- or eight-page document), are included in the contractual

Purpose & Identity

- As a **ministry of the Church** we believe our Catholic Identity goes beyond an agreement to adhere to the Ethical and Religious Directives.
- We use an integrated, comprehensive approach to express and to sustain our Catholic Identity. Key Elements include:
  - Promoting and Defending Human Life and Human Dignity
  - Promoting the Common Good and Justice
  - Promoting and Maintaining Holistic Care
  - Promoting a Participatory Community of Work and Mutual Respect
  - Living its mission in Solidarity with those who live in Poverty
  - Stewarding its resources on behalf of the ministry
  - Acting in Communion with the Church

ASCENSION HEALTH
CARE NETWORK

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AHCN Values

- **Service**—We care for individuals and communities, with a preference for those who are most vulnerable.
- **Creativity**—We invent innovative solutions to complex problems.
- **Wisdom**—We employ strategic insight to achieve clinical and operational excellence and ensure sustainability.
- **Reverence**—We exemplify reverence for all persons in our interactions with patients, associates, physicians and business partners.
- **Integrity**—We demonstrate trust and accountability in all our dealings.

Ascension Health Care Network

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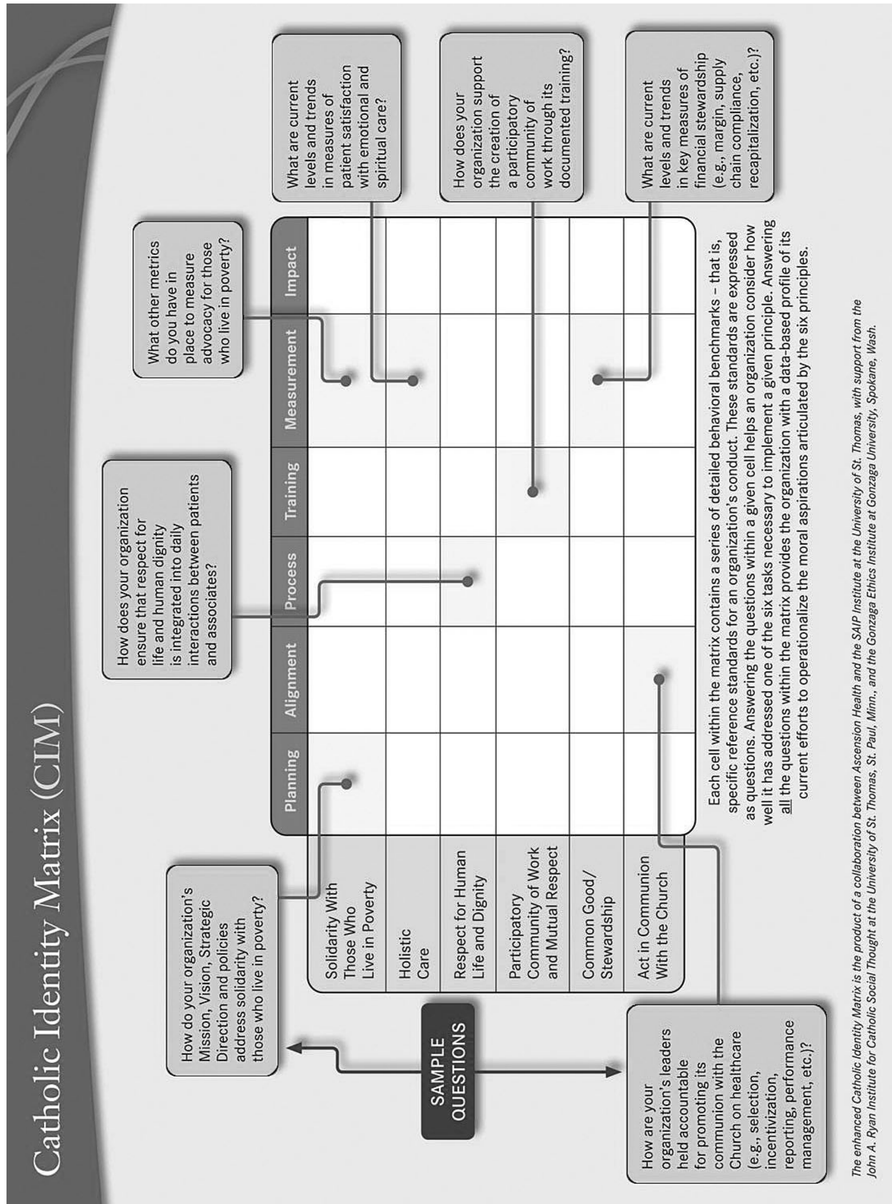
agreement that Ascension Health has with Oak Hill Capital Partners. So, our agreement is clear and detailed in providing that every one of these elements of Catholic Identity falls fully under the responsibility of Ascension Health.

Agreeing to do something and accepting responsibility for it is one thing; carrying it out on a day-to-day basis is something else entirely. Here is how it's done within our organization. First, in the leadership of every hospital there is a senior person who holds the role of vice president for mission integration, reporting directly to the CEO, who, as CEO, is held accountable for carrying out the elements of Catholic identity. Formation programs are also provided by Ascension Health for executive leadership, middle management, the board, physicians, and associates. We have a robust set of services around formation, and those are actively provided throughout the hospitals.

Our ethics services—and we have three of our ethicists here today—are available to all of these hospitals as well. Spiritual care is a core part of how we organize and deliver care. In fact, one of the things that I feel passionately about is that we, as Catholic health care providers, have failed to understand that providing Catholic health care, providing holistic, person-centered care, is a tremendous competitive advantage. We don't take advantage of that enough in the marketplace. We are different. We are qualitatively different, and focusing on this isn't only being true to our Catholic identity; focusing on providing this kind of care sets us apart from our competitors in the marketplace.

And, finally, work-place spirituality: the community of inspired individuals who provide care to our patients and the whole series of resources that Ascension Health brings forward. So the unique thing here isn't simply that we agree to abide by the *Ethical and Religious Directives*, and that we value our Catholic identity, but rather, that we also bring a full set of resources that we can bring to bear to assist hospitals in making this a reality on a day-to-day basis.

To evaluate how well we express Catholic identity, we have a set of metrics (called the Catholic Identity Matrix) that Ascension Health developed in concert with the Veritas Institute at the University of St. Thomas and with the Gonzaga Ethics Institute at Gonzaga University (if I can mention yet another university in this room), and it is based on Malcolm Baldrige's principles. Basically, it takes the key elements of Catholic identity and then walks us


Catholic Identity Matrix (CIM)
SAMPLE QUESTIONS
How do your organization's Mission, Vision, Strategic Direction and policies address solidarity with those who live in poverty?
How does your organization ensure that respect for life and human dignity is integrated into daily interactions between patients and associates?
What other metrics do you have in place to measure advocacy for those who live in poverty?
What are current levels and trends in measures of patient satisfaction with emotional and spiritual care?
How does your organization support the creation of a participatory community of work through its documented training?
What are current levels and trends in key measures of financial stewardship (e.g., margin, supply chain compliance, recapitalization, etc.)?
How are your organization's leaders held accountable for promoting its communion with the Church on healthcare (e.g., selection, incentivization, reporting, performance management, etc.)?
Planning
Alignment
Process
Training
Measurement
Impact
Solidarity With Those Who Live in Poverty
Holistic Care
Respect for Human Life and Dignity
Participatory Community of Work and Mutual Respect
Common Good/ Stewardship
Act in Communion With the Church
Each cell within the matrix contains a series of detailed behavioral benchmarks – that is, specific reference standards for an organization's conduct. These standards are expressed as questions. Answering the questions within a given cell helps an organization consider how well it has addressed one of the six tasks necessary to implement a given principle. Answering all the questions within the matrix provides the organization with a data-based profile of its current efforts to operationalize the moral aspirations articulated by the six principles.
The enhanced Catholic Identity Matrix is the product of a collaboration between Ascension Health and the SAIP Institute at the University of St. Thomas, with support from the John A. Ryan Institute for Catholic Social Thought at the University of St. Thomas, St. Paul, Minn., and the Gonzaga Ethics Institute at Gonzaga University, Spokane, Wash.

through questions around how we plan for actualizing Catholic identity; what the alignment mechanisms are to ensure that these elements are implemented; what processes we have in place; how we carry out this work on a regular basis; what training and education do we provide to our associates to make sure that they understand what is required by the particular element of Catholic identity; why they are doing what they are doing; and how they can best do what they do. The metrics help us determine how well we are doing and to measure the impact we are having on the quality of care, the quality of life of our associates, and the satisfaction of physicians who practice in the hospital.

The Catholic Identity Matrix is a very disciplined tool and its power lies in its ability to cause us to demonstrate that we are truly faithful to Catholic identity in all of its elements. Ultimately, the Catholic Identity Matrix helps Ascension Health Ministries, the canonical sponsor, evaluate how we are doing in implementing every element of Catholic identity.

So, I have explained the way we maintain Catholic identity in Ascension Health Care Network, I've talked about Ascension Health Alliance's authority. Ascension also has approval rights over the sale of any Catholic hospital, in accordance with canon law, as our hospitals are recognized by the Church as Catholic works, through the Public Juridic Person of Ascension Health Ministries. I've also talked about the oversight of day-to-day operation and integration.

Let us now turn to the for-profit issue. And I'm really very, very pleased that Seton Hall School of Law is sponsoring this Symposium because when I go around the country and talk to congregations who today sponsor Catholic hospitals, and I use the words "Catholic" and "for-profit" in the same sentence, their eyebrows raise. There is a bit of cognitive dissonance. There is a hurdle to overcome. A good way to think about it is this: if you take a look at graphic number 5, on the left are the ways not-for-profit hospitals acquire capital today, as well as the ways they use capital. On the right, you see the ways Ascension Health Care Network hospitals (for-profit hospitals) acquire and use capital. The acquisition process is pretty much the same: every hospital, whether its tax status is for-profit or not has to make a "profit" or go out of business—that's a basic principle of stewardship. So, the not-for-profit hospital makes a profit—then borrows money, invests its reserves in

"For profit" describes AHCN's tax status; not its purpose.

A <u>not-for-profit Catholic hospital meets its capital needs in three ways:</u>
- By making a profit on care it provides
- By borrowing money
- By investing in stocks, bonds, and other investment vehicles

A <u>not-for-profit Catholic hospital uses its capital for four purposes</u>
- To support its charitable mission
- To maintain its physical plants and replace equipment
- To invest in strategic initiatives that grow and sustain the ministry
- To provide a return on investment to its bondholders

An <u>AHCN Catholic hospital meets its capital needs in three ways:</u>
- By making a profit on care it provides
- By borrowing money
- By receiving equity capital from its shareholders

An <u>AHCN Catholic hospital uses its capital for four purposes</u>
- To support its charitable mission
- To maintain its physical plants and replace equipment
- To invest in strategic initiatives that grow and sustain the ministry
- To provide a return on investment to its bondholders and shareholders

ASCENSION HEALTH CARE NETWORK

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stocks, bonds and investments—and uses those profits to provide capital. It uses its capital to support its charitable mission, to maintain the physical plants, replace equipment—all those kinds of things—and, in the end, to provide a return on that investment to its bondholders. Bondholders don't lend you money simply because they feel good about you. They lend you money because they expect to earn interest on it.

For-profit hospitals acquire capital in similar ways: by making a profit and borrowing, but they receive equity capital from shareholders as well; so that is the difference, these are equity-based organizations. The way we use capital is to support our charitable mission. This is, of course, another notion we need to help people understand: that a for-profit organization can have a charitable mission. The point is, "for-profit" describes our tax status; it *doesn't* describe our purpose. Our purpose is continuing the healing ministry of Jesus—*that* is our purpose. We pay taxes, but our purpose is to continue this healing ministry. And so, whether not-for-profit or for-profit, we use our capital in very much the same ways; but in either case we have to provide a return on investment to our bondholders and to our shareholders.

Let me summarize the value we think we bring to the table. Of course, the reason this issue is on the table at all is that there are Catholic hospitals across the country that are facing the question of whether they are going to be able to continue to survive, to thrive in the long run. Wouldn't that be great if that were the only question; but in many cases we're talking about whether they will even survive over the next five years or so. We believe that we are a key part of the solution for many of them. First, we create value through management support provided by the largest Catholic health system in America. We also bring a scope and scale that a local hospital, no matter how capable the management is, simply isn't able to provide. We maintain these hospitals in perpetuity as works of the Catholic Church, and we believe we can strengthen Catholic identity in the hospitals that we work with because, again, we can bring the resources of Ascension Health that individual hospitals simply don't have the ability to mount.

We are contractually committed to serve the poor and the vulnerable. And the hospitals that come into Ascension Health Care Network will be required to have the same community-benefits policies and the same, or more generous, charity-care policies as As-

cension Health hospitals: that's the floor and they cannot drop below that floor.

One of the things I have not had a chance to do today, because it's not directly germane, is to talk about the value and the track record that Ascension Health has. We all like to brag about our organizations, but if you look at quality metrics—patient experience and the way patients rate Ascension Health hospitals, the kind of workplaces that we have, and our associate engagement and satisfaction—we are world class in all three areas. We can bring that to all the hospitals that we work with.

Something we don't talk about much is underfunded pension plans. Church plans have the advantage of not having to pay premiums into the Pension Benefit Guaranty Corporation, which oversees U.S. private-sector pension plans. They are not under the umbrella of the Employee Retirement Income Security Act (ERISA). Rather, they are funded as church plans. This gives them a special status. A lot of these pension plans have not recovered from the effects of the stock market in 2008-09. The ticking time bomb in Catholic hospitals across the country is severely underfunded pension plans, especially in those free-standing hospitals or those hospitals that are part of small, two- or three-hospital systems. Ascension Health Care Network assumes the liability for those underfunded pension plans and takes that concern off the table. And, finally, we will provide a source of capital that is critical to sustaining the mission, and that's our value proposition.

In sum, I believe we can bring tremendous value. I believe that there is no question that for-profit tax status can be entirely consistent with maintaining the Catholic health ministry. In fact, I would argue that in today's world it is necessary, beyond simply being appropriate. And at Ascension Health and Ascension Health Care Network, we believe we have a model that was put together very thoughtfully with the assistance of a lot of people who understand this topic very, very well. We are eager to start proving the value of this model. Actually, some of you have seen the announcement that there are seven hospitals that we believe will be joining Ascension Health Care Network here in New Jersey in the near future and we look forward to proving the concept.

Keith B. Pitts[**]

I want to tell you a little bit about Vanguard Health Systems. We have 28 hospitals in five states, with about $6 billion of revenue—and 90 percent of those hospitals were not-for-profit hospitals when we acquired them. We were a private-equity sponsor from the beginning, first with Morgan Stanley Capital Partners, now with Morgan Stanley and the Blackstone Group. We are a publicly traded company, too, with about 38 percent of the company owned by the public. The two funds, along with management, own the other 62 percent. We have been around since 1997, so we are 15 years old.

Of our 28 hospitals, eight were part of faith-based systems when we acquired them. St. Vincent Hospital in Worcester, Massachusetts, is a Catholic facility that has been for-profit for 15 years. The management team of our company did the original conversion 15 years ago, and we have owned it in our company for seven years. The Baptist General Convention of Texas had previously sponsored the Baptist Health System in San Antonio, a five-hospital system, when we acquired it. We still have a strong relationship with the Baptist General Convention of Texas and recently we acquired the Valley Baptist Health System in Harlingen and Brownsville, a two-hospital system in Texas that also originally was sponsored by the Baptist General Convention of Texas.

Our corporate values, our mission, vision, and values are similar to many health care organizations, both for-profit and not-for-profit. We allow our facilities, particularly our faith-based facilities, to adapt their mission, vision and values to honor the heritage of the organization. Our model is not overly complex. It is predicated on our corporate commitment, executed by our senior team, to honor the historical faith-based mission of our hospitals and, in so doing, to assure that we have alignment all the way down in our organization to the leadership of those hospitals and the assurance that organizational behavior is consistent with that commitment. For Catholic hospitals, compliance with the *Ethical and Religious Directives* (ERDs) is a threshold level of commitment. Through our stewardship agreement, the Bishop has the exclusive authority to interpret the ERDs. In addition, the Bishop must also approve all nominees for board membership of the local hospital, in addition

** Keith B. Pitts, Vice Chairman, Vanguard Health Systems.

to the three seats that are his prerogative. We further commit to foster a culture in the organization in the hospital that is consistent with Catholic teachings.

Consider St. Vincent. Generally, hospitals that we acquire have a need for capital, they have a need for different operating skills, and they have a need to attract certain services at scale. Certainly St. Vincent had those needs. St. Vincent Hospital now is a thriving, robust hospital and, I would argue, certainly is one of the largest and fiscally healthy Catholic hospitals in New England. It is a Top 100 hospital, Top 50 in cardiovascular services. It has a wide range of services starting with the beginning of life, through sophisticated tertiary services. St. Vincent has Centers of Excellence: a center for musculoskeletal services that is very strong; a large heart and vascular service that is, as noted by its Top 50 ranking, a very strong service in this community; a center for cancer services, with a cyber knife, high-end radio therapy, and, obviously, chemotherapy as well. Proudly, a new state-of-the-art cancer center is being built which will allow us to expand those services in the community even further.

Interestingly, St. Vincent also has had a long-standing teaching mission. There are more than 100 FTE residents at the hospital, reflecting relationships with a number of universities and academic medical centers, including the University of Massachusetts and Beth Israel-Deaconess Medical Center, which is a teaching hospital of Harvard Medical School.[1] St. Vincent has a very strong culture of medical education.

Finally, we look at the mission and ministry. In keeping with Vanguard's Covenant of Catholicity, we whole-heartedly sponsor and support our department of pastoral care: we have three priest chaplains, two sister chaplains, and a clinical pastoral education program with an Association for Clinical Pastoral Education-endorsed supervisor. Pastoral care and education are a significant focus at our Baptist systems in San Antonio and the Rio Grande Valley as well.

Saint Vincent in Worcester, Massachusetts, has operated for 15 years as a Catholic facility in two for-profit systems under the same

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[1] Emergency medicine services at Saint Vincent Hospital are provided by Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center. Surgical residents from Beth Israel Deaconess Medical Center perform rotations at Saint Vincent Hospital.

Catholicity Covenant under which it was originally created. While the Bishop has a direct oversight, including for the appointment of Catholic clergymen and the director of pastoral care, the department serves all faiths. We have a duly consecrated chapel, staffed and maintained by the Sisters of Providence.

I think that if you're going to be in this business—and this applies to anyone who makes a decision to acquire a hospital—you are going to own full-service hospitals. Your mission is to take care of everybody that comes into your hospital. If you don't have that as a personal commitment, you should find another business. Also, geography really is destiny relative to care for the poor. So, I think a lot of full-service hospitals, at least when it comes to real charity care, have a similar commitment. We generally do honor the charity care policy of a hospital we acquire—but in many cases, our charity care policy actually is more generous than what existed pre-acquisition. If you read the Michigan Attorney General's opinion on Vanguard's acquisition of the Detroit Medical Center, you will see that he requested, contractually, that the Medical Center adopt Vanguard's charity care policy, because it was more robust. And for those of you who know Detroit, we do have a mission to care for the poor there; we are the safety net health care system in Detroit.

If the Affordable Care Act is ultimately implemented, proposed coverage expansion will presumably level the playing field. But Medicaid reimbursement still leaves a gap to cost. I think the realities of Medicaid expansion are going to be pretty severe for those in underserved communities. Budgetary issues are going to force a lot of states to rethink the whole Medicaid system. When that happens, I think they will probably move toward a managed model and I think it's going to cause more stress on a lot of hospitals that already have an inordinate amount of stress. When you combine that with the present political pressure on commercial pricing, you can see that—particularly in states that have had some transparency around commercial pricing—many hospitals, especially in urban areas, are going to have a hard time surviving. That means that, effectively, whatever policy changes are made by states and Medicaid are going to decide which hospitals really can remain open.

Just to back up for a minute. Earlier there was a question about 501(c)(3) and pricing. If you look at St. Vincent again, by most measures, it is the highest value hospital in Massachusetts. It

is the fourth lowest paid hospital by the payers and by far the lowest paid hospital of the major teaching hospitals in Massachusetts. But it still has among the highest quality outcomes in Massachusetts. This shows that when you consider high quality together with low cost, it provides a very high value service in our community. Our competitor's cost and pricing in Worcester is, per discharge, $5,000 higher than St. Vincent, based on the publicly available information. As an example, if you are a Blue Cross patient in Massachusetts and you need a hip replacement and you come to St. Vincent, it costs around $23,000. If you go to our competitor in town, the same procedure costs around $35,000.

The concept of providing high value (high quality, at an affordable price) is going to become a very important thing this decade. This is something we are going to have to grapple with in the hospital industry.

501(c)(3) is a section of the United States Tax Code. It is not a reliable predictor of culture or organizational behavior. Rather, how your organization behaves is the best indicator of your culture. I don't really care what you put on the sign on the front of the organization. It is the same for every for-profit organization as well.

The 501(c)(3) doesn't exist in many other countries. This really is a creature of the United States tax code. Culture and organizational behavior are the true differentiations in health care organizations, especially in faith-based organizations; I absolutely agree with the premise that faith-based organizations that behave as they ought to have a competitive advantage in the markets. People really do feel and believe that faith-based care is better care.

David T. Vandewater**

So, I want to talk a little bit about the past, *my* past, because some of things that Michael Naughton and Dean Maines brought up this morning were critical information in regard to how you assess what's going on in for-profit medicine. And I want to first address for-profit versus taxpaying. Sometimes, when you say for-profit it almost demonizes the fact that you are trying to figure out a way to generate more income to your organization, and the reference shouldn't do that.

I started off with St. Francis Hospital down in Miami Beach, where we had Sister Mary Arghittu assisting us in trying to solve a problem for her and that organization at the time. And it goes all the way down to quite a bit of activity, particularly in the vicinity of 1994–'95, because of significant changes going on in the industry at the time. And whether it was Sister Judith Ann Karam that we did the transaction with in the Cleveland marketplace, or if you go back to Charleston, West Virginia and the things that we did there, we took on issues in regard to the particular hospitals that had challenges in front of them in that very specific time. And what we did with those facilities was figure out a way to make for-profit medicine work with a Catholic identity. And you know what? It wasn't that hard. It was a commitment that we had on our part, and that I had on my part, to making something happen that needed to happen.

Leo talks about the issue in regard to the need for capital or accessing the capital markets. You know, these entities felt constrained in their ability to find the capital necessary, but more importantly, to figure out a way to stay competitive. The people they were competing with in these markets were all not-for-profits. And so, what was happening was the other not-for-profits were undermining their ability to exercise their mission, and so what they sought were partners to figure out a way to assist them in that process—and that's what we did. And we did it, and we did it and we did it. So, if you look at this list of the faith based organizations that we acquired, a third of them were Catholic organizations. Some of those continue to have successful relationships today with for-profit entities.

*** David T. Vandewater, M.S., President, Chief Executive Officer, Ardent Health Services.

Not-For-Profit Experiences

Year	Organization	Location	Nature of Organization	Percentage
1992	St. Francis Medical Center	Miami Beach, Fla.	Catholic, Franciscan Sisters of Allegany	100
1992	Tulane University Hospital & Clinic	New Orleans, La.	Academic	80/20
1993	Cedars Medical Center	Miami, Fla.	Academic	100
1993	Miami Heart Institue	Miami Beach, Fla.	Jewish	100
1994	Rapides Regional Medical Center	Alexandria, La.	Community	50/50
1994	Southwest Texas Methodist	San Antonio, Texas	Methodist	50/50
1994	Winter Park Memorial Hospital	Winter Park, Fla.	Community	50/50
1995	St. Francis Hospital	Charleston, W.Va.	Catholic, Sisters of St. Joseph of Wheeling	100
1995	St. Vincent Charity Hospital & Health Center	Cleveland, Ohio	Catholic, Sisters of Charity of St. Augustine	50/50
1995	Timken-Mercy Medical Center	Canton, Ohio	Catholic, Sisters of Charity of St. Augustine	50/50
1995	St. John's West Shore Hospital	Westlake, Ohio	Catholic, Sisters of Charity of St. Augustine	50/50
1995	Providence Medical Center	Columbia, S.C.	Catholic, Sisters of Charity of St. Augustine	50/50
1995	JFK Medical Center	Atlantis, Fla.	Community	100
1995	Presbyterian/St. Luke's Hospital	Denver, Colo.	Presbyterian	50/50
1995	Swedish Medical Center	Denver, Colo.	Community	50/50
1995	Spaulding Rehabilitation Hospital	Denver, Colo.	Episcopal	50/50
1995	Aurora Presbyterian Hospital	Aurora, Colo,	Presbyterian	50/50
1995	Doctors Hospital	Springfield, Mo.	Community	100
1995	Rose Medical Center	Denver, Colo.	Jewish	100
1996	St. Joseph's Hospital	Parkerburg, W.Va.	Catholic, Sisters of St. Joseph of Wheeling	50/50
1996	St. David's Medical Center	Austin, Texas	Catholic, Ascension Health	49/51
1996	Medical Center of South Arkansas	El Dorado, Ark.	Community	50/50
1996	Metro West Medical Centers	Framingham & Natick,	Community	80/20
1997	St. Luke's Medical Center	Cleveland, Ohio	Episcopal	100
2001	St. Joseph Healthcare System	Albuquerque, N.M.	Catholic	100
2004	Hillcrest HealthCare System	Tulsa, Okla.	Community	100

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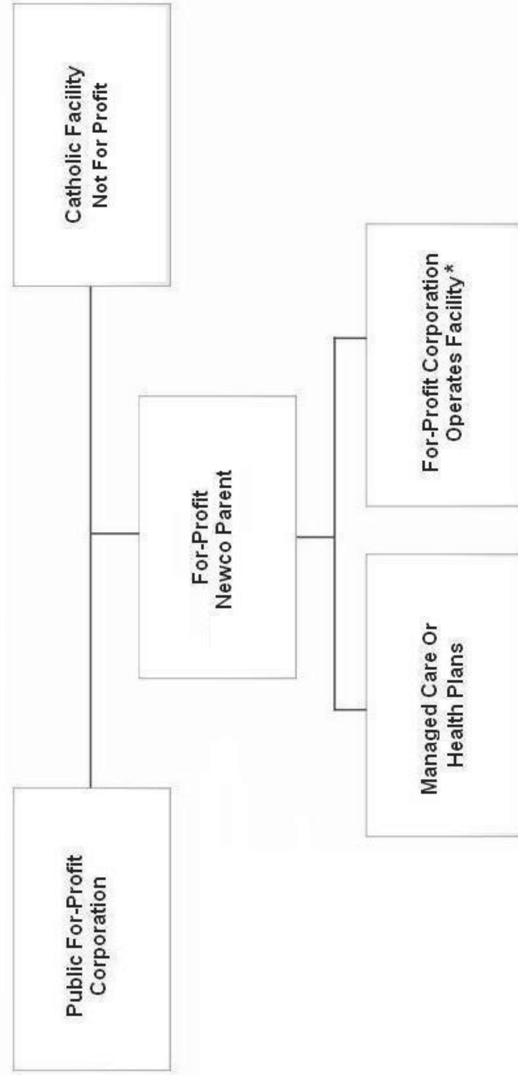
What does it mean if you look at an entity and it says, "Public For-Profit Corporation"? Public has different meanings to different people. Quite frankly, a public company could be a company that's on the stock exchange; a company that has public debt would likewise be considered a public company. Our company today is a private company, which means I do not have public debt outstanding, I have bank debt, but we're required to do some of the things that public companies do from the standpoint of reporting. The company that we operate today is one that has 11 hospitals, and we have a large managed care organization as part of our company out in the New Mexico market, and I'll talk a little bit about that later.

The ownership for the for-profit Newco parent, the determination of how much each of the entities owns from the, let's just say, the Catholic facility or the not-for-profit organization, depends on contribution and fair market value—and those things can be easily determined by third parties. From the time we began working with these enterprises, we had Bishops approving our transactions, participating in our transactions, and we had Rome making sure these transactions were acceptable.

So, where are we today? Eleven hospitals, one large health plan in two major markets: Tulsa, Oklahoma and Albuquerque, New Mexico. Now the Albuquerque, New Mexico facility has three of the facilities which came from the acquisition of the St. Joseph system from Catholic Health Initiatives (CHI), the longstanding operator of the facilities located in this market place. Our first intention in regard to the transaction was to keep CHI.

CHI's goal, however, was to leave the community and so it wanted us to buy them out 100 percent. The important part about this is CHI left a legacy with us. We were responsible for doing certain things that they wanted to do even though CHI was gone: remove St. Joseph's names from the facilities, which we did, so a new identity had to be established and it was, but there were other things that we committed to to ensure that the Catholic legacy lived on. We committed to change the entity, we committed to the chaplaincy program, and we maintained the indigent care policy. Quite frankly, our indigent care policy was much broader then the one utilized before us. No physician-assisted suicides or abortions, create a board of directors, and for that legacy to continue—to


Historical Non-Profit Catholic Hospital
Public For-Profit Corporation
Catholic Facility Not For Profit
For-Profit Newco Parent
Managed Care Or Health Plans
For-Profit Corporation Operates Facility*
*Hospital was designated as an official Catholic hospital by local Bishops
Ardent
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provide some capital into the organization to make it more competitive. So this is what we do.

In addition to that, we actually acquired another system in the community as well, that was Lovelace Health System, but we honored the commitments, we've infused about $300 million into the market, and we transformed the system completely into a much more competitive system. We have robust competitors there with Presbyterian and the University of New Mexico, so we created a new identity and made this organization more competitive.

The next location that we have is Hillcrest and this is in Tulsa, Oklahoma. Now Hillcrest was just a regular 501(c)(3), but likewise was in a situation that this organization did not have the ability to provide capital to its hospitals, and there were significant competitors—one being a very robust Catholic competitor, the Sisters of the Sorrowful Mother, that provide services there under St. John's name. But likewise this organization—Hillcrest—asked us to create a local board, maintain the indigent care policy (again, our indigent care policy went well beyond theirs), maintain services unless physician shortages existed, put capital into the facility, and continue educational relationships with Oklahoma University and Oklahoma State University—and we did that.

So, what did we do in this particular market? Honored our covenants that we had made with the organizations, taking care of the uninsured in that community (and we take care of more of the uninsured than any of our competitors, including our Catholic colleagues that are competitors), preserving medical education, and going well above the $100 million of capital that we indicated that we would put in, and actually infused $286 million into that marketplace.

So, if you look at these two markets, we likewise believe that we've improved the quality of the organizations compared to where they were, and quite frankly, a lot of that is associated with the lack of capital that existed and the capital that we were able to infuse into both of these facilities. We've increased access by creating more access points out to our communities. We've clearly raised the standard of care, and we grew and strengthened both systems.

As far as the future, it is going to look very much like the past. There is a common thread among the other presenters of models with Catholic health care facilities. I have likewise described my in-

Lovelace

Lovelace Health System, Albuquerque, N.M.

- **Honored covenants**
- **Invested $306 million**
- **Transformed system, expanded services & increased access of the former St. Joseph**
- **Created new identity**

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Hillcrest HealthCare System, Tulsa, Okla.

- Create Board of Trustees
- Maintain indigent care policy
- Maintain services unless physician shortage
- Invest $100 million in capital expenditures
- Continue OU & OSU residency programs

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Hillcrest HealthCare System, Tulsa, Okla.

- Honored covenants
- $84 million in care to the uninsured in 2011
- Preserved medical education
- Invested $286 million

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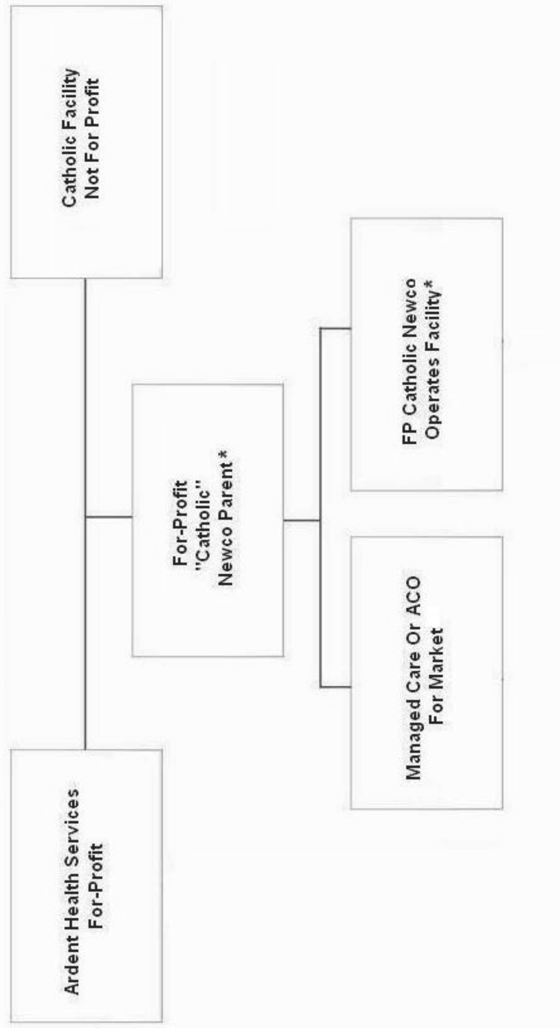
terpretation of the Historic Non-Profit Catholic Hospital model. There is one significant difference between the Ardent Proposed For-Profit Catholic Equity Model and the Ascension Health Care Network model, and it is significant. The Ardent Newco Parent is an official Catholic organization. This change is extremely important. It means that an official Catholic organization is fully participating, guiding and influencing all parts of the health care delivery provider and/or payor system. It positions a Catholic organization in the forefront of the health care system for the markets to be served. That is a powerful place to be and it allows for a significant positive impact on the quality, cost and accessibility of health care for the population of that market.

We have further redefined the model to allow for flexibility if and when it is needed. If there are certain mandatory services required for a population, which a Catholic organization cannot legitimately provide, or if certain mandated services cannot be paid for through a Catholic organization, Ardent has designed additional components to this model. These components will be owned, controlled, and funded by Ardent, but will provide the required services to deliver an integrated delivery/payor model.

I think the future drives me back to the past, but clearly if you think of what we've done in the past it will be, for me, a continuation of what I do in the future. As anybody looks at a transaction such as this, where you believe a Catholic organization can be for-profit (and obviously I've demonstrated that in some of the things that we did in our past), understanding long-term strategic goals is a very important issue for both parties. And if either party feels uncomfortable, obviously, it's not going to make a marriage that's going to work—and so that has to be the key ingredient, spending time with one another. None of the transactions that we got done in the middle '90s were done quickly—none of them. Everything took time, everything took relationship building—understanding who we are, what our personal values are; and those were important ingredients to the transactions. But at the end of the day, legal documents were very important, absolutely necessary to making everybody feel comfortable with what happens because the legal documents drive certain issues where personalities lead. People change, organizations change, and as organizations change, legal documents are necessary to protect all parties.

As long as you're aligning your objectives together I'm con-


Ardent Proposed For-Profit Catholic Equity Model
Ardent Health Services
For-Profit
Catholic Facility
Not For Profit
For-Profit
"Catholic"
Newco Parent *
Managed Care Or ACO
For Market
FP Catholic Newco
Operates Facility*
*Will be designated as official Catholic organizations by local Bishops
Ardent
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vinced that whether you're a taxpayer or not, you can make it work. Collaborating in regard to the design of the model is crucial. Every organization is different—needs are different, communities are different—and as long as everybody takes the opportunity to remember what the goal is: serving the public, serving the needy, serving those individuals coming to your facilities—everybody will get to where they need to be—and the tax status doesn't matter.

Nonprofit and For-Profit Enterprises: A Side-by-Side Comparison of the Law

*Timothy P. Glynn**
*Thomas (Tim) Greaney***

This joint presentation was given on March 26, 2012 at Seton Hall University School of Law, as part of the Symposium "Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry?" The purpose of the talk was to identify core differences (and some similarities) between the law governing nonprofit and for-profit enterprises. We did not seek to address or resolve questions about the appropriateness of a for-profit structure for Catholic hospitals and hospital systems; exploration of these matters was left to other Symposium participants. Because our goal was to offer background on governing legal principles to set the stage for the audience and the other presenters, we structured the session as a side-by-side comparison of nonprofit and for-profit law on ten important governance and management topics: corporate purpose, applicable law and enforcement, taxation, management powers, fiduciary duties, charitable obligations, election/removal of directors and management, executive and board compensation, disclosure obligations, and mergers and conversions.

Our presentation is reproduced below. Because our aim—a general comparison of the law governing nonprofit and for-profit entities—remains the same, we have made few substantive changes to our original talk. We have edited the presentation for style and clarity. We hope this format will offer readers (particularly those without legal training) a fairly concise primer on various legal concepts that might influence or help to frame the issues that the other Symposium participants are addressing.

Introduction and Themes

Thomas Greaney: Our mission statement for this presentation is

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to provide a fair and balanced comparison of the law applying to nonprofit corporations and for-profit corporations, specifically focusing on the healthcare sector. To do this, my colleague, Timothy Glynn and I have decided to give a side-by-side presentation, literally going from nonprofit to for-profit in discussing issues of governance, tax and finance pertinent to the questions posed by this Symposium.

As an initial matter, it's worth noting that there is controversy on both sides of the ledger. Nonprofit, tax exempt organizations have been under close scrutiny raising questions about how much charity care they provide and whether they are performing their mission under state corporate law and federal and state tax law. Likewise, there is the persistent question about the interplay of profits, markets, and health care.

Timothy P. Glynn: First of all, we are both named Tim so that might be somewhat confusing, so we can use shorthand, not-for-profit Tim, for-profit Tim. I, Timothy Glynn, will be for-profit Tim. We are going to do a side-by-side comparison, but we wanted to start with a few themes that we think are going to prevail in all the different particular topics we are going to discuss. Let me just take a moment to talk about these themes.

First of all, there is a diverse range of entity structures. Those of you who are familiar with the nonprofit side have seen this to some extent. On the for-profit side, there is even greater diversity in terms of potential structure. For example, in addition to the corporate form, you are going to hear about LLCs. We also have various kinds of partnerships (including some joint ventures), and there are parent-subsidiary relationships and the like. While we will focus primarily on for-profit corporations, the form does matter to some extent, and there are variations on the margins in terms of the law that applies to each of these forms.

I should also point out that even within the corporate form there are important differences—for example, with regard to closely held versus public or publicly traded firms. At least to some extent, there are different legal regimes that may apply to these two different kinds of corporations. This variation among types of corporations will play out in our discussion as well.

Secondly, we need to consider contract versus corporate law. Our principal focus in this particular forum is on the rights and

obligations arising from corporate law, but note that the parties also can order their affairs through contract. Keep in mind that, as an initial matter, these are separate bodies of law: corporate law is separate and distinct from contract law, and they have different governing principles and enforcement structures. However, there is also some overlap between these two areas of law, and, to some extent, contract can affect corporate law. So, although they are two distinct bodies which need to be considered separately, there is some interaction or overlap.

Third, we will need to consider flexibility and default rules. Probably the most important trend in for-profit corporate law over the last century has been growing flexibility, both in terms of the underlying form and in terms of the rules that govern the relationships of what I would call the "corporate parties"—shareholders, directors, and officers. This flexibility now manifests itself in the very structure of corporate law. Many of the doctrines we are going to consider are generally referred to as default rules. These are rules that apply when the parties have not agreed to modify them in any way. To be clear, the core requirements of federal securities law are not subject to party modification. But underlying state corporate law is now very much a default regime (or enabling regime) which provides a set of default rules that may, at least within some limitations, be modified by the parties.

The fourth theme is discretion. As you will see, corporate law affords principal corporate decision makers a tremendous amount of discretion. The outer boundaries of this discretion are framed by the various limitations which we will talk about, but there is enormous space within these outer boundaries for corporate principals to act according to their business judgment. In fact, this term, "business judgment," is an important one. The business judgment doctrine or business judgment rule is the principal manifestation of discretion in the corporate law setting and imparts, in practice, enormous amounts of discretion and flexibility.

Fifth and finally, we must acknowledge existing uncertainty. There remains uncertainty in how the law may play out in various circumstances for a variety of reasons which we will consider. In fact, the level of uncertainty within corporate law will be surprising to most non-lawyers. So, yes, we will try to be clear, but we will also be clear about where things are uncertain.

With that, we will turn to our side-by-side comparison.

CORPORATE PURPOSE

T. Greaney: Nonprofit corporations. Starting with what we labeled as corporate purpose, I'll begin with what are the two defining characteristics of a nonprofit corporation. The first is what theorists call the "non-distribution constraint." What that means is there is no sharing of profits with private persons. Distributing profits or dividends is forbidden under both state corporate law and federal and state tax law.

The second principle is the requirement of adherence to a charitable purpose, which is stated in the articles of incorporation of the nonprofit corporation. This requires that the assets of the nonprofit corporation be permanently dedicated to the corporate purpose. As a general matter then, the nonprofit's assets should stay committed to the framework of the charitable purpose that is announced in its corporate articles.

Note, this is not the same as the corporate "mission statement." The legal statement of corporate purpose that appears in the articles of incorporation is different than what most of you refer to as the mission statement of your institution. Sister Melanie DiPietro, in fact, has written about this and has differentiated the two explaining that the legal purpose is the *means* to accomplish the mission statement that the institution articulates for itself.

It also bears remembering that the nonprofit corporate form does not impose a limitation either on the existence or the magnitude of profits for nonprofit organizations. Nonprofits earn profit: indeed they have to, as the old adage, "no margin, no mission," suggests. More familiar to some of my law students is a statement by Justice Stewart in one of the leading tax exemption cases that tax exempt status is not a command to self-liquidate.[1] So, the idea here is that nonprofits have to earn profits and indeed that is part of their mission.

And, finally, remember, we are talking about a special breed of nonprofit—the public benefit corporation. More specifically, in health care, this sector of nonprofits is situated in the commercial sector—some call them "commercial nonprofits" because they are selling goods and services and competing in a market with for-profit entities.

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[1] Utah County v. Intermountain Health Care Inc., 709 P.2d 265 (UT 1985).

T. Glynn: Turning to the for-profit side, first of all, we consider the basic purpose. A for-profit corporation may be incorporated to conduct or promote any lawful business or purpose—very much of a change from about 150 years ago. Many jurisdictions do not even require a corporate purpose in the articles or certificate of incorporation. Moreover, the articles or certificate can state a more limited purpose or a more targeted purpose than simply saying "any lawful purpose." Thus, there is a lot of flexibility in terms of how a for-profit corporation can define its purpose.

But what about the fact then that a for-profit corporation is for-profit? Must a corporation prioritize profit over other considerations? Put another way, is shareholder wealth maximization or promoting shareholder value the norm that must frame management behavior? It might surprise you to learn that the enforceability of this norm, the shareholder wealth maximization norm, is largely unresolved and rarely tested for a couple of reasons. One, the issue can almost always be avoided: it can be avoided by the parties working together to resolve it, but it can also be avoided in how the litigation or the legal challenges are actually structured. Moreover, the issue does not arise when interests are aligned within the firm—that is, interests between shareholders and other corporate principals. So, this is largely unresolved and rarely tested for a couple of different reasons.

Now let us try, nevertheless, to frame where things stand with regard to this shareholder wealth maximization norm. Given the amount of discretion the decision makers have, along with various doctrines affecting enforcement, this norm is rarely directly enforceable and, hence, rarely challenged or affirmed. What this means, at minimum, is that principal corporate actors have significant—and I would actually go further than significant and say tremendous—discretion to serve charitable and other purposes. Many states have so-called constituency statutes (which you may have heard of) that allow, but do not require, directors to take into account the interests of non-shareholder constituencies and other norms in making decisions on behalf of corporations.

As a decisional norm, shareholder profit maximization often prevails because it is promoted by governance and compensation structures, such as performance based compensation for executives, rather than what we might call an enforceable legal mandate, or an enforceable stand alone legal mandate. So, there is a lot of

discretion, lots of space in which to operate, and other interests frequently can be served along with shareholder interests.

However, some courts have sharpened the obligation to serve the interest of promoting shareholder value in certain contexts. Again, this comes up rarely. But in some narrow contexts we do see this norm prevailing, including in the consideration of takeover offers, the deployment of certain defensive measures by one set of corporate parties, or in acts perceived to freeze out minority shareholders. So there are times at which courts have recognized that, in a particular context, the interest of shareholders must be served rather than other interests.

So, if the particular context were to allow a legal challenge, and there is a clear, direct conflict between shareholder and other interests, the law is uncertain and would depend on the nature of the board or shareholder action; party expectations as reflected in their dealings, contracts, and corporate documents; the extent of deprivation or denial of shareholder interests; and, probably, the state of incorporation. So, there is uncertainty here and also tremendous flexibility and room for discretion.

Applicable Law and Enforcement

T. Greaney: We will now turn to the areas of law that specifically apply to each sector, for-profit and not-for-profit.

So, the first order of business in most classes in law school is to ask what are the sources of law? (i.e., what are the laws that apply to this problem? To this situation? To this client?). The second core legal issue is: how are they enforced and by whom? On the nonprofit side, we have, obviously, many areas of law specifically applicable to health care, and to hospitals in particular, but here we are primarily concerned about governance, i.e., how institutions are run, and how they meet their objectives.

There are three bodies of law that are overlapping, and, as it turns out, sometimes inconsistent. The first is state nonprofit corporate law. It is a body of law, derived from statutes enacted in every state, which typically look very much like the laws applicable to the for-profit side. Although the two bodies of law are actually quite similar in many respects, they differ in ways that are very pertinent to our current discussion. I'll go through a few key differences.

Who enforces the nonprofit corporate law? Well, as we are go-

ing to see, a key characteristic of nonprofits, the fact that they lack shareholders, has considerable legal significance. The consequence is that there are no shareholder derivative suits available to enforce some of the laws we're discussing today; for the most part the responsibility to enforce the law resides only in the state attorney general. The state attorney general has the power to bring suits to keep the directors and the officers in line with certain of these state commands.

The second body of law is federal tax law, which is enforced by the Internal Revenue Service (IRS). The federal tax law governs exempt organizations, "EO's" as they are called by their friends. The central idea is that in order to qualify for tax exempt status—to be free of paying federal income tax—these corporations have to comply with this body of federal law. Now, you might ask: what has tax got to do with governance and how organizations are run? It turns out that the IRS is not shy about making suggestions, let's call it avuncular advice, about how corporations should be run. And many of the rules and edicts of the IRS have direct bearing on the corporate governance of tax exempt nonprofit organizations.

Finally, there is a parallel universe of state tax exemption. The state and local taxing authorities have rules and regulations governing qualification to be exempt from state income tax. Significantly, being exempt from state taxation is often more important than exemption from federal income tax, because if you are not making any money you do not have income tax liability. However, at the state level, exemption frees hospitals from state property taxes, sales taxes, and other levies. Not surprisingly in view of their declining tax revenues, some states have become eager enforcers of their tax exemption laws. The most prominent example is Illinois, which has taken the tax exempt status away from Provena Hospital and has investigated some fifteen other hospitals for providing inadequate levels of charity care.

A final area of private enforcement that is worth mentioning here is the law applicable to tax exempt bonds. There are two aspects of this law that are applicable in this context. First, federal law requires certain behaviors and certain standards in order for issuers of exempt bonds to maintain exempt status. Secondly, the bond holders often insist on all sorts of rights and covenants, vis-à-vis the hospitals to whom they're lending the money. That is an important source of *de facto* control. Some executives say, in fact,

that from the corporate perspective, being answerable to bond holders is in some ways more onerous than being answerable to a private shareholder group. For one thing, you have to pay your bond debt regularly, whereas shareholders can be put off.

Let me turn it over to Tim to talk about what governs for-profits.

T. Glynn: Like in the nonprofit context, in for-profit law, the baseline framing is under state law. Every state has a corporate law statute, and there are judicial decisions to fill in the gaps. For state law purposes, I will frame this slightly differently because there are some differences between a nonprofit and a for-profit here. Part of the difference can be found in the question: Who has standing or who has the right to enforce entity-related rights and obligations on the for-profit side? If we are talking about state corporate law, who can enforce those rights? Well, as it turns out, there are different groups, potentially, that can enforce these rights than on the nonprofit side. First, directors, who manage the affairs of the corporation in the first instance, are entitled to enforce corporate related obligations on behalf of the corporation itself.

Of course, if the directors themselves are being challenged—i.e., if their decisions in managing the affairs of the corporation are at issue—who has standing? Then the shareholders have standing, either directly, for certain kinds of claims affecting their individual rights as shareholders, or what we call "derivatively," which means on behalf of the corporation. There is an entire procedural structure for bringing claims derivatively which is beyond the scope of this presentation, but this is an important aspect of shareholder rights enforcement nonetheless.

Ordinarily then, these corporate actors are the parties who have standing to bring claims for corporate-law-related breaches. State regulatory authorities, as a general matter, do not have standing to bring claims on these matters. There are some exceptions to that, but as a general matter, there is a very limited role for state regulators. In addition to state regulators, there is also a very limited role for other stakeholders. Patients, employees, communities, and other stakeholder groups do not have standing to enforce corporate-law-related rights and obligations. They may still be entitled to bring claims, but if they are entitled to do so it would be under some kind of, what I would call, external law—some regulatory re-

gime outside of corporate law, like health regulations, tort law, employment law, or the like. Or they may have claims via contract. But they usually do not have standing to bring corporate-law-related claims.

The securities laws are different. These laws regulate our securities markets. They protect purchasers and sellers of stocks and debt securities. Generally speaking, those who have standing to bring claims in this context include the purchasers and sellers themselves, and also the federal and state securities regulators empowered to enforce these laws. So, we have a lot of direct regulatory oversight in the securities area, less so in the state corporate law area. In addition, Self Regulatory Organizations (SROs), like the stock exchanges, have their own regulatory arm that can bring claims in various ways.

Finally, in bankruptcy or insolvency, certain creditors may step into the shoes of the corporation, so creditors will have standing in bankruptcy and in certain other insolvency situations. This does, in some sense, extend standing for corporate claims to other groups. But again, as a general matter, for state corporate law purposes, it is directors and shareholders who may enforce rights against or for the corporation.

Taxation

T. Greaney: As I mentioned previously, tax law is very important to nonprofit exempt organizations. The first requirement is that exempt organizations have to articulate a charitable purpose in their articles. And we will consider shortly what that means. One would think the word "charity" should have a pretty clear meaning but it turns out the concept has a convoluted and confusing history in the hospital sector. Beyond that, Section 501(c)(3) law, the part of the Internal Revenue Code that governs exemption, prohibits what is called "inurement." Inurement is a prohibition against any part of the net earnings—the profits essentially—of a tax exempt organization going to benefit any private shareholder or individual. The idea is that the profits of the exempt organization must stay within the organization and any money that goes out should be exclusively for paying fair market value for goods and services received. In addition, federal tax law imposes a "private benefit" limitation that requires that for EOs dealing with somebody who is not

an insider, e.g., contracting with third parties, the exchange has to be at fair market value in relation to the benefits received.

In addition, there is another statute, the Excess Benefit Transaction Law. Although called a tax, it's really a penalty administered whenever a nonprofit exempt organization pays out too much money relative to the value received. When is this liability imposed? Executive compensation is one of the big areas where this law has particular currency, as it seeks to limit payment of excess value to insiders within the exempt organization. Other applications include exchanges between corporate insiders and their corporations, such as when a board member has a financial interest in a facility that is being leased to the hospital.

Finally, it is important to remember that there is no legal bar to a tax exempt entity providing non-exempt services. Essentially, it is entirely acceptable for a hospital system to provide services that are offered as for-profit businesses. Further, exempt hospitals do not have to pay taxes on non-exempt services if those services are substantially related to the exempt service that the hospital provides. There is a wealth of cases and rulings interpreting this provision with regard to sales of food, florists, and exercise facilities within the hospital. In addition hospitals can also operate for-profit businesses that do not meet the foregoing test and pay a "UBI" tax—an Unrelated Business Income Tax—on the profits of those businesses.

Tim, you have one second to talk about the for-profit side.

T. Glynn: For-profit corporations are non-exempt.

Management Powers

T. Greaney: This topic is really at the core of what nonprofit corporate law does. It deals with the central questions: who runs the organization, whose organization is it? And on both sides, for-profit and nonprofit, you will see and hear the phrase: "the corporation is managed under the direction of the board of directors." And at least in theory, plenary power is vested in a board of directors to run the corporation. Of course, in reality that power is almost always delegated to the management team.

What is peculiar or different about the nonprofit side of the ledger is there are no shareholders. So, the first question is: who is running the show? Who is choosing the directors and so forth? In

most nonprofit exempt hospitals, control is distributed under the so-called member model in which an entity (usually the canonical entity, the founder of the hospital that is responsible for the mission of the hospital as a ministry) is the member, the sole member often, of the entity. Under this model the member often has powers that are either parallel to, or above, and prior to the board of directors. So the member can reserve the power to make management business decisions on a wide range of issues, if such power is reserved to it in the articles of incorporation. The member can change the bylaws, remove and add directors, control management, and even take specific actions irrespective of what the directors do or, in fact, in place of what the directors do. This aspect has obvious advantages for the nonprofit organization because it links control directly to the entity—to the order or religious entity that controls the mission.

T. Glynn: The starting point in the for-profit context is somewhat similar to nonprofit. As a default matter, directors manage the affairs of the corporation, and there is tremendous discretion reserved to them largely through business judgment deference. They can often, as a board, delegate some of that authority to committees. Moreover, the board selects and monitors officers, and officers ordinarily are granted broad operational discretion to run the day-to-day affairs of the enterprise. So, structurally, if you think about this, there is tremendous discretion for the directors and also tremendous discretion for the officers who run the enterprise.

How about shareholders? As a default matter, shareholders have limited direct power. They have the power to elect directors. They also have the power to vote on what I call fundamental matters, although these matters ordinarily do not come before the shareholders unless the directors also approve these kinds of changes. They include amendments to the articles of incorporation or to the charter, the authorization of shares or new authorization of shares, mergers, sales of substantially all assets, dissolution, and other fundamental questions.

Shareholders also are entitled to vote on certain other matters pursuant to other legal regimes. For example, they are entitled to vote on executive compensation in publicly traded firms, because of tax law consequences and because of our federal securities regime. In addition, shareholder proposals are another type of item

that goes before the shareholders because of our federal securities regime.

Now, all of what I have just described at the state level is a default structure. The management powers conferred by state law can be modified substantially, particularly in the closely held context. For example, minority shareholders frequently negotiate for terms that provide protection through voting rights, voting powers, reserved powers, etc. These terms may be included in the articles or certificate of incorporation or in separate contracts—shareholder agreements, for example.

There are potential outer limits in terms of modifying these terms, and it is probably safer to reserve some of these powers in the certificate or in the articles as opposed to resorting only to contract, but there is broad discretion to modify the default terms that I began with in this discussion.

Fiduciary Duties

T. Greaney: I refer to fiduciary duties in class as the "legal glue" that holds the corporation together, or at least binds the corporation's executives and directors to the interests of their principals, the shareholders. It is the command to directors and officers to do the right thing by their corporations because they are actually, when you think about it, agents for their shareholders. This disconnect between ownership and control, which economists call the "agency problem," pervades all of corporate law. Essentially, the fiduciary duties function as legal constraints that hold accountable those who run the organization and bind them to do the right thing by the organization.

For directors and officers there is a strong trend now, in fact, I think a unanimous trend among the states, to apply essentially the same corporate duties as are applicable to for-profit entities. In other words, the duty of care and duty of loyalty are essentially interpreted in the same way for both for-profit and nonprofit corporations. There was a time in our history when a stricter standard was applied to nonprofits, but all states now recognize that at least the very large nonprofit organizations, which are primarily hospitals, are commercial organizations, i.e., they are profit-making businesses, and therefore hold them to the same fiduciary duties as their for-profit brethren.

In a nutshell, the duty of care is a duty to be informed and

make judgments subject to the so called business judgment rule, but also to make judgments that are "informed decisions" in the sense that the directors must pay attention to both sides of the issue.

The second is the duty of loyalty, which is not an outright prohibition on conflicts of interest, but does address problems which arise when a director has an outside or distinct interest apart from the corporation. A third duty, the so-called duty of obedience, does not apply to for-profits, it applies only to nonprofits. And the concept here is that directors of nonprofits have a distinct obligation to pay close attention to their mission. A way of thinking about this duty is that it tells officers and directors that their first thought in the morning should be to make sure the organization is adhering to its charitable mission. There is a noteworthy law review article written by Kathleen Boozang (with a little help from me) that discusses what the duty of obedience means.[2]

What about the member? I mentioned earlier that the single-member nonprofit corporation is common in health care systems. The law is not at all clear on the duties of the member to the corporation because there are few if any decided cases on the issue. However, the general understanding is that the law does not impose fiduciary duties on the member. Because the member has plenary control over the organization, the lack of a legal duty is perhaps not surprising, but in a few situations perhaps the member's interest and corporate interest may diverge, and there has been some academic writing suggesting that in rare cases a duty may be inferred.

T. Glynn: On the for-profit side, again, the basic duties are the same. You can think about it in a number of different ways. So to whom are these duties owed? Well, the default duties on the for-profit side, like the not-for-profit side, are owed to the corporation. Ordinarily they are not owed directly to the shareholders, which has some important implications, particularly in terms of enforcement.

In addition, the issues and uncertainty surrounding corporate purpose may be folded back into the analysis here. For example, to the extent there is a narrower framing of corporate purpose in the

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[2] Thomas L. Greaney & Kathleen M. Boozang, *Mission, Margin and Trust in the Healthcare Enterprise*, 5 YALE J. HEALTH L. 1 (2005).

articles of incorporation, that may make a difference with regard to the scope and nature of duties of corporate actors. But, as discussed earlier, there is much uncertainty out there about what purpose must be served (even if framed in the articles or charter) and the precise role of such purpose in any particular dispute.

Now, in terms of the duties themselves, care is framed by business judgment deference. The substance of board decisions generally is not subject to challenge unless there is a taint of interestedness, or the board members fail to reasonably inform themselves (in other words, they did not do their homework before they made a decision or the decision was somehow wholly irrational or in bad faith). Again, this provides directors with a tremendous amount of discretion: the substance of their decision—that is, what decision they made—is not subject to judicial scrutiny unless it is self-interested, the directors failed to do their homework, or the decision is completely outside of the bounds of rationality.

Loyalty and good faith. Loyalty is the duty to act on behalf of the firm: one must not compete with the firm or engage in self-interested transactions unless those transactions are "fair" to the firm. So there is more robust scrutiny when you have transactions that may implicate loyalty concerns. There are some other duties out there as well. For example, directors have a duty not to abandon or abdicate entirely their decisional or oversight responsibilities. There are also some heightened duties that are triggered in the takeover and merger context and the like.

Securities law imposes its own set of duties. These are essentially disclosure and anti-fraud obligations. And, again, those apply to publicly traded firms with some exceptions—some small parts of the federal securities regime also apply to closely held firms.

Officers also have care and loyalty duties. In some ways, they are more robust than the duties that are owed by directors, but enforcement of those duties tends to be by the directors. Again, the directors manage the affairs of the corporation. So, perhaps ironically, there is less law out there on officer breaches, or alleged officer breaches of duties, because it is the board of directors that is positioned, for the most part, to determine whether or not to take action if an officer is not complying with his or her duties.

Turning to shareholders, as a general matter shareholders do not owe one another robust duties, nor do they owe the firm inde-

pendent fiduciary duties. But there are two important exceptions to that—important particularly in a context like this where you have multiple important players. One, controlling shareholders must act for the corporation and its shareholders as a whole and cannot disproportionately benefit from firm activities at the expense of other shareholders. So controlling shareholders have the obligation to serve the purposes of the corporation as a whole.

In closely held enterprises, there is an additional set of duties that apply. And these can be characterized as duties tied to expectational interests: one shareholder or shareholder group cannot defeat the legitimate expectations of other shareholders, unless there is a legitimate business interest in doing so. The pressure point here is what constitutes a "legitimate business interest." Why do we have heightened duties in the closely held context? Well, because exit is very, very difficult and there are some other ways in which closely held firms differ from publicly traded firms.

In this context especially, it is, I would suggest, advantageous for the parties within a closely held corporate structure to define their expectations in great detail—in advance—to the extent they can in the corporate documents and via contract.

Charitable Obligations

T. Greaney: Although this is an area where one might expect to find clarity, as suggested earlier, there is confusion and inconsistency on what exactly are the charitable obligations of charitable organizations. One would think the courts and legislatures should give clear guidance on what constitutes charity because that is why tax exemptions are granted—and that, presumably, is why the organization's sponsors decided to establish a nonprofit organization in the first place. Well, not so much. What we have seen under federal law is a series of cases and interpretations by the IRS that have drifted away from what most people would assume is embraced by the concept of charity. For hospitals the requirement, going back to the '50s, was pretty much a quantitative standard. It was an expectation that a certain amount of care be given to indigent persons incapable of meeting their bills.

One of the all-time great mistakes in tax law occurred in 1969 when the IRS took a look at charitable standards for hospitals and said, "you know what, we just adopted and passed Medicare and Medicaid, so there isn't going to be much need for charity care

anymore." Yes, everybody laughs now, but that's what it said. And the end result was the IRS adopted a "community benefit standard" that allows charitable hospitals to satisfy their obligation by merely having an emergency room, providing Medicare and Medicaid coverage, and being open to their physician staffs.

That decision has given rise to a lot of criticism as studies have documented that many tax exempt hospitals, though certainly not the majority, provide very little care that would be branded as charitable, in the sense of providing free or discounted health care to indigent individuals. In fact, the Affordable Care Act tries to tackle that problem, at least indirectly, by requiring exempt hospitals to undertake community needs assessments, publicize their financial assistance policies, and actually report on the results.

A couple of states—Pennsylvania and Texas—have imposed quantitative standards. In the wake of the Provena decision I mentioned earlier, Illinois recently adopted a notably more prescriptive approach. If I was asked to predict the future, I would certainly suggest there's going to be more aggressive movement on that side. And, perhaps more importantly, some states are toughening up their interpretation in the courts or through their taxing authorities. Illinois is the most well known example, as I mentioned, having stripped Provena of its exempt status and now looking closely at the tax exempt status of five other exempt hospitals.

T. Glynn: In the for-profit corporate world, there are no legal obligations to serve charitable purposes—at least no corporate-law-related legal obligations. There is discretion to serve these purposes, of course, as I talked about before, but no obligation.

Election/Removal of Directors and Management

T. Greaney: Nonprofit hospitals often adopt a flexible structure in the form of a membership-controlled corporation in which members can elect the board and also have removal powers, cementing the linkage between members' interest and control.

T. Glynn: In the for-profit context, again, the default rules are such that shareholders elect directors by one share, one vote, but all of that is subject to modification by the parties. For removal of directors, the default rule in most jurisdictions now is with or without cause, but it has to be at a shareholder meeting. And there are

some limits to that, particularly if there are minority shareholders or non-controlling shareholder protections in place. Selection and removal of officers, at least as a corporate law matter, are reserved to the directors, but this too is subject to modification by the parties, usually by contract.

EXECUTIVE AND BOARD COMPENSATION

T. Greaney: Again, here you see a difference between the two organizational forms because there is greater oversight on the nonprofit side. Although the board of the nonprofit organization has the discretion to set the level of management compensation, as I mentioned earlier, that decision is subject to oversight by the IRS and state taxing authorities regarding whether that compensation is excessive in some sense. Moreover, several state attorneys general have made a point of litigating, threatening, or shaming executives on the issue of their compensation.

How do you gauge excess compensation? There is a debate, obviously, about whether the standard for nonprofit exempt organization salaries should be different than for-profit. I think the general rule is that nonprofits are competing in the same labor market and that the standard should be the same. Nevertheless, excessive compensation, however defined, has attracted the attention of some state taxing authorities and the attorneys general at least in situations suggesting potentially egregious examples of abuse.

Just as a side note, one might also ask, "well, is nonprofit compensation tied to financial performance, as it is in the for-profit sector, and if so does it make a difference?" I do not know of any definitive study providing the answer, but I was told that there is one survey claiming that 70 percent of nonprofit hospitals pay financial incentives to their executives for financial performance. Apparently many hospitals are also tying incentives to mission objectives, including performance on the charity side.

T. Glynn: On the for-profit side, I think the principal take away is that there are few substantive limitations on officer compensation. Members of the board of directors are also usually compensated (although some members might be and some members might not be). Boards have to be a little more careful because there is a duty of loyalty overlay, so challenges are possible, but they are rarely successful. With regard to officers or executives, as

long as there is negotiation that bears resemblance to an arms-length transaction or an arms-length negotiation, usually executive compensation is not subject to legal challenge.

The form of compensation, again, plays a role because performance-based compensation is now standard for a whole host of reasons. And compensation tends to be structured to align executive compensation with shareholder interests, albeit this alignment is imperfect. Again, this may be a way in which the shareholder wealth maximization norm is enhanced without an underlying, direct legal mandate that may be enforceable in any given situation. So compensation matters for that purpose, but there is very little in the way of substantive limitations on executive compensation.

Disclosure Obligations

T. Greaney: We have seen a number of areas where the scrutiny of nonprofits has been greater than the for-profit area. For a long time, the financial conditions of nonprofits were a black box. There were very few disclosure obligations on nonprofit organizations. That has changed considerably with the IRS instituting new reporting requirements under its Form 990, including much more detailed financial reporting and disclosures about bond financing, publication of an organization's mission statement, and articulation of governance and management policies. Again, it is the IRS nudging nonprofits along towards what it considers good management practices. And also, importantly, the quantity of charitable care is becoming more publicly disclosed.

T. Glynn: In for-profit firms, the duty of loyalty may carry with it an obligation to make disclosures to other corporate constituencies. So there are certain internal disclosures under state law. The principal disclosure regime that we have in corporate law is our securities law, and there are various disclosure mandates, both initial and periodic disclosures, that apply to publicly traded firms.

So, we can think about where there is more or less in the way of disclosure. Publicly traded firms have robust disclosure obligations, at least in terms of financial disclosure. (Nonprofit) Tim talked about the separate disclosure obligations for nonprofit disclosure. Closely held for-profit corporations have neither set of obligations. Thus, among these three corporate forms, closely held firms have the fewest disclosure obligations, although there are

some disclosure mandates that come from other external legal regimes, not from corporate law itself.

CONSOLIDATIONS AND MERGERS

T. Greaney: In closing, perhaps a little beyond our scope, but worth noticing, is that in the area of mergers, consolidations and closures, there are special obligations for the nonprofit, especially when the sale is to a for-profit entity. These transactions implicate a mix of state statutory law, charitable trust law and other laws, the general rule and upshot of which is that the charitable assets must remain in the charitable stream. So if there is money being paid to an entity, it has to stay on the charitable side, i.e., in the control of an entity dedicated to a charitable purpose. In some situations, foundations have been created where it is not possible to place the charitable assets in an entity serving the exact same charitable purpose as the prior entity; the so-called cy-pres and quasi-cy-pres legal doctrines are invoked to assure that the assets go into an enterprise whose purpose is at least roughly comparable to the original charitable mission.

T. Glynn: Briefly, on the for-profit side, there are a few external limitations in this context. There may be other regulatory regimes that play a role, but there are not the kinds of scrutiny that you see on the nonprofit side. Directors and shareholders are the ones that would approve various kinds of mergers or consolidations. The default rules can be modified to some extent, but as I mentioned previously, this is one of those few contexts in which the obligations to protect shareholder interests or share values may be sharpened, and there is a fairly significant body of law on that issue. Thus, this is one area where there is some pressure along the "corporate purpose" lines.

There are also over-arching securities law obligations when you have a publicly traded firm that is engaging in some kind of merger or other takeover. We do not have time, however, to explore these in detail.

For-Profit v. Nonprofit: Does Corporate Form Matter? The Question of For-Profit Eligibility for Religious Exemptions Under Conscience Statutes and the First Amendment

*Angela C. Carmella**

I'll talk this afternoon about whether corporate form matters to hospital conscience laws and to the Religion Clauses of the First Amendment.[1] These conscience laws allow hospitals to refuse to provide abortion, sterilization and contraception on moral or religious grounds.

Religious exemptions are quite common in state and federal law.[2] Sometimes courts mandate them under the Free Exercise Clause.[3] But more typically, they are found in legislation and regulations. The Establishment Clause, also within the First Amendment, sets the outer boundaries of the kinds of exemptions that are permissible, making sure that any given exemption promotes religious liberty rather than religious privilege.[4]

Religious exemptions can give churches and their affiliated organizations freedom from expensive regulation or taxation. But often the exemptions explicitly promote core religious exercise: by allowing religious organizations to define themselves and engage in their missions. By way of example, take the federal employment discrimination law, Title VII: it contains an exemption that allows religious organizations to hire and fire based on religious criteria.[5] Religious organizations that qualify are better able to define their missions without government interference. Consider the case of the hospital telemetry technician fired from her job with a Catholic

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1 U.S. CONST. amend. I (providing in relevant part, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.")

2 James E. Ryan, *Smith and the Religious Freedom Restoration Act: An Iconoclastic Assessment*, 78 VA. L. REV. 1407, 1445 (1992) (noting over two thousand religious exemptions in state and federal legislation); *see also*, Angela C. Carmella, *Responsible Freedom under the Religion Clauses: Exemptions, Legal Pluralism, and the Common Good*, 110 W. VA. L. REV. 403 (2007).

3 Sherbert v. Verner, 374 U.S. 398 (1963); Wisconsin v. Yoder, 406 U.S. 205 (1972).

4 Corp. of Presiding Bishop v. Amos, 483 U.S. 327 (1987).

5 42 U.S.C. § 2000e-1 (2006).

hospital.[6] The technician was a practicing Wiccan; the hospital allegedly had fired her because of her religion. The federal court found that the Title VII exemption applied to the Catholic hospital, which meant it was free to make that employment decision based on religious grounds.

Federal and state conscience protection is critical to the identity and mission of Catholic hospitals. So the question becomes this: Are Catholic for-profit hospitals protected to the same extent as Catholic nonprofits under the First Amendment and under religious exemptions? Can for-profit hospitals make the same claims as nonprofits to religious freedom and religious conscience? These are novel questions. There are simply no cases that provide a direct answer. We operate between two competing positions. On the one end, we find a comfortable fit between the nonprofit corporate form as an indicator of religiosity, and the for-profit form as an indicator of secularity. We see this traditional thinking represented in this quote from Supreme Court Justice William Brennan in 1987, when he noted that:

> The fact that an operation is not organized as a profit-making commercial enterprise makes colorable a claim that it is not purely secular in orientation. . . . Unlike for-profit corporations, nonprofits historically have been organized specifically to provide certain community services, not simply engage in commerce. Churches often regard the provision of such [nonprofit] services as a means of fulfilling religious duty and of providing an example of the way of life a church seeks to foster.[7]

At the other end from this traditional position, we note that corporate form alone has never been held to determine rights under the Religion Clauses. Judge John Noonan of the 9th Circuit has written:

> Just as a corporation enjoys the right of free speech guaranteed by the First Amendment, so a corporation enjoys the right guaranteed by the First Amendment to exercise religion. . . . The First Amendment does not say that only religious corporations or only not-for-profit corporations are protected. The First Amendment does not authorize Congress to pick and choose the persons or the entities or the organizational forms that are free to exercise their religion. All persons—and under our Con-

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[6] Saeemodarae v. Mercy Health Servs., 456 F. Supp. 2d 1021, 1040 (N.D. Iowa 2006).

[7] *Amos*, 483 U.S. at 344 (Brennan, J., concurring).

> stitution all corporations are persons—are free. A statute cannot subtract from their freedom. . . .[8]

So with this framework in mind, the following discussion gives an overview of the statutes that protect conscience. Then it addresses the caselaw that does say something about religion and for-profits. Much of it comes from interpreting the Title VII exemption for religious employers. While it does not have direct applicability to our novel question, it may have some indirect relevance and provide issues to consider.

Conscience Protection: Federal and State

In response to *Roe v. Wade*,[9] in 1973 Congress passed the Church Amendment (referring to Senator Frank Church).[10] This law provides that hospitals that get federal money cannot be required by a court or public official to provide abortions or sterilizations if the hospital prohibits them "on the basis of religious beliefs or moral convictions."[11] Two other federal conscience laws focus on abortion and do not require a showing of religious or moral grounds: the Coats Amendment protects residency programs from losing accreditation if they refuse to train doctors to perform abortions;[12] and the Weldon Amendment protects hospitals that de-

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8 EEOC v. Townley Engineering & Manufacturing Co., 859 F.2d 610, 623 (9th Cir. 1988) (Noonan, J., dissenting).

9 410 U.S. 113 (1973).

10 42 U.S.C.A. § 300a-7 (West 2012).

> Sterilization and Abortion. (b) . . . . The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Construction Act by any individual or entity does not authorize any court or public official or other public authority to require . . . (2) such entity to (A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions . . . .

Id.

11 The Church amendment does not define "entity."

12 42 U.S.C.A. § 238n (West 2012).

> Abortion-related Discrimination in Governmental Activities Regarding Training and Licensing of Physicians, effective 1996: (a) . . . The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that (1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions; (2) the entity refuses to make arrangements

cline to perform (or refer for) abortions by withholding federal funds from any governmental program that discriminates against them.[13] None of these laws define the hospital or health care entity in terms of its corporate form.

In addition to federal conscience protections, most states have refusal laws in place.[14] Most common are refusal laws regarding abortion, which exist in forty-four states.[15] These state laws authorize enumerated health care providers (the scope of coverage varies) to refuse to provide abortions. While the majority of these laws do not require that a hospital articulate a reason for the refusal,[16]

> for any of the activities specified in paragraph (1). . . . (b) (1) . . . [Government, as above] shall deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions . . . . (2) Rules of construction . . . . (c) Definitions . . . (2) The term "health care entity" includes an individual physician, a postgraduate physician training program, and a participant in a program of training in the health profession.

Id.

[13] Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 508(d).

> (1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health-care facility, organization, or plan.

Id.

[14] The interaction of federal and state law is outside the scope of this presentation, but note that important issues exist. For instance, state enforcement of a law requiring a hospital to provide abortions could trigger possible de-funding under the Weldon Amendment.

[15] *State Policies in Brief: Refusing to Provide Health Services*, GUTTMACHER INST. (2012), *available at* www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf (hereinafter, GUTTMACHER).

[16] ALASKA STAT. ANN. § 18.16.010 (West 2011); ARK. CODE ANN. § 20-16-601 (West 2011); COLO. REV. STAT. ANN. § 18-6-104 (West 2011); DEL. CODE ANN. tit. 24 § 1791 (West 2011); FLA. STAT. ANN. §390.0111(8) (West 2011); GA. CODE ANN. § 16-12-142(a) (West 2011); HAW. REV. STAT. ANN. § 453-16 (West 2011); IDAHO CODE ANN. § 18-612 (West 2012); ILL. COMP. STAT. ANN. ch. 745, Act 30/1 (West 2011); IND. CODE ANN. § 16-34-1-3 (West 2011); IOWA CODE ANN. § 146.2 (West 2011); KAN. STAT. ANN. § 65-444 (West 2012); LA. REV. STAT. ANN. §§ 40:1299.32-40:1299.33 (West 2011); ME. REV. STAT. ANN. tit. 22 § 1591 (2011); MD. CODE, HEALTH-GEN. § 20-214 (West 2011); MICH. COMP. LAWS ANN. 333.20181 (West 2012); MINN. STAT. ANN.

about a dozen states require that the refusal be based on religious or moral grounds, as expressed in the hospital's governing documents, votes or policies.[17] (Note that conscience statutes often say that in addition to being able to refuse, the refusing hospital will not suffer any penalty, discrimination or liability on account of the refusal.)

Two state courts have limited their abortion conscience laws to *religious* objectors: they refuse to apply their state conscience laws to secular nonprofits, but they say nothing about for-profits.[18] California is the only state that makes corporate form relevant—the refusal to provide an abortion can only be made by a *nonprofit hospital* "organized or operated by a religious corporation or other religious organization."[19]

With respect to sterilization, sixteen states have conscience laws that allow hospitals to refuse to provide this procedure.[20] Nine of these require the objecting hospital to have religious or moral grounds,[21] while the remaining seven are silent on the reason for the refusal.[22]

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§§ 145.42, 145.414 (West 2011); NEB. REV. ST. § 28-337 (2011); NEV. REV. STAT. ANN. 449.191 (West 2010); N.J. STAT. ANN. § 2A: 65A-2 (West 2011); N.M. STAT. ANN. § 30-5-2 (West 2011); N.C. GEN. STAT. ANN. § 14-45.1(f) (West 2011); N.D. CENT. CODE ANN. § 23-16-14 (West 2011); OHIO REV. CODE ANN. § 4731.91 (West 2011); OR. REV. STAT. ANN. § 435.475 (West 2011); S.C. CODE OF LAWS 1976 ANN. § 44-41-40 (2011); S.D. CODIFIED LAWS § 34-23A-14 (2011); TENN. CODE ANN. § 39-15-204 (West 2011); TEX. OCC. CODE ANN. § 103.004 (West 2011); VA. CODE ANN. § 18.2-75 (West 2011); WASH. REV. CODE ANN. § 9.02.150 (West 2011); WYO. STAT. ANN. §3 5-6-105 (West 2011).

17 ARIZ. REV. STAT. ANN. § 36-2154 (2011); CAL. HEALTH & SAFETY CODE § 123420(c) (West 2012); KY. REV. STAT. ANN. § 311.800(3) (West 2011); MASS. GEN. LAWS ANN. ch. 272 § 21B (West 2011); MISS. CODE ANN. § 41-107-7 (West 2011); MO. ANN. STAT. § 197.032 (West 2011); MONT. CODE ANN. tit. 50, ch. 20 § 111 (West 2011); N.Y. PUB. HEALTH LAW § 2994-n(1) (McKinney 2011); 43 PA. STAT. § 955.2 (West 2011); 1953 UTAH CODE ANN. § 76-7-306 (West 2011); WIS. STAT. ANN. § 253.09 (West 2011).

18 Doe v. Bridgeton Hosp. Ass'n., Inc., 366 A.2d 641 (N.J. 1976); Valley Hospital Ass'n., Inc. v. Mat-Su Coalition for Choice, 948 P.2d 963 (Alaska 1997).

19 CAL. HEALTH & SAFETY CODE §123420(c) (West 2012).

20 *See generally* GUTTMACHER, *supra* note 15.

21 ARK. CODE ANN. § 20-16-304 (West 2011); ILL. COMP. STAT. ANN. ch. 745, act 70/3 (West 2011); MASS. GEN. LAWS ANN. 272 § 21B (2011); MISS. CODE ANN. § 41-107-7 (West 2011); MONT. CODE ANN. § 50-5-502 (West 2011); N.M. STAT. ANN. § 24-8-6 (West 2011); 43 PA. STAT. § 955.2 (West 2011); WASH. REV. CODE ANN. § 70.47.160 (West 2011); WIS. STAT. ANN. § 253.09 (West 2011).

22 GA. CODE ANN. § 31-20-6 (West 2011); IDAHO CODE ANN. § 39-3915 (West 2012); KAN. STAT. ANN. § 65-447 (West 2012); ME. REV. STAT. STAT. ANN. tit. 34 § 7016

Federal law does not protect a hospital's decision to refuse contraception, but nine states allow hospitals to refuse on religious or moral grounds.[23] And most of those states allow pharmacies to refuse as well. Notably, pharmacies are typically for-profit entities; it is fair to say that in most instances, however, the states extending conscience protections to pharmacies were seeking to protect individual pharmacists, particularly those practicing in solo settings, as well as religious hospital pharmacies, from having to provide a service in violation of their religious beliefs.

These conscience laws regarding abortion, sterilization and contraception seek to protect hospitals that refuse to provide these services. There are also conscience laws that allow hospitals, as employers, to refuse to pay for insurance coverage of morally objectionable services. For example, eighteen out of the twenty-eight state statutes exempt religious employers from having to cover contraceptives in their employees' insurance plans.[24] Note, however, that fourteen of these conscience exemptions are explicitly limited to nonprofits.[25]

(2011); MD. CODE, HEALTH–GEN., § 20-214 (West 2012); N.J. STAT. ANN. § 2A: 65A-2 (2011); W. VA. CODE ANN. § 16-11-1 (West 2012).

23 *See generally*, GUTTMACHER, *supra* note 15. ARIZ. REV. STAT. ANN. § 36-2154 (2011); ARK. CODE ANN. § 20-16-304 (West 2011); COLO. REV. STAT. ANN. § 25-6-102 (West 2012); ILL. COMP. STAT. ANN. ch. 745, act 70/3 (West 2011) (general right to conscience); ME. REV. STAT. ANN. tit. 22 § 1903 (2011); MASS. GEN. LAWS ANN. ch. 272 § 21B (West 2011); MISS. CODE ANN. § 41-107-3 (West 2011) (general right to conscience); TENN. CODE ANN. § 68-34-104 (West 2011); WASH. REV. CODE ANN. § 48.43.065(2)(a) (general right to conscience).

24 ARIZ. REV. STAT. ANN. § 20-826(Y)(Z) (West 2011); ARK. CODE ANN. § 23-79-1102 (West 2011); CAL. INS. CODE § 10123.196 (West 2011); CONN. GEN. STAT. § 38a-503e (West 2011); DEL. CODE ANN. tit. 18 § 3559 (West 2011); HAW. REV. STAT. § 431:10A-116.7 (West 2011); ME. REV. STAT. tit. 24, § 2332-J (2011); MASS. GEN. LAWS ANN. ch. 176B § 4W (West 2011); MD. CODE ANN. INS. § 15-826 (West 2011); MO. REV. STAT. § 376.1199 (West 2011); NEV. REV. STAT. ANN. § 689A.0417 (West 2011); N.J. STAT. ANN. § 17:48-6ee (West 2011); N.Y. INS. LAW § 3221(1)(16) (West 2011); N.C. GEN. STAT. § 58-3-178 (West 2011); OR. REV. STAT. § 743A.066 (West 2011); R.I. GEN. LAWS § 27-18-57 (West 2011); W. VA. CODE § 33-16E-2 (West 2011); *see also*, Michigan Civil Rights Commission, Declaratory Ruling on Contraception Equity, *available at* http://www.michigan.gov/documents/Declaratory_Ruling_7-26-06_169371_7.pdf. Other sources place the number higher, see, e.g., National Conference of State Legislatures, Insurance Coverage for Contraception Laws, *available at* http://www.ncsl.org/default.aspx?tabid=14384 (noting twenty states with religious employer exemptions).

25 Arizona, Arkansas, California, Connecticut, Hawaii, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Oregon, Rhode Island, West Virginia. *See also* Catholic Charities of the Diocese of Albany v. Serio, 859 N.E.2d 459 (N.Y. 2006) (unsuccessful challenge to narrow religious exemption); Catholic Charities of Sacra-

At the federal level, we also see the new Health and Human Services rule under the Patient Protection and Affordable Care Act[26] (issued August 2011) and its very narrow religious employer exemption.[27] Because of the narrowness, the rule would require Catholic hospitals to provide insurance coverage for their employees for not only contraception but also sterilization as well. After a barrage of criticism from the bishops and others, President Obama announced that religious organizations with religious objections to such coverage would not have to pay (their insurers would)—but note that this proposed accommodation, at least in its current form, is limited to nonprofits.[28] The law and its attendant regulations regarding contraceptive coverage face ongoing litigation.[29]

The following section continues to pursue our framing questions: Does corporate form matter when a for-profit makes a claim that it has religious or moral grounds for refusal? And where there is no statutory protection for conscience refusal, does corporate

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mento v. Super. Ct., 85 P.3d 67 (Cal. 2004), *cert. denied* 543 U.S. 816 (2004) (unsuccessful challenge to narrow religious exemption).

26 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 42 U.S.C.).

27 Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46, 621 (Aug. 3, 2011). The regulation requires employers to provide coverage, without cost sharing, for preventive health services including "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." *Id.* The religious employer exemption is limited to those employers that have the inculcation of religious values as their purpose; primarily employ and serve persons who share their religious tenets; and are non-profit organizations.

28 The Obama administration refused to expand the religious employer exemption and instead proposed an accommodation that would allow "non-exempted *nonprofit religious organizations* with religious objections to contraceptive/sterilization coverage" to avoid cost sharing for those services (emphasis added). *See,* Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8728 (Feb. 15, 2012). A month later the administration sought comment on ways to structure this proposed accommodation and asked specifically for comments regarding "which religious organizations should be eligible for the accommodation and whether, as some religious stakeholders have suggested, for-profit religious employers with such objections should be considered as well." Certain Preventive Services Under the Affordable Care Act, 77 Fed. Reg. 16501, 16504 (Mar. 21, 2012).

29 O'Brien v. U.S. Dep't of Health and Human Servs., No. 4:12-cv-476, 2012 WL 4481208 (E.D. Mo. Sept. 28, 2012); Wheaton Coll. v. Sebelius, No. 12-1169, 2012 WL 3637162 (D.D.C. Aug. 24, 2012).

form matter when the for-profit makes a constitutional claim to a free exercise right to refuse?

RELIGIOUS CLAIMS OF FOR-PROFIT CORPORATIONS

There are no decisions about whether a for-profit corporation can assert its own rights under the Free Exercise Clause. The issue has simply not been addressed—and certainly not in the context of these complex corporate structures. First of all, most of the cases involve conscience claims by small businesses: a landlord who refuses to rent to an unmarried couple,[30] or a wedding photographer who refuses to take photos of a same-sex marriage.[31] In such cases, courts usually say to the religious claimant, once you enter the commercial marketplace you have to play by the rules of the marketplace. Your faith did not require you to be a landlord or to be a photographer.

Several cases came very close to the issue of for-profit free exercise claim but circumvented it. They involve laws regarding emergency contraception. Two states, Washington and Illinois, required pharmacies to stock and dispense Plan B without any conscience exemption. (This was before Plan B became available to women younger than eighteen without prescription.[32]) Pharmacies filed lawsuits in both states claiming the right to refuse under the Free Exercise Clause. In *Stormans, Inc. v. Selecky*,[33] the federal district court held in February, 2012, that the state of Washington had violated the Free Exercise Clause because it had no conscience ex-

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30 Swanner v. Anchorage Equal Rights Comm'n, 874 P.2d 274 (Alaska 1994) (any burden landlord suffers from refusing to rent to unmarried, cohabiting couples in violation of anti-discrimination law is self-imposed; "voluntary commercial activity does not receive the same status accorded to directly religious activity").

31 Willock v. Elane Photography, HRD No. 06-12-20-0685 (N.M. Hum. Rts. Comm. Apr. 9, 2008) (photographer refusing to photograph same-sex commitment ceremony ordered to pay money to client who was turned away).

32 On August 24, 2006, the FDA approved nonprescription (behind-the-counter) access to Plan B from pharmacies staffed by a licensed pharmacist for women 18 or older; in March, 2009, a federal district court ruled (Tummino v. Torti, 603 F. Supp. 2d 519, (E.D.N.Y. 2009)) that Plan B must be made available on the same terms to women aged 17 or older. In April, 2009, the FDA announced that the government would not appeal the court's ruling. Those under the age of 17, however, must still have a prescription to gain access to the drug.

33 No. C07-5374, 2012 WL 566775 (W.D. Wash. 2012) (note that the state's conscience law applied only to individual pharmacists). This decision was the result of a remand from the Federal Court of Appeals for the Ninth Circuit, Stormans, Inc. v. Selecky, 586 F.3d 1109 (9th Cir. 2009).

emption. The Free Exercise Clause is violated on a showing of government discrimination targeted at religious practice. The court found the hallmarks of discrimination: the law was neither neutral nor generally applicable. It was not neutral because the burden of the law was specifically targeted at religious and moral objectors; further, the court was especially concerned with the selective enforcement: indeed, the state enforced it against several small pharmacies but had no plans to enforce it against Catholic hospital pharmacies. (In Illinois, the state Supreme Court allowed a similar case to proceed on a Free Exercise claim with a similar analysis of discrimination.[34])

At an earlier point in the *Stormans* litigation, the intervenors argued that the pharmacy had no standing to assert a Free Exercise claim precisely because it was a for-profit corporation.[35] But the 9th Circuit declined to decide this issue. When closely held[36] corporations are involved, courts consider the free exercise claims of the owners rather than the claims of the entity.[37] The free exercise rights are those of the pharmacist owners, not those of the for-profit.

So the narrow inquiry on corporate form doesn't yield much. Most constitutional issues look at a broad range of practices and policies to determine how religious an organization is.[38] It is in this context that the Supreme Court has weighed in on what it thinks about for-profit activities vs. nonprofit activities. Yet this too may not yield much to illuminate the question of the Catholic for-profit hospital. Nonetheless, it remains useful to look at the extant caselaw.

In *Tony and Susan Alamo Foundation v. Secretary of Labor*,[39] the United States Supreme Court would not exempt the Alamo Foundation from minimum wage laws under the Free Exercise Clause.

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[34] Morr-Fitz, Inc. v. Blagojevich, 901 N.E.2d 373 (Ill. 2008).

[35] Test shoppers from Planned Parenthood had made this argument in Stormans v. Selecky, 586 F.3d at 1119–1120.

[36] A company with a very limited number of individual shareholders.

[37] *Id.* ("We decline to decide whether a for-profit corporation can assert its own rights under the Free Exercise Clause and instead examine the rights at issue as those of the corporate owners."); *see also* EEOC v. Townley Engineering & Manufacturing Co., 859 F.2d 610, 623 (9th Cir. 1988) (Noonan, J., dissenting).

[38] *See, e.g.*, Thomas C. Berg, *Religious Structures under the Federal Constitution*, *in* RELIGIOUS ORGANIZATIONS IN THE UNITED STATES: A STUDY OF IDENTITY, LIBERTY AND THE LAW 129–131, 152–166 (James A. Serritella, ed. 2006).

[39] 471 U.S. 290 (1985).

The foundation was a religious nonprofit with forty commercial businesses; it employed drug addicts and criminals in these businesses to help with their rehabilitation. The Court held that the foundation had to comply with minimum wage and overtime laws. It noted that the labor law contained no religious exemption precisely because Congress had already thought this through: It did not want nonprofits engaged in commercial enterprises to gain an unfair competitive advantage over for-profits.[40] This could adversely affect private industry.

Most of the discussion of religion and for-profits arises in the Title VII exemption context—that's the exemption that allows religious organizations to discriminate on the basis of religion in employment, regardless of whether the job is secular or religious.[41] This exemption was challenged as an Establishment Clause violation. The Supreme Court's opinion in *Corporation of Presiding Bishop v. Amos* explicitly discusses the distinction between nonprofit and for-profit activities.[42] In that case, a Mormon nonprofit organization operated a gymnasium and hired only Mormons. It fired the custodian when he was found to be no longer in good standing in the Mormon Church. The Court held the exemption constitutional as applied to *nonprofit* activities of religious employers. The exemption allowed the church to define its mission, and to select employees for that mission, without government interference.

Several justices concurred separately to emphasize that they were comfortable with the exemption only as it applied to *nonprofit corporations and nonprofit activities.* Justice O'Connor wrote, "It is not clear . . . that activities conducted by religious organizations solely as profit-making enterprises will be as likely to be directly involved in the religious mission of the organization. . . ."[43] Justice Brennan noted that "[i]t is conceivable that some for-profit activities could have a religious character, so that religious discrimination with respect to these activities would be justified in some cases."[44] Of course, the opinion did not reach the precise issue of whether the

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40 Note Professor Berg's discussion of this issue, *supra* note 37, at 163–166.

41 42 U.S.C. § 2000e-1.

42 483 U.S. 327 (1987). The distinction was before the Court because the District Court had found that the exemption allowed "churches with financial resources impermissibly to extend their influence and propagate their faith by entering the commercial, profit-making world." *Id.* at 337.

43 *Id.* at 349 (O'Connor, J., concurring).

44 *Id.* at n. 6 (Brennan, J., concurring).

exemption would apply to for-profit corporations or for-profit activities of nonprofits.

In these Supreme Court cases we see that the Court is regarding for-profit commercial activities as those endeavors clearly distinct from nonprofit activities. A church operating a commercial office building would be engaged in commercial activity; a church operating a soup kitchen would be involved in charitable, nonprofit activity. In the context of the hospital issue before us, the distinction is less clear: nonprofit and for-profit hospitals both deliver health care—they are both engaged in a commercial enterprise.[45]

In a recent Title VII exemption case, the 9th Circuit noted the similarities between nonprofit and for-profit hospitals. In *Spencer v. World Vision*,[46] the court was devising a test to determine what kinds of entities counted as religious corporations under the Title VII exemption. There are many such tests among different courts, and often corporate form is one consideration among many factors.[47] In *Spencer*, the court held that any time a religious entity charges fees for goods and services (beyond nominal amounts), it would not be considered a religious corporation eligible for the Title VII exemption. The case itself involved World Vision, a Christian relief organization that did not charge for its services. Obviously under this test, no religiously affiliated hospitals would be eligible, regardless of corporate form. In fact, the judge in concurrence used religious hospitals to illustrate his point that since nonprofits are like for-profits in that both make money, they should not be considered religious corporations for purposes of this exemption.[48] He wrote in dicta:

> Nonprofit status affects corporate governance, not eleemosynary activities. 'For-profit' and 'nonprofit' have nothing to do with making money. For example, physicians may organize a hospital as a nonprofit affiliated with a church, stating a religious purpose of healing the sick in its articles and bylaws. The hospital may then charge full market prices to patients and their insurers and pay [market rate salaries to employees]. It can de-

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45 The term "commercial nonprofits" was first coined by Yale professor Henry B. Hansmann in *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 840–41 (1980).

46 633 F.3d 723 (9th Cir. 2011).

47 *See generally* Roger W. Dyer, Jr., *Qualifying for the Title VII Religious Organization Exemption: Federal Circuits Split Over Proper Test*, 76 MO. L. REV. 545 (2010).

48 *Spencer*, 633 F.3d at 741 (Kleinfeld, J., concurring).

> fend its religious purpose with the true argument that whatever church it affiliates with promotes healing of the sick as a religious duty. Yet the nonprofit hospital differs from a for-profit hospital only in that the board does not have to concern itself with pesky stockholders and does not have to pay income taxes on the excess of revenues over expenses and depreciation. The free exercise concern protected by the exemption does not suggest that the hospital should be allowed to discriminate in religion in hiring, since physicians, nurses, and other employees can perform their tasks equally well regardless of their religious beliefs.[49]

On the other hand, the case of the Catholic hospital that was free to fire the Wiccan technician under the Title VII exemption obviously took a different approach.[50] That hospital was a nonprofit founded by the Sisters of Mercy. Its mission was to continue the healing ministry of the Catholic Church. Under its bylaws the hospital had to conduct itself in accord with church guidelines and the *Ethical and Religious Directives for Catholic Health Care Services* promulgated by the United States Conference of Catholic Bishops. Orientation introduced new employees to the hospital's Catholic history, identity, and mission; the hospital's pastoral care department hosted on-site chaplains and daily Mass in the chapel; all statuary, symbols, decoration, iconography and artwork identified the hospital as Catholic. The court considered all of these facts to hold that the nature and atmosphere of the hospital were "undisputedly religious." It was undeniably a religious corporation eligible for the Title VII exemption. Where the *World Vision* court would have held the hospital ineligible solely on the ground that it charged fees for its medical services, other courts, like this one, take other factors, like religious atmosphere, into account. But, as we know, the question still remains open for for-profit organizations.

THE RELIGION CLAUSES: SOME QUESTIONS TO EXPLORE

So the Title VII cases, the area that actually is open to analyz-

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[49] *Id.* at 745–46. Judge Kleinfeld was responding to Judge O'Scannlain's separate concurrence. Judge O'Scannlain had argued that a nonprofit corporate form indicated the religious nature of an organization. Judge Kleinfeld is therefore noting how a nonprofit can be in the money-making business (and therefore non-religious); he is not considering the possibility of a religiously-affiliated for-profit corporation.

[50] Saeemodarae v. Mercy Health Servs., 456 F. Supp. 2d 1021, 1040 (N.D. Iowa 2006).

ing religious claims of for-profits, ends up giving little authoritative guidance. Now let's turn to the Religion Clauses. Because we have no law to directly answer the question regarding the relevance of corporate form, I will leave you with a list of issues that are worthy of future exploration. First: What is the nature of a religious or moral claim when made by a corporate entity? Whose claim is it? The church's? The corporate entity's? And when there are multiple entities within a complex corporate structure, which of those entities?

Second, how does the law of free exercise apply? The Supreme Court over the last two decades has focused its attention more closely on the form and design of the law rather than on the nature and identity of the religious claimant. Laws that are neutral and general are presumptively constitutional;[51] laws will fail under the Free Exercise Clause if they are intended to or designed to discriminate against religious practice or among religious groups.[52]

But a showing of discrimination is not necessary under the theory of hybrid rights.[53] If a claimant can show that a law creates a burden on both religion and speech rights,[54] or on religion and property rights,[55] a hybrid might exist. This would make a court scrutinize the law under a heightened standard of judicial review, for greater free exercise protection.[56]

Third, is the Establishment Clause at all relevant to conscience exemptions? To be constitutional, exemptions that are given by legislation have to promote the free exercise of religion by removing a governmentally created burden.[57] Courts take other factors into account: for instance, they consider the kinds of burdens placed on similar organizations that don't get the exemption, like secular hospitals precluded from refusing certain services.[58] They also consider the balance between the exemption and other significant societal interests, like the concern with gaining an unfair competitive advantage over other businesses.[59] Do conscience laws lead

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51 Empl. Div., Dep't. of Human Res. of Or. v. Smith, 494 U.S. 872 (1990).

52 Church of the Lukumi Babalu Aye v. City of Hialeah, 508 U.S. 520 (1993).

53 *See Smith*, 494 U.S. at 881, which allows for this possibility.

54 Cantwell v. Connecticut, 310 U.S. 296 (1940).

55 Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925).

56 *See also* Religious Freedom Restoration Act, 42 U.S.C. §2000bb-2000bb-4 (2000) (federal statute that subjects federal laws that burden religion to strict scrutiny).

57 *See* Corp. of Presiding Bishop v. Amos, 483 U.S. 327, 337 (1987).

58 Texas Monthly, Inc. v. Bullock, 489 U.S. 1 (1989).

59 *See generally* Cutter v. Wilkinson, 544 U.S. 709 (2005); Bd. of Educ. of Kiryas Joel

to unfair advantage, or to the opposite?

In sum, whether conscience protection—statutory or constitutional—will attach to for-profit hospitals remains an open question. Perhaps some answers will begin to emerge as for-profit corporate challenges to the federal regulation regarding contraceptive coverage move through the federal courts.[60]

Vill. Sch. Dist. v. Grumet, 512 U.S. 687 (1994); Estate of Thornton v. Caldor, Inc., 472 U.S. 703 (1985); *see also* Berg, *supra* note 37.

[60] Three such challenges have been decided by federal district courts. Two courts granted preliminary injunctions sought by family-owned businesses and their owners, *see* Legatus v. Sebelius, No. 12-12061, 2012 WL 5359630 (E.D. Mich. Oct. 31, 2012) and Newland v. Sebelius, No. 1:12-cv-1123, 2012 WL 3069154 (D. Colo. July 27, 2012). The *Legatus* court, relying on Stormans, Inc. v. Selecky, No. 07-5374, 2012 WL 566775 (W.D. Wash. 2012) (discussed *supra*), stated that "Weingartz Supply Co. was founded as a family business and remains a closely held family corporation. Accordingly, the court need not, and does not, decide whether Weingartz Supply Co., as a for-profit business, has an independent First Amendment right to free exercise of religion. For the purposes of the pending motion, however, Weingartz Supply Co. may exercise standing in order to assert the free exercise rights of its president, Daniel Weingartz, being identified as 'his company.'"

The *Newland* court identified (without deciding) many questions "of first impression" that "merit more deliberate investigation." "Can a corporation exercise religion? Should a closely held subchapter-S corporation owned and operated by a small group of individuals professing adherence to uniform religious beliefs be treated differently than a publicly held corporation owned and operated by a group of stakeholders with diverse religious beliefs? Is it possible to 'pierce the veil' and disregard the corporate form in this context? What is the significance of the pass-through taxation applicable to subchapter-s corporations as it pertains to this analysis?"

In contrast, the court in O'Brien v. U.S Dep't of Health and Human Services, No. 4:12-cv-476, 2012 WL 4481208 (E.D. Mo. Sept. 28, 2012), dismissed a challenge by a small business and its owner, finding no statutory or constitutional infirmity in the requirement to provide contraception coverage to employees. The court "decline[d] to reach the question of whether a secular limited liability company is capable of exercising a religion within the meaning of RFRA or the First Amendment." *Id.*

For-Profit vs. Nonprofit: Financial Operations and Performance

*Arnold T. Stenberg, Jr.**
*David M. Cyganowski***
*Sr. Melanie DiPietro (Moderator)****

Sr. Melanie DiPietro

This session is about finances and what actually happens in meeting the bottom line, from both the for-profit and nonprofit perspectives.

The speakers have worked on both sides of the for-profit and the nonprofit sector. Arnold Stenberg is currently the Executive Vice President and Chief Administrative Officer of All Children's Hospital and Health System, for which he was instrumental in bringing about its membership in the Johns Hopkins Health System. So, he's not only talking to us from both nonprofit and for-profit experience, but with the experience of academic medicine, which is a mission that might be analogized to ministry as a specialty within the nonprofit sector. David Cyganowski, again, has been involved in both the profit and not-for-profit sectors, and he's recognized as a national expert in acquisition of capital and finance and mergers. In fact, he was instrumental in the acquisition of a for-profit system by a nonprofit system. So, I think he can talk from both sides of this interesting question.

Arnold T. Stenberg, Jr.

Let me give you just a little bit of flavor for my background so you can maybe appreciate where I'm coming from on some of the questions being addressed here today. I spent the first 18 years of my career as a practicing CPA where I did some of the traditional finance services, but also spent a great deal of my time involved in health care, mergers, acquisitions, debt offerings, operations im-

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provement, those typical type of health care projects. I left that to join the largest for-profit health care company in the country, which was also a great experience.

During those six or eight years I could say I went through the best of times and the worst of times; think back to the '90s and all that happened in health care during that era. And for the last 12 years I've been involved in a specialty pediatric hospital—secular environment, but very, very mission oriented.

What I'm going to try and do is compare and differentiate key operating characteristics among for-profits and nonprofits, from the perspective of someone who's been there and lived from the details at the facility level all the way up to the corporate office level. In order to do that, I really have to set some baselines because as you all understand there is a huge difference—both within the for-profit world and the nonprofit world—of what a system or a health care delivery system is like. So to do that, I basically said I would consider this in light of a typical multi-facility nonprofit system and also compare it to a typical for-profit structure.

I am assuming that neither the for-profit system that is the potential purchaser of the nonprofit, nor the nonprofit itself, is in financial distress—because that has a huge impact on a lot of the items I'm going to talk about.

Also, I think you all have experience with this—the culture you operate in has a huge impact on how you view the process of carrying out your mission. Management skills are all over the board, so the range of capability of a management team is critically important to accomplishing any changes you may be going through. And then, needless to say, market conditions are different all over the country and could put providers in different situations. What health care reform might mean is a wholly separate topic in itself.

The views expressed here are mine, and come from my particular experience. So, I have a number of key areas that I've boiled this down to that I want to try and help you appreciate from more of an operations perspective in different environments. So these are what I would call the big three, starting with the budgeting and planning areas.

In the for-profit you're looking mostly at a corporate office, in a nonprofit you're looking at a member or a parent board or what reserve powers might exist. So, operationally, the budget is your

friend. The budget is the way you formalize and lay out in front of you those outcomes or results you expect. Periodically enumerating your goals gives you an ability to monitor them, to determine whether you were successful or not. So, really, at the end of the day, regardless of the type of system, my experience is that the budgeting process is fundamentally similar.

I do have to point out though that my experience within the nonprofit world has been that there is a huge variation with respect to board or corporate input on things like budgeting. I have worked with some nonprofit systems that, candidly, drove harder and pushed harder in a centralized controlled way then any for-profit I've ever worked with. So there is a lot of variation in this category.

Capital planning is really a critical element. Many of you have spent time talking about this, as far as the technical structure, but when I get into capital planning this is really what your balance sheet looks like and most often it has to do with investments, bricks, mortar, equipment; and then, likewise, capital is a broad term, it refers to the other side of the balance sheet—the debt side—but I'm going to talk about that separately. Here again, when I looked at this and thought through my experience, although one—the for-profit side—may have more of a centralized or disciplined approach to it, nonetheless, at the end of the day the outcome is the same: to develop the plan you have to invest and to sustain yourself.

I look at strategic planning a little bit different because, basically, at the end of the day health care is local. So, health care delivery depends upon the facility itself, the region you're in, or the local market. In a nonprofit world, you probably have a little more local engagement. On the for-profit side, I think you've seen them become more sophisticated and maybe more disciplined and consistent across networks. There are variations here between sectors, and I think this is a matter of how systems have developed or what pace they'll move along.

There's a lot of differentiation in debt structures between for-profit and nonprofits. I like to think of the for-profit side and the corporate office side as probably only being limited in debt structures by their own creativity in the market conditions. So you'll see all kinds of variations of debt structure; when for-profits need capital, when they need to invest, they can go out, do any number of

instruments, short-term, long-range, different subordinations—and it is generally driven through the corporate office because they exercise the oversight and issue the debt.

The nonprofit side comprises typical tax exempt types of financings, and by definition they tend to be more local—they tend to run through a Financing Authority of some kind or some other body. A lot of the systems have moved to obligated groups, but even there the basic structure of the tax exempt transaction, I think, causes you to work on much more of a local level. So, I think there is quite a bit of variation between the for-profit structure and the nonprofit structure with respect to their accessing debt.

Asset management gets into, in a simple sense, cash, investments, the balance sheet—particularly the asset side of the balance sheet, obviously. And in your traditional nonprofit health care setting, this was the kind of thing the management team and the board became heavily involved in. Increasingly, among many systems, and in the not-for-profit health care sector overall, there has been an effort for a more sophisticated approach to this—where one might sweep cash, centralize investments, do things like that.

In the for-profit environment it's been common for decades to use more aggressive, or sophisticated, asset management techniques among all of a system's facilities. So, I think, fundamentally, there's still a lot of variation in the industry between nonprofit and for-profit on how assets are managed.

And then margin and cash flow. At the end of the day these are what make a difference in sustainability. It's been referenced many times, "no margin no mission," and that holds true regardless of whether you're for-profit or nonprofit. These are key management disciplines, corporate disciplines that allow you to make the decisions you make on a day-to-day and year-to-year basis, so I look at these as being very similar irrespective of sector.

Day-to-day operations is really your front line management team. This is how you deliver what you have planned for, it's how you treat your customer, how you care for the patient, and there's no doubt this is delivered locally, and they're very, very similar throughout the industry.

Compensation, touchy topic. If you look at health care delivery and you look at the thousands of people involved in it, there are two key areas. The first is staff—whether clinical, physician, administrative support staff—and that is heavily locally driven. And

whether you're a for-profit or nonprofit you're still out there competing for the best employees, your compensation ranges, therefore, are probably nearly identical in your local market.

When you get to management I think there are probably a lot of misunderstandings about how the thought process fundamentally works. The one thing we know is that in the nonprofit world, as was mentioned earlier in this Symposium, you have a lot of scrutiny and a lot of guidelines, and a lot of requirements in the process you go through among, particularly, those highly compensated employees on the management side.

Now, in the for-profit world you don't have that, so because of that there's a lot of variation within. I think there's probably a myth that every person at a management level in a hospital or a corporate health system retires wealthy. But, actually, in the vast majority of situations in that local hospital, for example, and up to the regional level, management in either nonprofit or for-profit systems is probably very similarly compensated in the aggregate—just a different way of getting there. So, in the for-profit world, yes, you might have stock options but, candidly, a lot of times the compensation is lower—you put more at risk, if you will.

Also, as you know, there's been a lot of controversy on the nonprofit side about the level of compensation, ranging from the political—with the IRS being pushed by Congress to consider the reasonableness of executive compensation in nonprofits—to the practical, trying to keep talent and trying to keep people highly compensated through deferred structures, different types of supplemental executive plans, and things like that.

Regarding compensation in the for-profit versus nonprofit settings, however, I think fundamentally it's a gap that's got to be narrowed. Nonprofits' understanding and implementation of those different financial arrangements and compensation instrumentalities utilized in the for-profit world, I think, probably still makes for a pretty wide gap.

Another key area I think important for consideration in thinking about the difference between the for-profit and nonprofit sectors is quality measures. The only thing we know for sure is the customer or the patient ultimately is a decider on this. So, these are looked at everywhere from the local facility on up through a corporate structure. And at the end of the day, I think, it's very

difficult to differentiate very much what a for-profit system does and a nonprofit system does in this regard.

And the final key area debated in both sectors comes back to the definition of what is a community benefit, and what does that community expect from a health care provider? It's much broader than: Did I do some free clinics? Or, did I give away some car seats or some training or something like that? A lot of it does get back to charity and the expectation of what the nonprofit is responsible for by having tax exempt status. And then when you get to the for-profit side, you have to ask the question: Does the local mayor, does the city council, does the state—appreciate the fact that I'm paying property taxes, I'm paying local taxes, and then I'm paying federal taxes? And at the end of the day, how do you really differentiate that as far as the true "benefit to the community"? So this does vary a lot, and in this regard nonprofits and for-profits are dramatically different, but I think the substance of the point could be a long discussion.

So, finally, if I step back from this, it was a very interesting exercise that boils down to expectations. What do I expect out of this form of structure? And then I do really believe the gaps are narrow. As I mentioned early on, nonprofits themselves vary dramatically from one system to the next. For-profits, particularly in the last couple of decades, have moved a lot more towards what's important to the customer, what's important to the community, how do I get more creative, and how do I improve quality? So I do think, other than those big, big legal structural questions, the gaps are narrowing.

Now, that said, my experience is if you've seen one you've seen one. What's critical apart from the legal structure is: What's the culture like, what's the market like, what are my expectations, what am I trying to deliver at the end of the day and how do I make those all work?

David M. Cyganowski**

My most important message today does not involve the facts and figures—but to say in an unequivocal way that neither for-profits nor private equity are crying out to Catholic health care as the shark in the water yelling, "Bear! Bear! (Sell! Sell!)." In my 30

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years of working on behalf of not-for-profit organizations and comparing the health care systems in the United States to those around the world, I have come to believe that we are truly blessed with hospitals and health systems that are laser-focused on mission and quality.

You've heard this morning from three prominent for-profit health care leaders—David Vandewater, Keith Pitts and Leo Brideau—who firmly believe that delivering high-quality health care in a safe and affordable manner is key to being successful. Like their not-for-profit peers, they also believe that strong financial performance is necessary to generate the capital needed to reinvest in their companies and improve the quality of health care delivered to their patients. So, from a "mission" perspective, one could argue that the most successful for-profit health care systems are not all that different than their not-for-profit peers. It's their tax status that makes them different. As stated by Sister Irene Kraus, whom I had the good fortune of meeting early in my career, "*No Margin, No Mission,*" is a quote that we in health care will always remember.

A Changing Industry

This is a period of high urgency for the nation's health care providers, but also a period of great opportunity. Health care is rapidly moving from a volume-based business model that has been in place since the enactment of Medicare many decades ago to a new value-based delivery model in order to improve the lives of the patients in the communities served. The transition will not be easy as health care systems adapt to the new model. But, based on economic principles and unsustainable health care costs, we firmly believe that the new model is "going to happen," independent of what occurs in the courts or the incoming Congress or of whom occupies the White House going forward. We also believe that developments stemming from the new model are already occurring in 2012 and will accelerate in 2013. It will not be possible for any hospital executive or board member to ignore or avoid the related changes and challenges. But, it is possible for health care leaders to understand the changing environment and to manage those changes to their best ability, positioning their organizations for a better future.

Health care leaders are wrestling with the new value proposition—providing the best possible quality and access at the lowest

possible price—which is so different than the "more-market share, more-patients, more-services, more-revenue" proposition that has driven the Medicare model for 40-plus years. Management in some organizations is aggressively embracing value-based care delivery, believing it is the right thing to do and working hard to move their organizations forward. In other organizations, executives seem slow to accept the change, hoping that the old model will endure.

But given rapidly escalating federal and state fiscal problems and the cost pressures the old model places on the business community and patients, the business case for the old model is insupportable. Succeeding in this new environment will require a "Point of View." The notion of a Point of View is an important corporate management principle, which Jeff Immelt, CEO of General Electric, articulated. He said, "Any executive who wants to change things should be guided by a point of view about what's going on in the world, and [then] invest around that point of view."[1]

So now, with the stage set, let's take look at Kaufman Hall's Point of View. We believe that:

1. Health system revenues will be under severe pressure and payment mechanisms will migrate toward value-based approaches;
2. Inpatient and outpatient use rates will decline;
3. A new set of core competencies will be required for health system success;
4. Health systems will learn how to solve a manufacturing problem;
5. Health systems will consolidate at an accelerated pace—horizontally and vertically; and
6. The competitive landscape will be reshaped.

I can't help but remember what Wayne Gretzky would say: "I don't skate to where the puck is; I skate to where it's going to be." I believe that for Catholic health care, that represents the opportunity for transformative partnerships with the for-profit sector.

Change is just around the corner. We operate, live and do business in an industry that is extraordinarily fragmented. A comparison of concentration in health care to concentration in the top 5 or 10 other industries, such as semi-conductor supplies, retail pharmacy and airlines, shows how fragmented health care is relative to

[1] Steve Lohr, *GE Goes With What It Knows: Making Stuff*, N.Y. TIMES, Dec. 4, 2010, at BU1, *available at* http://www.nytimes.com/2010/12/05/business/05ge.html.

the rest of corporate America. The biggest 10 companies in semiconductor supplies, retail pharmacy, and airlines control 65 percent, 68.2 percent and 83.6 percent of market share in their industries respectively, while the 10 biggest health systems control only 21.7 percent of market share. And to put it into more concrete terms, we'd have to combine four really big for-profit hospital management companies—HCA, Community Health Systems, Tenet, and Universal—to match the combined size and market share achieved by what is considered a "baby" merger in the airline industry—Southwest Airlines and AirTran, which barely made it into the news. In the Catholic arena, it would take the combination of eight of the largest Catholic health systems to match the size of the combined Southwest/AirTran entity.

The take away is that, due to similar pressures experienced across many industries, health care is on the verge of significant consolidation. Whether in markets in Massachusetts, Connecticut, Illinois or the West, we've reached the "tipping point" where health care systems are coming together very quickly with a blurring of roles among "traditional" market players. This represents an opportunity for us to think outside the box and design partnerships that really are going to ultimately improve the quality of care that we're delivering at a cost affordable to our communities and nation.

What's Occurring Nationwide?

So, what are we seeing and hearing? At Kaufman Hall, we're witnessing an unprecedented level of partnership discussions between and among every conceivable type of provider. When regional systems with $4 to $6 billion of top-line annual operating revenue sit down at the table, the first thing out of their leaders' mouths is, "We want to become a 'super-regional'; to be an organization with $10 to $15 billion in three to four years." We're seeing strong, independent hospitals that are not financially distressed conducting disciplined, strategic options analyses and asking the questions, "Is our mission best served by continuing the *status quo*, or is pursuing a different option a better strategy for the future? Are we better off being alone and independent or should we be part of something bigger?"

There is a lot of activity in the for-profit sector. Private equity money is flowing into the industry as well, and new market entrants

and new types of mergers of non-traditional industry participants are developing. Health insurers are acquiring hospitals again! Didn't they already do that in years past and fail?

And then, probably most exciting, we're seeing new care models put in place nationwide, such as CareMore in California, which offers coordinated, aggressive care focused on senior citizens who have chronic diseases, and companies like QuadMed. QuadMed is owned by a multi-billion-dollar graphics company in Milwaukee. Ten years ago, its CEO said, "I'm tired of paying insurance companies 10 percent increases every year. We should go out and try to provide workplace primary care and wellness-anchored health services ourselves." And today, QuadMed has more than 10 clinics with employed primary care doctors, and they've brought down their health care costs by more than $2,500 per employee.[2]

HEALTH CARE ENTITY TYPES AND BENEFITS

What is the current ownership and control status of the nation's 5,000 community hospitals? Approximately 58 percent are not-for-profit, 22 percent are governmental, and 20 percent are for-profit.

What are the advantages of being a not-for-profit hospital or system? No taxes—at least most of the time, although there is a growing constituency of local and state leaders that are disguising payment reductions as hidden taxes. Not-for-profits can also borrow money at a lower rate. Many not-for-profits have strong reputations and identities in their communities. I've never met a health care chief executive officer that believes anything other than "health care is local." Some not-for-profits have tremendous philanthropy opportunities and results. Would that continue if their tax status changed?

What are some of the advantages of for-profit systems?[3] Advantages include capital access, with broader, deeper, and more in-

[2] Douglas McCarthy & Sarah Klein, *QuadMed: Transforming Employer-Sponsored Health Care Through Workplace Primary Care and Wellness Programs*, THE COMMONWEALTH FUND, July 2010, *at* http://www.commonwealthfund.org/Publications/Case-Studies/2010/Jul/QuadMed.aspx.

[3] Data cited in this section comes from the Citi Growth Study and public sources. Much of the Citi Growth Study pertinent to this discussion may be found in a presentation by Citi's Healthcare Financial Management Association, Adapting to a New Reality . . . Positioning for Success (Jan. 19, 2012), slides *at* http://www.hfmahudson valleyny.org/files/IRWIN_1.19.12.pdf (last viewed Dec. 20, 2012).

vestment classes, nimble decision-making ability, efficiency and scale. For-profits really out-distance not-for-profits in two areas: compensation costs and operating revenue growth. Large for-profits have achieved compensation expense ratios in the 39 to 42 percent region for the past 10 years, while the comparable ratio range for not-for-profits is 47 to 51 percent. Annual operating revenue growth of for-profits is above 10 percent; not-for-profits achieve annual growth of about 7 percent. For-profits have scale: 90 percent of for-profits have a top line of more than $5 billion; only 5 percent of not-for-profits exceed the $5 billion mark. What does that mean? The economies of scale and efficiencies gained through size by for-profits enable greater operating margins. From 2001 to 2010, operating margins of not-for-profits with $1 to 5 billion of top line revenue were about 1 percent; for those with $5 billion of top line revenue, they were about 3 to 4 percent. In contrast, for-profits achieved operating margins ranging from about 8 to about 13 percent during the same period.

Kaufman Hall has conducted an extensive study of the "case for scale in health care," focusing just on not-for-profits, and showing the same results—profitability correlates with scale. The bigger you are, the greater the economies of scale you will realize. The more money you make on an operating basis, the more total margin you make. And more often than not, "bigger is better." When big organizations go through bad times, like during recent years, they have had greater flexibility with capital expenditures. Although capital-spending ratios trended downward during the recent Great Recession, health systems with scale consistently spent a higher proportion of depreciation than their smaller counterparts and significantly more dollars on an absolute basis, year-over-year. Such spending provides a competitive advantage.

Concerning capital access, it is increasingly difficult for not-for-profit organizations to borrow money—although they can borrow at lower rates than the for-profits. The not-for-profit arena consists of the "haves" and "have-nots." If you are a strong system with a strong credit rating, you're going to have access to capital; but if you're not as strong, you're going to have less capital access at higher costs. For-profits have broader, deeper access, more investor classes, more private equity, and more public equity. Bottom line: for-profits have more capital available to them today than not-for-profits.

Moving Forward

So the questions are: How can we create transformative partnerships? How can we bridge the gap? We think the "elephant in the room" is the value proposition. A not-for-profit should very carefully analyze the core competencies that it needs to develop in order to evolve from its current status and meet the requirements of the post-reform health care system. What is your system's value proposition and might that value proposition overlap with for-profit players? "Between-the-bookend" partnership options and models are growing every day. The unicorn that we're all seeking actually has some relevance. And, 10 years from now, a model like an accountable care organization is going to look a lot different than it does to most efficient health care systems today.

One additional—but critically important—take away: *If you wait too long, it can be too late*. Consider Hawaii Medical Center, which looked at options until it went bankrupt. You have to be proactive, you have to be dynamic.

And so, ladies and gentlemen, my message today from Kaufman Hall is this: As you look at opportunities for transformative partnerships, bridging the gaps and combining Catholic systems with secular systems and with for-profit systems, choose your partner carefully. Return to and don't waver from the value proposition that you have identified as critical to being a phenomenal organization for patients in your communities going forward.

Rating Agency Metrics for For-Profit and Nonprofit Health Care Corporations

*Adam Kates**
*James LeBuhn***
*Megan Neuburger****

Adam Kates: When Sister Melanie called me, she asked us to highlight the differences with which the financial markets view not-for-profit hospitals and for-profit hospitals. She also described to us the diverse list of attendees who were anticipated to be here, and asked us to keep this discussion at a high level, without going into too much of our potentially foreign finance language, so that we could keep our discussion in terms that everybody here could easily understand.

That being said, from a high level, our process is a committee process. Everything we do at a rating agency is committee based; every rating that you see is a result not of just one or two analysts. It's the result of an entire committee and its view on a particular credit. Ultimately, at the end of the day, what we look at is a little bit different than what an equity analyst looks at. At the end of the day, all we're interested in is a credit's ability to service principal and interest. What the rating ultimately represents is the probability of default on payment of principal and interest.

In that sense, it's not a beauty contest. We have our criteria that we use. Every hospital and health care system does not have to be exceptional in each and every single criterion. Every criterion is a factor, but at the end of the day our focus is on whether a credit can confidently pay its principal and interest and the risks present that may limit its ability to do so. That's an important point with which to frame the rest of the conversation, especially when we're viewing the differences between for-profit and not-for-profit hospitals.

From a high-level overview, the nonprofit hospitals in our portfolio are typically rated higher than the for-profit health care systems. There's more diversity within our portfolio of nonprofit

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hospitals than on the for-profit side. For-profits are typically larger national systems, whereas there is a great degree of variability of size and market presence amongst the nonprofits.

The nonprofit hospitals tend to have a less risky financial profile than the for-profit systems. The presence of equity investors within the for-profits means that for-profit systems often have to structure their balance sheets a little bit more aggressively, and that's reflected in the average credit ratings.

One of the fundamental questions that we were asked to address here is whether the missions of not-for-profit and for-profit hospitals and health systems are fundamentally different. From a clinical perspective, the high-level answer to that question is no. However, differences between the for-profits and not-for-profits exist and are highlighted within our credit analysis.

James LeBuhn: As Adam said, "are the missions different?" No. But the motivations of both at the board and management level can be very different between the for-profits and not-for-profits. The motivations and incentives of any entity can be different depending on who the constituencies are. Clearly if you're a for-profit organization, your primary constituency is the shareholder who is primarily interested in maximizing shareholder value. In delivering health care, once you get into the clinical space, I don't think there's any difference between the not-for-profits and the for-profits.

However, operational differences exist in regards to answering to those constituencies, whether it's shareholders on the for-profit side or one of the many constituencies on the not-for-profit side—including the community, the bondholders, the board of directors and the employees. It's very important to look at those different motivations and how the resulting incentives can affect operations.

A. Kates: We're now going to touch upon a few areas at a very high level, starting with our rating spectrum. For those of you who are unfamiliar with our rating spectrum, we work on a scale of AAA down to B and below. BB and below is below investment grade.

There are some AAA credits in the corporate world, but there are no AAAs in the health care world, whether for-profit or not-for-profit. Across all three rating agencies there are a handful of AA+ rated nonprofit hospitals and health care systems. Fitch has only one AA+ rated health care system within its portfolio. The median

rating within Fitch's nonprofit health care portfolio is A- while the median rating within Fitch's for-profit health care portfolio is B+.

J. LeBuhn: Within our portfolios, we rate a lot more not-for-profit hospitals than for-profits, because generally it's a much more fragmented market. Further, the median revenue of the not-for-profit hospitals is significantly smaller than that of for-profits.

Fitch rates 322 hospitals, of which 248 credits are included in our median report. Of the credits in the AA category, the median revenue is equal to approximately $1.7 billion. The median revenue among the A rated hospitals is approximately $480 million. Among the credits in the BBB category, the median revenue is approximately $321 million. Clearly scale is important from a rating standpoint.

Megan Neuburger: Among our for-profit ratings, we have public ratings on six of the large publicly traded hospital companies. There are only seven publicly traded for-profit hospital companies. The median rating on the for-profits is B+ as opposed to A- on the not-for-profits. What that implies, if you look back at the rating scale that Adam spoke of, is that the for-profit hospitals are a full four notches below the average rating among the not-for-profit hospitals.

Looking back at that rating scale, the rating agencies make a big distinction between investment grade versus non-investment grade credits. Within the for-profit world, all of the ratings are solidly non-investment grade, which we refer to as being high yield. As a result, we would define the for-profit hospital space as being a "high yield sector."

Within the hospital universe you have a very fragmented universe of providers. But when you look at the 20 percent of the market that is for-profit, what you see is it's actually quite concentrated amongst the largest players and amongst the publicly traded companies. That distinction will be more important when we discuss rating drivers and business risk.

A. Kates: One of the important factors within the nonprofit hospital portfolio is that there are some very large institutions here, including multi-billion dollar, AA credits. However, there is a large diversity in entities that we rate. We rate everything from national health care systems with multiple hospitals down to single site com-

munity hospitals. There's a high degree of variability within our credits both for size, revenue, operating profitability, and sophistication of management. One of the things that makes our sub-sector very unique is the diversity within the portfolio.

J. LeBuhn: Looking at the trends of affirmations, upgrades, and downgrades can give an idea of a sector's stability. Looking at the trends within Fitch's nonprofit health care portfolio, rating actions have been very stable. Between 2005 and 2011, there was a total of almost 1,200 rating actions. Of those rating actions, approximately 80 percent were affirmations, while approximately 10 percent were downgrades and approximately 11 percent were upgrades. Overall, from a credit perspective, the industry has been relatively stable despite confronting many economic, regulatory and operating challenges.

In terms of rating criteria, what do we look at? We're going to discuss the criteria that both the nonprofit and for-profit health care analysts look at, as well as areas where the analyses differ.

Our ratings reflect the likelihood of timely payment of principal and interest. What goes into that? There are a lot of different factors, including both qualitative and quantitative factors. On the quantitative side, profitability is clearly the engine that makes everything go and enables an entity to fund both operations and capital investments through cash flow. Leverage represents how much debt an entity has while liquidity represents how much cash and investments an entity has accumulated. Liquidity levels are probably one of the biggest differences between the for-profit and nonprofit credit profiles.

From a legal standpoint all of the retained earnings at a nonprofit must be reinvested in nonprofit purposes and this typically means that the retained earnings remain within the corporation on the balance sheet. So guess what happens? Many nonprofit hospitals have built up strong cash positions. From a ratings standpoint, having a lot of money in the bank is a strong credit positive.

Differences also exist in the use of debt and leverage levels. There are differing motivations between the nonprofits and for-profit hospitals regarding the use of debt.

The qualitative metrics analyzed are similar between the nonprofit and for-profit hospital sectors. Utilization statistics are important in the rating process, including inpatient and outpatient

volume trends, payor mix and case mix index. Additionally, service area characteristics, market share and competitive dynamics are important, as are physician alignment initiatives. Capital needs are also another important factor as projected capital spending will impact an organization's liquidity and leverage levels as well as its competitive position in the market.

Strength of the management team is an additional qualitative factor and is one of the areas that is the hardest to judge and the hardest to articulate. However, we typically look to an organization's past successes with large capital or strategic projects and management's ability to confront difficult operating challenges.

Operating earnings before interest, taxes, depreciation and amortization (EBITDA) has become an increasing area of emphasis on the nonprofit side. With the large cash balances built up, investment earnings were historically used to supplement or enhance operations at the nonprofits. However, with the decline in the capital markets in 2008 and 2009, both investment income and operations compressed. As a result, Fitch increased its focus on operating items that are within management's control. Therefore, Fitch increased its focus on operating EBITDA.

Significant liquidity metrics used in evaluating nonprofit hospitals include days cash on hand, cash to debt, and cushion ratio. The amount of unrestricted cash and investments an entity has relative to debt is extremely relevant in the credit process and a high cash to debt ratio is, in our opinion, indicative of a very high likelihood of timely payment of principal and interest.

Debt service coverage ratio represents how many times you can pay off your maximum principle and interest payment through cash flow. An analogy can be made to a mortgage payment: after you pay all your expenses what do you have left over in terms of revenues available to pay your debt service and how many times do you cover that?

M. Neuburger: I'd like to back up for one second and put a little bit of context around some of my comments on the for-profit rating criteria. As Adam mentioned at the outset, a bond rating is really nothing more than our opinion of an issuer's willingness and ability to pay debt principal and interest on time. From the perspective of an investor, whether we're rating a for-profit entity or a not-for-profit entity, that rating should be telling the investor ex-

actly the same information. So there's really no difference to the investor looking at a credit rating for either of those two entities. And because the ratings are on an ordinal scale with higher generally being better, the rating should be roughly comparable. So, when we get into this conversation of the specific qualitative and quantitative measures that we're considering on the for-profit versus not-for-profit side, the short answer is that the process is not dissimilar; we're not looking at dissimilar types of metrics.

At the end of the day, the question is then, why are the ratings so wildly different when we're looking at the for-profits versus the not-for-profits? The way I think about it is that there are two main components to determining the credit rating: one component is business risk and the other component is financial risk. What we generally see when we're looking at the not-for-profits versus the for-profits is that, speaking in generalities while recognizing that there's always going to be exceptions to these rules, there are lower business risks at the for-profit entities offset by higher financial risks. Business risk is a broad category with all sorts of quantitative and qualitative measures that can affect anything before you get to your fixed charges of capital and taxes. These primarily include all the drivers of the top line, the drivers of operating income and EBITDA.

In general, the size and scale of the for-profit systems confer certain benefits that aren't always present with the not-for-profit hospitals. For-profit operations typically have a larger scale. HCA, for example, has approximately 160 hospitals and approximately 40,000 licensed beds. Additionally, they're in 20 states nationally, so the operations have scale and geographic diversity. Therefore, there is a bigger base over which to spread fixed costs and to achieve efficiencies of scale, so they tend to be more profitable when you look at EBITDA margin. Additional benefits from scale and diversity of service areas include decreased exposure to Medicaid cuts in any one service area. Another benefit that accrues to for-profit hospital systems is the ability to pick and choose the markets in which they operate more so than a not-for-profit does. They typically target markets that are fast growing, with strong demographics, and low labor costs. These factors typically create a lower degree of operating risk.

The second broad component is financial risk. All else being equal, typically we see higher financial risk in the for-profit world

than on the not-for-profit side. The rating is a balance of these two things. If an entity has increased business risk but lower financial risk, those two things can, to a certain extent, offset each other in the credit profile.

In general, financial risk refers to all of the company's decisions about how it's going to finance its growth. At its most basic component, this gets down to whether a company is going to finance growth with debt or equity and what mix is it going to use and what kind of capital structure is it going to target? Generally, the higher the debt in the capital structure, a company is going to have more financial leverage and more financial risk. This means they have a greater fixed-cost burden, because debt comes with fixed costs. Typically, all else being equal, for-profit entities tend to carry higher debt loads than the not-for-profit entities do, so they have higher financial leverage and greater financial risk.

It's important to note—not to over-simplify the conversation—that there's equity as a component of a capital structure no matter what type of entity it is. The difference comes down to who holds that equity. Is it a private investor, is it public shareholders versus a governmental or not-for-profit, does that accrue to the taxpayers or to the constituents of that not-for-profit entity? So, what it comes down to, when we talk about financial risk, there are really different motivations amongst that group of equity holders, be it a for-profit entity versus a not-for-profit entity.

Investors in the equity of a for-profit entity are interested in getting the best return that they can on their investment. That's their goal in holding the equity of the organization. They want to see market value grow as much as possible, all else being equal. Management of for-profit companies realize this and they try to positively influence market value by increasing the book value of the company and they do that through growth in net income.

This drive to grow net income leads to a couple of things, most importantly, to the credit rating. We have found that it generally leads to higher debt at the for-profit entities versus the not-for-profit entities because companies can use debt as leverage to increase the return on their investment, all else being equal.

What we've seen over the past decade in the for-profit hospital industry is really a focus on driving growth through acquisitions. In general, there's a lot of conversation at publicly held companies around dividends and share purchases. There hasn't been a big

use of capital in the for-profit space. We've seen a little bit more in recent years, but the big focus for cash deployment has been hospital acquisitions. The reason for that is that an investor can get a better return by a company using cash to buy a hospital than that investor receiving a dividend payout and having to go out and reinvest that dividend.

The second reason we typically see higher debt and financial risk in the for-profit world versus the not-for-profit sectors is the high historic prevalence of private equity's involvement in the hospital sector. Leverage buyouts have been very prevalent in the space over the past decade and they've added a lot of debt to balance sheets. Private equity likes the hospital sector for a couple of reasons: the first is that it's historically been an economically defensive industry; the second is that it's very cash generative. When you're looking to do a leveraged buyout, you need an entity that can support the debt that you need to put on the organization to realize a good return on your investment. Historically, the hospitals have been able to support a lot of debt because they generate positive cash flow; lots of leverage in the transaction means a better return on your capital.

J. LeBuhn: From my standpoint, and there may be some differences of opinion here, I think that for a long time there was a belief that not-for-profit management skills weren't commensurate with what you saw on the for-profit side, but I disagree with that. I think that differences in operational performance reflect the differing motivations of the constituent base. The retained earnings at the nonprofits allow those organizations, in my opinion, not to be so focused on generating higher profit margins as might be needed on the for-profit side.

What we're seeing now is the hospital sector confronting what we all believe is going to be a much tighter reimbursement environment. In the aftermath of 2009, including the financial meltdown and the recession, we've generally seen increased operating performance in the not-for-profit sector. Management teams were challenged with maintaining their profitability and making tough decisions that perhaps they hadn't had to do before in order to maintain their margins so that they could continue to achieve their missions.

Additionally, one other factor from a rating standpoint is that

in the not-for-profit space the capital structures generally are much longer, with 30-year debt amortizations, whereas in the corporate world it's typically five to ten year debt with bullet maturities, including the use of operating lines of credit to refinance the debt.

In the not-for-profit space, with those strong balance sheets and the investor base—which is typically mutual funds that generally like the 30-year deals—we see level debt service over a much longer period of time. We don't see the spikes in debt service present in the for-profits where, as a borrower, you have to look to replace revolving lines of credit and are therefore dependent upon access to the capital markets in order to roll over or extend out some of those shorter debt maturities. That is another fundamental difference between the for-profit and not-for-profit space.

A. Kates: As we've seen, there are some significant differences that become apparent in our analyses. These differences are primarily driven by operational differences, need for growth, diversity of markets versus sole markets, ability to pick and choose markets, and also the debt structures.

Another distinguishing factor of for-profit health care from not-for-profit health care is the presence of equity. As Megan pointed out, some form of equity is always present. In the not-for-profit health care sector, unrestricted net assets are typically regarded as the equivalent of shareholder equity. However, there's not the presence of public equity and stockholders. We feel that this does make a difference, as public companies have the presence and the pressure of equity analysts. The equity analysts are primarily concerned with whether or not a stock price is going to go up or down or stay the same. Based upon these expectations, the equity analyst concludes with recommendations to buy, sell or hold a particular stock. This places an additional pressure on for-profit management.

A lot of the equity-related metrics, whether it's Enterprise Value, price to earnings (PE), PE Growth, are based upon the stock price and ultimately the ability to increase the total value of the company. This increased focus on growth is absent in the not-for-profit world. Although it doesn't affect our work directly, it is a difference that is present in the for-profit and not-for-profit worlds.

M. Neuburger: In talking about public equity and the presence of equity, all else being equal, for a not-for-profit entity, generally,

they view their credit rating as the higher the better because it implies a lower cost of capital—which is true on both the not-for-profit and the for-profit side. But with the for-profit side, because you do have this component of managing public equity and managing returns to equity holders, there are other competing motivations aside from the cost of debt capital. So, while a higher rating does confer lower costs of capital in terms of debt, it also implies certain restrictions on how you're going to manage your balance sheet.

So, for a for-profit entity, it's not always the case that a higher rating is better. The way the for-profit hospital industry is structured right now, in general, there's just not the financial incentive for these companies to manage their balance sheets conservatively enough to have an investment grade rating because it would cost them too much in terms of what they would have to give up in terms of their flexibility to finance their capital structure.

J. LeBuhn: Let me make one final comment.

You're beginning to see two things. You're beginning to see a blurring of the lines between the not-for-profit and for-profit sectors. We've seen joint ventures and I think you're going to see that take place more often. There's also going to be a greater blurring of the lines between traditional roles within the health care sector in general. You've seen that already between hospitals and physicians as physicians are increasingly seeking to become employees of hospitals. Additionally, Highmark and West Penn Allegheny is potentially a watershed event. Are we going to see more of those types of transactions? I don't know, but that is something that we are keeping our eye on. The point being that the differences among the various sectors of the health care industry may become a bit more fuzzy.

Health Care: Public Good or Private Good?

*John V. Jacobi**

I will talk about mission from a civic perspective. That is, I will discuss how the concept of mission has been important to the groups that I have worked with throughout my career in public service and public interest. And I want to talk about the importance of mission to decision makers in state government in their analysis of conversions from for-profit to nonprofit; about how decision makers regard the value of the nonprofit form and the mission of nonprofit providers.

These arguments are arguments that you've heard: you heard in earlier panels why conversion is necessary to attract management talent, and the need to raise equity capital. The pushback has always been related to mission. That is, there's a perception that nonprofit organizations are what we could loosely refer to in this context as a public good, not in the economic sense, but in the broader public policy sense. There's also a perception that community control will provide benefit to the people served. So here's what I mean by mission, which is different than what you heard at this Symposium in a religious context, but that I think reflects what is generally regarded as "mission" when people from a non-religious perspective talk about it. These values are values that all of the nonprofit, as well as the for-profit, health care institutions that were discussed thus far at this Symposium embrace. It does not include some of the core ministry principles that are important to religious nonprofits. And it includes keeping the funds in the community, that is, not allowing the funding to be siphoned off and sent out to investors, rather, plowing it back into services.

The question for people in advocacy, government, and institutions is: Is this preference for nonprofit forms an artifact? Is it something that no longer has a basis in economic reality, in public policy reality, or is there continuing vitality to the concept of adhering to a preference for nonprofit forms?

These are three reasons that are advanced for favoring the nonprofit form. And when I say favoring the nonprofit form, I

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mean preferences for nonprofit forms by people like commissioners of health when they're considering where the money goes, where the franchise for a hospital goes, and so on. So health is a public good; there is broad agreement that health is not an ordinary consumer good, but that it is a public good for many reasons, some of them having to do with the broad public benefit of keeping people healthy, and some having to do with a sense of fellow feeling or a sense of empathy for people that would lead us to believe that providing health is something that's different in kind than ordinary consumer goods.

The second one is more of an economist's perspective. That is, unverifiability. This is the traditional justification for the nonprofit form that was advanced most prominently by Henry Hansmann, a professor at Yale Law School.[1] And the idea here is that the business of some nonprofits, and particularly so-called commercial nonprofits, compete with for-profit firms and firms with other kinds of organizations, including governmental organizations. But nonprofit forms are important because the delivery of health care is infinitely complex and, therefore, difficult to monitor and regulate. And if it is difficult to monitor and regulate, it is important for there to be indicia of trustworthiness in lieu of hard evidence of the delivery of value to consumers. The sense of many decision makers is that the nonprofit form is more trustworthy because attention is focused more directly or more exclusively on care and not on a profit motive or return of investment to shareholders.

So the first argument favoring the nonprofit form is the public good argument, the second is this unverifiability argument, and the third has to do with altruism. The third argument is that many people go into the business of providing health care as an altruistic calling, and it is important given the gaps and the complexity of health finance and health care delivery that people who approach the delivery of health care from an altruistic perspective be supported or rewarded. That is, if people are willing to commit their time and talent for (presumably) below-market compensation, regulators should welcome their offer and favor their corporate form. There should, therefore, be a preference for altruistic providers, who may gravitate to the nonprofit form.

So, where does this preference for nonprofits manifest? One

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[1] *See* Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 Yale L.J. 835 (1980).

well-known place is tax exemption. I won't spend time on that, except to say it is takes the form of income, property, and sales tax exemptions. The second one is health planning, including Certificate of Need and Licensure. As time has gone by, the emphasis has moved from health planning and Certificate of Need to Licensure as a screen for who gets to be able to provide health care services. That is, government still screens market entrants, but less for centralized planning purposes and more for consumer protection purposes. And agency decision makers have tended to prefer, historically, nonprofits for the reasons that I stated. This has manifested itself in unwritten, and sometimes written, preferences for the nonprofit form when, for example, there are competing Certificates of Need, or in licensure decisions, changes of ownership, and changes of management, and so on. There sometimes is subtle (or not so subtle pressure) to prefer the nonprofit form.

The third domain where preference for the nonprofit form may appear is reimbursement and finance. Most "essential community providers" are either nonprofits or government agencies. Preference for essential community providers has been expressed, for example, in Medicaid regulations and contracts, where managed care organizations in many states are required to include them in their networks. This preference is a recognition that essential community providers are doing the work that the market place will not replace if they go away and that, therefore, public reimbursement should favor them to encourage them to stay in business. The Affordable Care Act[2] also has essential community provider provisions, and in some situations will require that qualified health plans include essential community providers. So, this preference for nonprofit forms is expressed in preferential rules and policies in health financing.

There's a pushback of course. In recent years, there has been resistance to, and questioning of, what used to be more or less an article of faith. This preference can be captured as a perception that nonprofit providers are willing to do work focusing on the patients and not extracting profit, so we should continue to prefer that form. But the pushback is that such preferences might be inef-

[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 42 U.S.C.).

ficient. If we prefer nonprofits, we might spend more than necessary to get the care we need. To the extent that case is made, decision makers pay attention. And as times have gotten harder, the decision makers have increasingly said, all things being equal, I would prefer nonprofits, but if a for-profit can come in and make a business case that it can do it cheaper, that's worth considering.

The second pushback to the preference for nonprofits has come from a questioning of the unverifiability thesis. As we have developed evidence-based medicine, as quality metrics have become more sophisticated, as health information technology has allowed remote monitoring of the delivery of health care, it is less true than it was that the delivery of sophisticated, high-quality health care is unverifiable. If it becomes verifiable, trust is less important. As Ronald Reagan used to say, "trust, but verify."

Finally, the Affordable Care Act[3] promises nearly universal coverage. If nearly everyone is covered, does mission still matter? But *is* everybody going to be covered? That might be the goal, but even as it's drawn up, the Affordable Care Act will still leave approximately 25 million people more or less uninsured.[4] And these are the most vulnerable people. They are undocumented persons.[5] They are people who are disconnected from society. Those continuing to be uninsured will include people who will be formally eligible for health care coverage, either Medicaid or some other form of coverage, but simply won't take it up because they are so disenfranchised, so dislocated from society that they can't maintain membership in a Medicaid program.[6] They'll be the most vulnerable, and the least attractive from a business perspective. So the ACA's promise of expanded coverage won't solve all of the access problems.

Similarly, evidence-based medicine is great, and quality metrics are great. It remains true, however, that the human body is infinitely variable and that health care is extremely complicated.

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[3] *Id.*

[4] *See* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION (June 2012), *available at* http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[5] *See* ALISON SISKIN, CONG. RESEARCH SERV., TREATMENT OF NONCITIZENS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (March 2011), *available at* http://www.ciab.com/workarea/downloadasset.aspx?id=2189.

[6] *See generally* LEIYU SHI & GREGORY D. STEVENS, VULNERABLE POPULATIONS IN THE UNITED STATES (2d ed. 2010).

And that while we should continue to improve evidence-based medicine and use quality metrics where they're available, we all know that they are not the complete answer. We still rely on the art of medicine and the good will of health care providers to fill in the gaps.

So what is the connection? What's left? What's left of the importance of nonprofits from this civic mission perspective that I am describing? There are a couple of reasons to think that the nonprofit form is still important. And when I talk to people who are involved in these issues, these continuing issues of trust and community involvement are the kinds of things that they raise. I think that there is power in these assertions. I am not saying that the people who presented at this Symposium from a for-profit perspective do not embrace community and mission in the for-profit form; I believe them when they say that they really are committed to providing sound care. I think that they are people of good will and they try to use their organizations for good and in advancing the mission of their Catholic identity and their sense of civic mission.

But the question is, at the margins, does nonprofit form nevertheless matter? And here are the arguments. The importance of community. Now I think that there are reasons to believe that health care delivery should be well connected with the community in large part because health care should be responsive to community needs and wishes. And that's not controversial. But the questions is, are nonprofits better at that? And I think that there is an assertion, which I don't have much to say about, that the nonprofits are better at it. I think that many nonprofits are good at it, and I do think that there are some for-profits who also do a good job of responding to their communities. The question is does the form incline an organization to be more community centric?

The second issue is this capital lock issue. And this is an argument that I as well as others have advanced in the past. I think it is falsifiable, but I continue to think that it's something worth thinking about. And that is that debt financing has sort of a paradoxical virtue in making the capital of the organization somewhat less liquid and, therefore, sort of nailing the feet to the floor of organizations and inclining them just to stay in their community.

The third thing is the following. Again, this is argument about effects at the margins, and I am not saying that nonprofit is good, for-profit is bad here. There are difficult financial and operational

decisions in the future for health care entities, particularly hospitals. When decision makers at a hospital are faced with the argument that they should expand their pediatric out-patient clinic because there is a dearth of pediatric service in the community and the pediatric clinic is overstressed with demand, should the management of the hospital agree even if the pediatric clinic is a money loser? Again, I take the for-profit presenters at their word, I believe them when they say that they are very interested in what the community needs, but at the margins, the fact that there has to be a return on the investment for a for-profit hospital will affect that decision, and incline the hospital to look more skeptically at the arguments for expanding a public use non-remunerative service in the community. I think it depends on the organization, but from a structural perspective, there is a difference, and the corporate form matters.

I felt yesterday, when listening to the for-profit presenters describing their deep commitment to mission, that their presentations were strongest on issues of their treatment of employees, their adherence to high quality care, and their adherence to religious perspective; all of which is extremely important, but doesn't get to the point that I was making: when tough decisions about maintaining or initiating a marginally remunerative service, nonprofit and for-profit hospital managers may well approach the decision differently.

A couple of concluding thoughts. I think it is uncontroversial that the need for capital is only going to be more important as time goes on. As organizations are thinking of health information technology, forming ACOs, supporting patient-centered medical homes, that takes money. You cannot do a lot of that stuff without capital, so capital is going to be very important. And I guess that the question is whether my assertion is correct. People have argued, bankruptcy lawyers in particular, that bond covenants can be just as restraining on management decisions as are the demands of equity shareholders. If that's true, then the distinction between corporate forms, to the extent it relies on the "capital lock" argument of the distinction between debt financing and equity financing, is less powerful. I think it depends on the situation. I'm skeptical that that's always true, but I do think it's an important thing to think about, and I don't want to be closed-minded about that issue.

So is there a need for nonprofits in the future? Now the strong version of the conclusion that flows from my point that access to capital will be increasingly important in the future is that only for-profits will be able to command the amount of capital necessary for improvements in health care and, therefore, we all have to do everything we can to make sure that the mission follows. The weak version is that it is easier to get access to capital in the for-profit form, in which case there's a difficult balancing that has to be made, hence, this conference. But my assertion is that incentives matter, if only at the margins, and that we should not assume that just because good people are advancing for-profit forms, the formality of the corporate form is unimportant.

Ministry and Catholic Identity: Are They the Same?

*Sr. Doris Gottemoeller**

Are Ministry and Catholic Identity the Same? On the face of it, the answer is "no." One is an activity, the other is an assertion about the fundamental character of an organization, its DNA, from which springs, presumably, numerous activities. So let me re-cast the question slightly: "Is for-profit health care compatible with our Catholic identity?" By implication, can for-profit health care be a ministry of the Church?

Let us begin with "Catholic identity." When is something entitled to be called Catholic in any official sense? I would suggest that there are three requirements. First, the entity must assert and claim its identity as Catholic by some sort of public declaration. It can't be a secret. By way of counter-example, a major West Coast health system has just asserted that it is no longer Catholic. Dignity Health announced it is a "not-for-profit organization, rooted in the Catholic tradition, but is not an official ministry of the Catholic Church."[1]

Second, this declaration of Catholic identity has to be validated by Church authority, usually the bishop of the place in which the would-be Catholic entity functions, but sometimes by a dicastery in Rome. There is no formal procedure for this. Typically, a religious congregation founds an organizational ministry with the implicit, if not explicit, consent of the presiding bishop and has it listed in the Catholic Directory of that bishop's diocese. The diocese, in turn, adds it to its listing in the *Official Catholic Directory*[2] for the United States. Most of these designations occurred generations—even a century or more—ago. A bishop's confidence in al-

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1 Press Release, Dignity Health, New Name and Governance Structure Preserve Identity and Integrity of Catholic and non-Catholic Hospitals, Position Organization for Growth (Jan. 23, 2012), *available at* http://www.businesswire.com/news/home/20120123005666/en/CORRECTING-REPLACING-Catholic-Healthcare-West-Dignity-Health (last viewed Dec. 21, 2012).

2 P.J. Kennedy & Sons, The Official Catholic Directory (National Register Publishing, 2012).

lowing such an organization to be designated as Catholic usually rested on the fact that it was founded by and remains under the direction of a religious congregation that is presumed to be pursuing the work of the Church. The opposite can happen of course—a bishop can declare that an entity is no longer Catholic, as happened in 2010 when Bishop Olmsted of Phoenix stripped St. Joseph's Hospital of its Catholic identity after concluding that it did not adhere to the *Ethical and Religious Directives for Catholic Health Care Facilities*, which position he reaffirmed in 2012 even after the hospital affiliated with a Catholic university.[3]

Now we come to the third requirement for a Catholic organization. Unlike the first two, it is multifaceted and requires discerning judgment. But, I would argue, it is at the heart of identity. It is the requirement that the organization embody in its culture and performance behavior compatible with Catholic Church teachings. What are those teachings? For the sake of simplicity (and at the risk of caricature), I have created a Top Ten list[4] for health care services:

1. The organization's *mission statement* affirms its Catholic identity and declares its intent to provide essential human services expressive of Gospel teachings.
2. It has a *special concern for the poor and disadvantaged,* as evidenced by its proactive efforts to meet their needs and by its expenditures for community benefit.
3. It promotes *wages and benefits and working conditions* that honor the dignity of each employee, including participation in workplace decisions, as well as the right to be represented by a union.
4. It commits to *excellence in spiritual care*, including for persons of diverse faiths and traditions.
5. *It provides prenatal, obstetrical, and postnatal services* for mothers and their children in a manner consonant with the mission.

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[3] Ken Alltucker, *Phoenix Bishop Olmsted Reaffirms St. Joseph's Hospital Decision*, THE REPUBLIC, Jul. 23, 2012, *available at* http://www.azcentral.com/business/articles/2012/07/23/20120723phoenix-bishop-olmstead-reaffirms-st-joseph-hospital-decision.html.

[4] Comparable examples of such a list include the Catholic Health Association's *A Shared Statement of Identity for the Catholic Health Ministry* and the statements of some Catholic systems, e.g., Catholic Health Partners' *Thirteen Foundational Standards* or the Sisters of Charity of St. Augustine Health System's *Statement of Faith Obligations.*

6. *It provides end of life care,* including palliative and hospice services, with reverence for the dignity of the individual and care for the family.
7. It sponsors *formation programs* for trustees, senior leaders, employees, and physicians that build understanding of and commitment to the mission.
8. A well-developed *ethics function* guides decision-making in the clinical and organizational spheres.
9. The organization uses its public voice to *advocate for policies* that promote the common good: a more compassionate and just society.
10. *It limits involvement in cooperative arrangements* with organizations whose mission is incompatible to remote mediate material cooperation.

In addition to these "Catholic" requirements, of course, are those that pertain to health care itself: superior quality, honest and transparent business arrangements, and compliance with the innumerable federal and state regulations that govern the provision of health care. All of the qualifications on the Top Ten list are tangible and admit of observation and measurement. They also are aspirational, in the sense that improvement is always a possibility. This is where the element of discerning judgment comes in. No Catholic organization has maximized the opportunity embedded in each of these Top Ten, but we all want to be known for our efforts and challenged to do more. The consistent effort to excel in each of them creates a culture that is distinctive.

You will recognize in the Top Ten list references to the *Ethical and Religious Directives for Catholic Health Services*.[5] Also foundational to the List are the Catholic Social Teachings, a body of teachings beginning in the late 19th century, working its way to the present, and largely articulated in papal encyclicals and episcopal letters. These teachings contain practical implications of the Gospel for our age. Here we find the working in modernity of such concepts as human dignity, sacredness of life, the common good, a preferential option for the poor, and respect for the rights of workers. A fuller explication of Catholic identity would require a deeper dive into these core teachings. However, for our purposes here, it is

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[5] U.S. CATHOLIC CONFERENCE OF BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 36, § 6.68 (5th Ed. 2009), *available at* http://www.usccb.org/about/doctrine/ethical-and-religious-directives/.

enough to affirm that identity is more than a superficial veneer, easily altered. It pertains to the DNA of an organization, its *raison d'etre* and its characteristic activities, both internal and external. Note that not-for-profit did not appear on the Top Ten list. However, it has long been understood that this structure best facilitated accomplishment of these essential requirements.

We can sum up this first part, then, by saying that the three requirements for Catholic identity that I have described—assertion, validation and integration—represent a progression from "thin" to "thick" Catholic identity. I want to assume that the latter is really what we are looking for. We sometimes hear the pejorative phrase "Catholic lite" used to describe some collaborative arrangements involving nominally Catholic entities. I would assert that a genuine Catholic identity is not something contractually negotiated; it permeates the culture of an organization.

Let us turn now to the second key word in the question before us: "ministry." We commonly speak of health care as a ministry of the Church. What does that mean? Until a few decades ago, ministry was a word associated by Catholics with the work of Protestant clergy: We had priests, they had ministers. Today it means the public work of a Catholic organization in fulfillment of its mission or the work of an individual specifically commissioned by the Church. For our purposes, it is the first meaning that applies. It is the public service rendered by an organization that bears a Catholic identity, e.g., a school, university, hospital, residence for the elderly, etc. It is an official Catholic work, not just the work of Catholics. It is not necessarily everything the Catholic organization does, but that which enacts its mission.

The Catholic Church has long been known for its institutional ministries in the United States—the largest not-for-profit health care sector, the largest social service agency (Catholic Charities), and the largest private-sector education system. As Bryan Hehir wrote more than fifteen years ago:

> The Catholic Church is institutional by instinct and by nature. . . . Size never proved anything, but there is something to presence. If one seeks to influence, shape, direct, heal, elevate, and enrich a complex industrial democracy, it cannot be done simply by the integrity of individual witness. It is done by institutions that lay hands on life at the critical points where life can be injured or fostered, where people are born and die, where they learn and teach, where they are cured and healed, and where

they are assisted when in trouble.[6]

Bringing the testimony closer to home, the *Constitutions* of my religious congregation, the Sisters of Mercy, states in #5, "We sponsor institutions to address our enduring concerns and to witness to Christ's mission."[7] Generations come and go. Gifted leaders pass from the scene and others take their place. But the work goes on, largely because the institution provides a continuity of witness and service. The institution or health system is held accountable to its Mission by its sponsors, historically a religious congregation or a diocese, more recently a group of co-sponsors or a public juridic person (notably, the Symposium presentations of the new for-profit models by Ardent and Vanguard made no mention of sponsors).

For centuries these institutional ministries have been organized on a not-for-profit basis. In fact, the not-for-profit model has prevailed across the United States in practically all faith-based and community hospitals. Now we are seeing some of them translated into for-profit models. Is there a theological principle at stake? Or is there some doctrinal proviso that needs to be observed? Let me respond by asserting that there is no authoritative doctrinal teaching on the matter. It is a matter of practical and historical experience that the not-for-profit model has been especially amenable to the nature and purpose of institutional ministries. It has facilitated clarity of purpose and accountability to the Church. Could a for-profit model accommodate the same ends?

There is an oft-cited speech by the late Cardinal Joseph Bernardin to the Harvard Business School Club in which he makes the case for not-for-profit health care:

> Healthcare—like education, and social services—is special. It is fundamentally different from most other goods because it is essential to human dignity and the character of our communities. It is, to repeat, one of those "goods which by their nature are not and cannot be mere commodities." Given this special status, the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient, and a healthier community, *not* to earn a profit or a return on capital for shareholders. This understanding has long been a central ethical

6 J. Bryan Hehir, *Identity and Institutions*, 76–8 HEALTH PROGRESS, Nov.–Dec., 1995, at 17, 18.

7 Sisters of Mercy of the Americas, *Constitutions* (Silver Spring, MD, 1992).

tenet of medicine. The International Code of the World Health Organization, for example, states that doctors must practice their profession "uninfluenced by motives of profit."[8]

However, one of the qualities that mark the Church as a living community is its ability to change in response to the signs of the times. There are numerous examples of practices once deemed incompatible with fidelity to the Gospel, such as borrowing money at interest, that have become acceptable. And other practices long tolerated, such as slavery, have been condemned. Bringing the matter closer to hand, Pope Benedict XVI wrote in *Caritas in Veritate,* his third papal encyclical, in 2009:

> When we consider the issues involved in *the relationship between business and ethics*, as well as the evolution currently taking place in methods of production, it would appear that the traditionally valid distinction between profit-based companies and non-profit organizations can no longer do full justice to reality, or offer practical direction for the future. In recent decades a broad intermediate area has emerged between the two types of enterprise.[9]

What the Pope envisions is

> . . . a broad new composite reality embracing the private and public spheres, one which does not exclude profit, but instead considers it a means for achieving human and social ends. Whether such companies distribute dividends or not, whether their juridical structures correspond to one or another of the established forms, becomes secondary in relation to their willingness to view profit as a means of achieving the goal of a more humane market and society.[10]

Pope Benedict's predecessor, Pope John Paul II, gave some helpful distinctions about the role of the market in regulating access to public goods such as health care. He noted that the market protects freedom and promotes innovation. At the same time, it is subject to moral limits. First, for those without resources, the best functioning market is of no help; they cannot enter the market.

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[8] Joseph Cardinal Bernardin, Archdiocese of Chicago, Making the Case for Not-for-Profit Healthcare, Address at the Harvard Business School Club of Chicago, Chicago, Ill. (Jan. 12, 1995) *available at* http://www.gpo.gov/fdsys/pkg/CREC-1995-03-06/html/CREC-1995-03-06-pt1-PgS3543-2.htm.

[9] Pope Benedict XVI, *Caritas in Veritate* 46 (June 29, 2009), *available at* http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate_en.html.

[10] *Id.*

Second, the market does not distinguish the intrinsic value of different goods. This latter point is directly relevant to health care. A pure supply-and-demand calculus is inadequate in assessing health care policy. Health care is a necessary good, essential for human well-being. Hence, it cannot be treated as other goods that may be desirable but are not essential for human well-being.[11] It is true that both for-profit and not-for-profit institutions vigorously compete for market share; can we say that each is equally motivated by a desire to improve the health of the community, with emphasis on the poor and underserved? I would suggest that a comparison of their community benefit expenditures, location and service lines might give the answer.

Toward a Solution

Given that there is no authoritative teaching prohibiting for-profit health care, and an implicit openness to change in such matters, I think the answer to our question about the compatibility of for-profit health care with Catholic identity comes down to a prudential judgment in specific instances. Lest we think that this conclusion constitutes a cowardly evasion, prudence sets a high standard. It is "the virtue that disposes practical reason to discern the true good in every circumstance and to choose the right means of achieving it."[12] Going back to my earlier list of ten essential characteristics of Catholic health care institutions, the questions become: Can they be maintained as Catholic and optimized as for-profit while discharging the required legal and fiduciary duties to investors? What is the true good in this circumstance and what may be considered the right means?

In making that prudential judgment—which may vary from one example to another and which may require uncommon wisdom and courage—I would suggest two considerations that ought to guide the discernment: the integrity of the ministry itself and provisions for its continuity. Both call for attention to the possible unintended consequences of any choice.

By integrity I mean a consistent and good faith effort to main-

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11 Pope John Paul II, *Centesimus Annus* (May 1, 1991), summarized by J. Bryan Hehir, *The Ministry's Future in a Turbulent World*, 91–5 Health Progress, Sept.–Oct. 2010 at 72, 74.

12 Catechism of the Catholic Church, Article 7, No. 1806 (Doubleday, 2d ed. 1995).

tain and optimize the ten requirements listed above. Note that they begin with a public statement that asserts the Catholic identity and declares an intention to act in ways compatible with that identity. It goes without saying that there are tensions among the various requirements. For example, the commitment to a preferential option for the poor requires outreach programs to meet their needs and a generous commitment to charity care. At the same time we want to provide wages and benefits that contribute to the dignity of workers and their families and reinvest in the ministry in order to provide excellent care. It is not always an easy balancing act, but neither imperative can be sacrificed. Recall Pope Benedict's words envisioning that profit, rightly used, be a means of achieving a more humane market and society.

Furthermore, operating in a secular milieu, where we assume responsibility for the health of a community, many or most of whose members are not Catholic, automatically subjects us to pressures to act in ways contrary to our Mission. Integrity also requires guarding against cooperation in practices inimical to Catholic identity and teachings. As the *Ethical and Religious Directives* acknowledge, the provision of health care in most communities today involves new partnerships with other institutional providers as well as with payers and physicians: "Any partnership that will affect the mission or religious and ethical identity of Catholic health care services must respect church teaching and discipline."[13] Parsing the precise distinctions among the various modes of cooperation could occupy us for hours, but in practice, the final arbiter of whether a proposed cooperative agreement is acceptable is the local bishop, who will take into consideration the possibility of action contrary to Catholic teaching and identity. Can we expect shareholders to be respectful of these distinctions? These challenges to our integrity are not, strictly speaking, a consequence of a for-profit structure, but they comprise the world in which we operate.

An unintended consequence of a transition to for-profit status may be to jeopardize the tax-exempt status of facilities that remain not-for-profit. For-profit Catholic hospitals will be taxed. This might prompt public officials to suggest that, since we are "all alike," all Catholic hospitals should be taxed. To give an example of the implication: the system for which I work, Catholic Health

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[13] U.S. CATHOLIC CONFERENCE OF BISHOPS, *supra* note 5, at 68.

Partners, spent $365 million in 2010 for community benefit, as defined by the Internal Revenue Service. It is hard to imagine that we would be able to maintain that level of charity care and outreach if we lost our tax-exempt status.

Turning to the second consideration, continuity of the ministry requires that the commitments made at its inception endure over time. Will covenants entered at the time of transition to for-profit status endure if the entity is sold to another owner? According to materials made available by Ascension Health Care Network, Ascension Health Alliance has sole authority over all elements of Catholic Identity in perpetuity (subject to the rights of the local Ordinary). Moreover, Ascension Health Alliance has set in place provisions to ensure that, for any acquired Catholic hospital, its operations, programs, policies, characteristics and services remain in conformity with that identity. However, if there isn't a legally enforceable way to do this in some of the new models, transition to Catholic for-profits will just be an interim step along the way to eventual loss of Catholic Identity.

One of the factors in ensuring continuity of mission is the strength of formation programs for trustees, senior executives, and employees throughout the organization. From my experience, the continual development in understanding and appropriating the mission and values and the principles of Catholic social teaching and ethical standards can be incorporated into the workplace in a way that respects the religious diversity of the workforce and contributes to a distinctive culture. A related issue is whether or not any of the trustees or executives are members of the Catholic Church. One way historically that communication has been maintained with the Church is through the sponsors and the senior executives. If there are no sponsors in that historical sense and if few or none of the senior executives and/or trustees are Catholic, there can be a credibility problem. It is my impression that few, if any, of the new models have addressed this issue.

I mentioned above the need to be alert to unintended consequences in whatever path we choose. Will the new option of sale to a for-profit investor cause some Catholic hospitals to hold on to the point of near failure, without making some necessary but hard choices, such as seeking a Catholic system with which to align, or perhaps closing and converting the resources to other community needs? Other consequences to be avoided are the diminishment of

the Church's witness in the public square through the gradual erosion of our institutional presence, a loss of distinctive identity that entitles us to speak on behalf of the poor, the vulnerable and the disenfranchised.

To return to the question with which we began, is for-profit health care compatible with our Catholic identity? Can it be a ministry of the Catholic Church? I would suggest that the jury is still out. The judgments involved with regard to "true good" and "right means"—the goal of prudence—will take time and experience to discern. Simultaneous with the movement to for-profit models is the development of "hybridized models"—Catholic systems with significant non-Catholic divisions. How much of this can we do without diluting the Catholic identity beyond recognition? Maintaining the integrity of the Mission and preserving it through time will take dedicated leaders who see the vision and who have the requisite talent to enact it. It also will take collaboration among Catholic lay leaders and the bishops, because the prudential judgments involved will not reside solely with the hierarchy. Venues for these trusting and mutually respectful conversations are not very common at the present time.

In closing, let me cite again some words of the late Cardinal Bernardin, this time from a pastoral letter entitled *A Sign of Hope*. It was written after he had been diagnosed and treated for pancreatic cancer, when his views on institutional health care were more than theoretical. He wrote:

> Although illness brings chaos and undermines hope in life, we seek to comfort those who are ill, whether or not they can be physically cured. We do so by being a sign of hope so that others might live and die in hope. In this we find the Christian vocation that makes our healthcare truly distinctive. It is the reason we are present to believers and nonbelievers alike. This is the heart of Christian healthcare: caring for people in such a way that they have hope.[14]

One cause for hope is that we are asking the right questions. May our work here these days strengthen that shared purpose.

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[14] Joseph Cardinal Bernardin, *A Sign of Hope* (Oct. 18, 1995), *in* SELECTED WORKS OF JOSEPH CARDINAL BERNARDIN: HOMILIES AND TEACHING DOCUMENTS 81 (Alphonse P. Sully, ed., 2000).

Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry? Canonical Commentary: Tools for Exploring the Question

*Sr. Sharon Holland**

This presentation seeks to identify analytical tools helpful to decision-makers faced with the questions attendant to conversion of a Catholic health care ministry to the for-profit corporate form. I start by examining briefly the nature of canon law[1] and then reviewing a specific evolution in the interaction of civil law and canon law in Catholic health care structures. These matters, together with some reflection on the learnings gleaned from this evolution, could prove to be "tools" for further exploration.

Introducing the Code of Canon Law

The Church, in continuing the mission of Christ in the contemporary world, always functions in two legal jurisdictions: church and state; canon law and civil law. Canon 22 expresses a basic relationship:

> Civil laws to which the law of the Church yields are to be observed in canon law with the same effects, insofar as they are not contrary to divine law and unless canon law provides otherwise.[2]

At the same time, the legal norms of the Church must always be in harmony with its teaching or doctrine, as set forth in the documents of the Second Vatican Council.[3] Consequently, in considering today's question, it is fundamental that Catholic health

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1 All references to canons herein are to the 1983 Code of Canon Law (Codex Iuris Canonici (1983)); *see* Code of Canon Law, Latin-English Edition: New English Translation (Canon Law Society of America, 1998), *available at* http://www.vatican.va/archive/ENG1104/_INDEX.HTM.

2 1983 Code of Canon Law, c. 22 (83 CIC c.22).

3 Pope John Paul II, apostolic constitution, *Sacrae disciplinae leges* (January 25, 1983) *in* Code of Canon Law, Latin-English Edition: New English Translation xxx (Canon Law Society of America 1998), *available at* http://www.vatican.va/holy_father/john_paul_ii/apost_constitutions/documents/hf_jp-ii_apc_25011983_sacrae-disciplinae-leges_en.html.

care be committed to continuing the healing mission of Jesus, in accordance with the Church's social doctrine and ethical norms on the dignity of human life. From this it results that economic resources are to be at the service of that mission and that juridical structures for the administration of goods must allow for continuing the mission of healing as a ministry of the Church, in accordance with doctrine.

Various canons illustrate an interface with civil law. Canon 1254 asserts that the Church's right to possess temporal goods is precisely for the sake of its mission in worship, works of the apostolate and charity—especially toward the needy—and the support of ministers.[4] It is useful to remember that the Code of Canon Law is applicable throughout the world. The statement from Canon 1254, that the Church "by innate right is able to acquire, retain, administer, and alienate temporal goods independently from civil power" is intended to vindicate the Church's right to own temporal goods before governments that do not recognize that right.

The handling of temporal goods, in the service of mission, often is spoken of in terms of the biblical good steward, householder or administrator. Canon 1284 refers to many practical points in this regard, including certain references to civil law.[5]

Among the duties of the administrator under the auspices of canon law is the observance of justice in the workplace. Canon 1286, 1° states that administrators "in the employment of workers are to observe meticulously also the civil laws concerning labor and

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[4] 1983 CODE, c.1254 (83 CIC c.1254):

> § 1 To pursue its proper purposes, the Catholic Church by innate right is able to acquire, retain, administer, and alienate temporal goods independently from civil power.
>
> § 2 The proper purposes are principally: to order divine worship, to care for the decent support of the clergy and other ministers, and to exercise works of the sacred apostolate and of charity, especially toward the needy.

[5] 1983 CODE c.1284 (83 CIC c.1284):

> § 1 All administrators are bound to fulfil their function with the diligence of a good householder.
>
> § 2 Consequently they must:
>
> 2° take care that the ownership of ecclesiastical goods is protected by civilly valid methods;
>
> 3° observe the prescripts of both canon and civil law or those imposed by a founder, a donor, or legitimate authority, and especially be on guard so that no damage comes to the Church from the nonobservance of civil laws;

social policy, according to the principles handed on by the Church."[6]

Finally, canon law contains a broad recognition of civil law on contracts. Canon 1290 states:

> The general and particular provisions which the civil law in a territory has established for contracts and their disposition are to be observed with the same effects in canon law insofar as the matters are subject to the power of governance of the Church unless the provisions are contrary to divine law or canon law provides otherwise. . . .[7]

In moving toward how this reflection on canon law touches the structures under consideration, I have found useful a statement by Robert T. Kennedy, well known canonist and civil lawyer, in his *Note on the Canonical Status of Church-related Institutions in the United States*.[8] It is a "defining characteristic of being Catholic," writes Kennedy, that an entity is at least subject in some degree "to the governance of ecclesiastical authority."[9] As we shall see, some ecclesial entities, such as public juridic persons, have this characteristic by definition in canon law;[10] others have it by concession of authority.[11]

FOUR DECADES OF EVOLUTION IN THE CANON LAW-CIVIL LAW RELATIONSHIP IN CATHOLIC HEALTH CARE

From our present vantage point in history, we can observe a certain evolution in the relationship between civil and canonical

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6 1983 CODE c.1286 (83 CIC c.1286).

7 1983 CODE c.1290 (83 CIC c.1290).

8 Robert T. Kennedy, *Note on the Canonical Status of Church-Related Institutions in the United States, in* NEW COMMENTARY ON THE CODE OF CANON LAW (J.P. Beal et al. eds., 2000).

9 *Id.* at 172.

10 1983 CODE c.116 (83 CIC c.116):

> § 1 Public juridic persons are aggregates of persons (*universitates personarum*) or of things (*universitates rerum*) which are constituted by competent ecclesiastical authority so that, within the purposes set out for them, they fulfil in the name of the Church, according to the norm of the prescripts of the law, the proper function entrusted to them in view of the public good.

11 1983 CODE c.216 (83 CIC c.216):

> Since they participate in the mission of the Church, all the Christian faithful have the right to promote or sustain apostolic action even by their own undertaking, according to their own state and condition. Nevertheless, no undertaking is to claim the name *Catholic* without the consent of competent ecclesiastical authority.

structures in the Catholic health care ministry over the past four decades. It must be acknowledged that in the life of the Church, forty years is not a long time, but we also are aware that we live in a time of rapid change.

Prior to the 1970s, there was, normally, what we might call a *unified civil and canonical structure*. The ministries of a religious institute (or diocese) were considered part of the institute's (diocese's) same public juridic person—what might be termed its ecclesial corporate person (c. 116 § 1). Likewise, the ministry functioned in civil law through the institute's same nonprofit corporation. As ministries of the religious institute, they were, by definition, works done "in the name of the Church."[12] The superior and council governing the religious institute also were the Trustees of the civil corporation, and the properties dedicated to the ministry were, by definition, ecclesiastical goods, at the service of the Church.[13]

Following the 1970s, there was a transition to a *separate civil corporation* for the ministry, retaining the same canonical structure. The ministries remained part of the canonical public juridic person of the religious institute but were formed into a separate, nonprofit civil corporation. The motivations for this change came from the availability of Medicare and Medicaid funding. The segregation of funds for accountability and a distancing of spheres of liability were essential. However, a debate ensued over whether the religious institute had actually alienated (i.e., relinquished all rights of ownership over) the properties of the ministry in a way that severed their link to the religious institute's ecclesial identity (working "in the name of the Church") and their identity as ecclesiastical goods serving ministry.

The dilemma regarding canonical rights of ownership was resolved by establishing for the religious institute certain "reserve powers" in the civil documents (Articles of Incorporation and Bylaws) of the ministry. These reserve powers enabled the religious

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12 1983 CODE c. 675 (83 CIC c.675):

> § 3 Apostolic action [of a religious institute], to be exercised in the name and by the mandate of the Church, is to be carried out in the communion of the Church.

13 1983 CODE c. 1257 (83 CIC c.1257):

> § 1 All temporal goods which belong to the universal Church, the Apostolic See, or other public juridic persons in the Church are ecclesiastical goods and are governed by the following canons and their own statutes.

institute's leadership to maintain control over the Catholic identity of the ministry and the alienation or endangering of its properties, and, often, to appoint the Board of Trustees.[14]

The above ordering, and various expressions of it, remains in practice for many Catholic health care systems today. However, a further step of evolution has been taking place, this time in a revision of the canonical piece of the equation. In the 1990s came the first move to a *distinct canonical structure* in relation to the existing civil corporation.[15] This involved the replacement of the religious institute as the ecclesial corporate person, with a new ministerial public juridic person (or PJP). The civil, nonprofit corporation remained essentially the same, with minor adjustments in the bylaws.

The point of contact with ecclesial governance was now the governing body of the PJP, usually referred to as the "Members." These persons hold essentially the same reserve powers as did the leadership of the religious institute in the previous structure. The ministry continues, as the work of an ecclesial public juridic person, to be carried out "in the name of the Church," and the properties remain ecclesiastical goods at the disposition of the ministry.

In this Symposium, we have begun to explore the potential of other structures, including the possible replacement of a canonical structure with a contract or agreement. A civil law corporation, possibly for-profit, would remain, but perhaps without a parallel canonical juridic person, with rights over ministry and temporal goods embedded in the civil corporate documents. This kind of exploration has only begun, but it can be useful to glean something of what has been learned through these decades of evolution.

Learnings from the Recent Evolution of Canonical and Civil Structures Governing Catholic Health Care Ministries

In working with Catholic health care systems during this evolution, perhaps the lesson of greatest import that emerges is the ur-

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[14] For greater detail on this evolution, see Sr. Sharon Holland, IHM, *Vatican Expert Unpacks Canonical PJP Process*, 92-5 Health Progress at 50, 52–53 (Sept.–Oct. 2011).

[15] For an account of the twelve-year history of this first petition, see Patricia A. Cahill, *Public Juridic Person—the Charter for the Vision*, *in* Catholic Health Initiatives: A Spirit of Innovation, A Legacy of Care, 77–78 (Patricia A. Cahill & Marianna Coyle, eds., 2006).

gent necessity of quality *Formative Programs.* The Members governing public juridic persons and the Trustees of corporate boards, whether religious or lay, together with other corporate leaders in Catholic health care, need regular ongoing opportunities for updating and shared reflection. In the contemporary atmosphere of complex health care delivery, topics regularly include: Catholic identity; ministry "in the name of the Church"; the nature and role of the public juridic person; the nature and role of the civil corporation; skills in developing positive relationships with bishops in their role of oversight and with the Holy See; doctrinal and ethical developments; and the import of civil law and public policy changes.

Closely related to these are the programs and personnel for *Mission effectiveness* or *Mission integration.* Constant efforts are needed to assure that a sense of ministry permeates the whole fabric of institutions and the system as a whole. The mission statement must be given concrete application by all personnel, in every department and set of relationships.

Mutual relationships within the Church must be fostered and respective concerns understood. Diocesan Bishops have a broad role of oversight of apostolates carried out within their jurisdiction.[16] The concept of the ministerial public juridic person is quite new to Bishops as well as to most of us, and it often implies a shift from religious to lay leadership in the ministry. This, too, sometimes raises concerns for Bishops.

The United States Conference of Catholic Bishops (USCCB) is under considerable pressure in view of the Patient Protection and Affordable Care Act. They are intent on protecting the right of the Church to carry on health care as a ministry, in harmony with Catholic Church teaching and under the governance of ecclesial entities (diocese, religious institute, ministerial public juridic person). While institutions are located in particular dioceses, systems cut across the nation and so right relationships with the USCCB are to be cultivated as well.

Finally, the Apostolic See[17] is frequently involved owing to the

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[16] For example, 1983 CODE c. 394 § 1 (83 CIC c.394, § 1) states: "A bishop is to foster various forms of the apostolate in the diocese and is to take care that in the entire diocese or in its particular districts, all the works of the apostolate are coordinated under his direction, with due regard for the proper character of each."

[17] Canon 361 provides a definition: "In this Code, the term Apostolic See or Holy See refers not only to the Roman Pontiff but also to the Secretariat of State, the Coun-

pontifical status of many religious institutes and their new ministerial public juridic persons. The Apostolic See was quite thorough in its study of the proposed new model in order to ensure the works would remain Catholic and the goods would be administered as ecclesiastical goods in service of the ministry. One of its concerns regarding increased lay leadership was not a question of professional expertise or fidelity to the Church, but rather a concern that experience gained in the business world might easily allow the "bottom line" to become margin rather than ministry.

Considering all that is at stake, it is of critical importance to cultivate right relationships of ecclesial communion through regular communication and open dialogue.

Concerns of a Canonist in Considering the Question of For-Profit Structures for Catholic Health Care

As a canonist considering the topic of this symposium, a number of questions have arisen. Speakers have addressed many of them, but we have only begun to identify the issues, much less resolve them.

A logical first question might be: *What appear to be the most evident effects of sale to a for-profit institution?* At first sight, the canonically established governing role of an ecclesial entity (religious institute, diocese or ministerial PJP) appears to be terminated. Therefore, by definition, the ministry would no longer be carried out "in the name of the Church" and the goods would no longer be "ecclesiastical goods." Secondly, public perception identifies for-profit corporations with attention to profit-making more than with ministry. In this election year we are conscious of large corporate campaign contributions and significant corporate lobbying power. Would for-profit health care lobbying in Washington focus on the same issues as those advocated by the social doctrine of the Church?

This prompts a further question: *Could some relationship with ecclesial governance be maintained along with the authorization to be called Catholic?*

- Might some models include a PJP that exercises certain re-

cil for the Public Affairs of the Church, and other institutes of the Roman Curia, unless it is otherwise apparent from the nature of the matter or the context of the words." 1983 Code c. 361 (83 CIC c.361). For a discussion of the specific competency regarding these PJP petitions, see Holland, *supra* note 14 at 54–55.

serve powers to protect Catholic identity in the event of for-profit acquisitions?

- Could agreements be elaborated that guarantee the essentials of Catholic identity in acquisitions by for-profit organizations?

Without consideration of nonprofit or for-profit status, early sales to other than Catholic systems were simply considered by the Holy See as alienations placing the works beyond Church governance. When a petition for alienation was presented that included an agreement to observe the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs)[18] for three years, this was seen by officials as good will, but beyond ecclesial vigilance.

- Would a statement of commitment to observe the ERDs be clearly understood as a commitment to its full content, including Catholic identity, Catholic social teachings such as workplace justice, care of the poor and vulnerable, and community needs assessment, and not simply as the exclusion of proscribed procedures?
- Would those involved be educated/formed to understand and fulfill the responsibilities undertaken by the Agreement? Would funds be available for this?
- Who would be the parties to the Agreement?
- Who would be responsible for a review of the effective observance of the Agreement?
- What would be the effect of failure to fulfill the Agreement? Who would be authorized to act?
- Are such agreements with for-profits necessarily understood to be of limited duration?

As the exploration of the Symposium topic continues, more questions and more responses will be presented. In the process, a faithful continuation of the healing mission of Jesus must remain the focus.

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[18] U.S. CATHOLIC CONFERENCE OF BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), *available at* http://www.usccb.org/about/doctrine/ethical-and-religious-directives/.

Is the For-Profit Structure a Viable Alternative for Catholic Health Care Ministry? A Practitioner's Response to the Canonical Commentary: How it Works in Current Legal Structures

*Sr. Melanie DiPietro**

Introduction

Some for-profit (public and privately owned) health care corporations have been given a Catholic identity by a local bishop because of an underlying contractual agreement.[1] The observations in this paper focus on the legal effect and canonical consequences of changes that may occur in the relationship of a Catholic hospital to both its related responsible canonical public juridic person[2] and to the Church itself in the transition from a public charitable health care corporation[3] to a for-profit health care corporation.[4] These comments, which seek to identify the relational differences arising from a change in corporate form, are based on the Mem-

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1 *See* Lisa Wangsness, *For-profit Saint Vincent Hospital May Offer Peek at Caritas Future*, Bos. Globe, Apr. 28, 2010 *available at* http://www.boston.com/news/health/articles/2010/04/28/for_profit_saint_vincent_hospital_may_offer_peek_at_caritas_future/ (describing Saint Vincent Hospital of Worcester, Mass. as a for-profit Catholic hospital); *see also* P.J. Kennedy & Sons, The Official Catholic Directory 1521 (National Register Publishing, 2011) (listing Saint Vincent Hospital, Worcester, Mass. as part of the Diocese of Worcester).

2 A public juridic person is a canonical entity similar to the corporation in American law. It is a separate entity from the person or things that make it up. Most commonly in health care, the public juridic person is the religious institute such as the Sisters of Charity or the Sisters of St. Francis or Daughters of Charity. More recently, new public juridic persons have been erected to succeed to the canonical responsibility of a religious institute for the health care apostolate. In this paper, public juridic person refers to either a religious institute or a newly created public juridic person. *See* Code of Canon Law, Latin-English Edition: New English Translation c.116 (83 CIC c.116) (Canon Law Society of America, 1998) *available at* http://www.vatican.va/archive/ENG1104/_INDEX.HTM. All references to canons herein are to the 1983 Code (Codex Iuris Canonici (1983)).
Id.

3 A public charitable corporation is a corporation described in the Internal Revenue Code, Section 501(c)(3).

4 The various models of a for-profit structure that were the topic of the Symposium are included in these Proceedings.

bership model of governance[5] that is the dominant governance structure in Catholic health care corporations. The Members are usually the canonical authority[6] (hereafter Canonical Leadership) of the related responsible canonical public juridic person.

The focus of the observations in this paper is the legal governing authority of the Canonical Leadership of the responsible canonical public juridic person in its related health care corporation, comparing the possible distinctions that arise in the non-profit versus for-profit corporate form. The observations offered in this paper stress the legal difference between *governing* authority in a corporation and personal or political influence of persons in the corporation. The analysis of this legal difference to the Church requires clarity of language and some important analytical distinctions.[7]

A Framework for Observations: Distinctions with a Difference

The authentic interpretation of canon law belongs to the legislator.[8] In contrast, canonical praxis refers to the way in which particular canonical principles have been applied—in practice—to specific facts and circumstances by trained canonists. This paper arises from the author's own canonical and legal practice representing Catholic healthcare corporations and, as such, contributes only the author's practical experience and legal and canonical considerations to the discussion.

The first distinction important to the following observations is the use of the phrase "related responsible canonical public juridic

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5 Described in some detail in these Proceedings by Sr. Sharon Holland, *Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry? Canonical Commentary: Tools for Exploring the Question.*

6 In canon law, competent authority refers to the person who has either legislative, executive or judicial authority as granted by the Code of Canon Law. In a diocese, the Bishop is competent authority. In a religious institute, the major superior is competent authority.

7 While these distinctions were assumed in my presentation at the Symposium, the use of sponsorship language during the discussions in both presentation and questions suggests to this writer that an explicit discussion on a disciplined use of terms may be helpful.

8 1983 Code of Canon Law, c.16 (83 CIC c.16):

§ 1 The legislator authentically interprets laws as does the one to whom the same legislator has entrusted the power of authentically interpreting.

§2 An authentic interpretation put forth in the form of law has the same force as the law itself and must be promulgated. . . .

person" instead of "sponsorship." The point is to stress the canonical significance of the responsibility of a public juridic person for its entrusted apostolate. "Sponsorship" is a term that has been widely used in the context of the governance of Catholic health care organizations that are currently the responsibility of a public juridic person because the corporation is the instrumental means by which the apostolate of health care of the public juridic person is currently carried on in the not-for-profit sector. However, the term has evolved in various contexts and multiple models of "sponsorship" have been offered. Some of these models may not, in my judgment, provide civil law protection for appropriate governing authority of the Canonical Leadership of the related responsible canonical public juridic person in the governance of the health care corporation.

Therefore, "sponsorship" is not used in this discussion focusing on the relationship of technical canonical principles to civil law corporate structures. Instead, I employ the phrase "canonically responsible public juridic person" because the precise focus of this paper is the use of "civilly valid methods"[9] to provide legal protection for the implementation of canonical principles relevant to the responsibilities of Canonical Leadership for its apostolate. Stability is an important canonical principle in the status of a public juridic person and its apostolate. While all persons engaged in an apostolate must act in communion with the Church, ultimate responsibility and accountability for the apostolate of a public juridic person is vested in identified religious superiors. The use of the term "sponsor," however, is elusive, as it is subject to the different usages of context and explicit admissions that the term has no canonical or legal meaning. Greater precision, therefore, is obtained by referring to "the responsible public juridic person" which is a term defined in canon law. The responsibility of Canonical Leadership for its apostolate is also grounded in canon law. As such, in the context of civil corporate form discussions, parameters for canonical praxis are more objective and this objectivity is more helpful when trying to determine the effectiveness of civil law methods to protect selected canonical principles.

In canon law, an apostolate (or ministry), such as health care, is entrusted to a public juridic person; as noted above, the Canoni-

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[9] 1983 CODE at c.1284, §§ 1–3 (83 CIC c.1284 §§ 1–3).

cal Leadership of the public juridic person is responsible for its apostolate.[10] The Membership model in a charitable corporation positions the individual persons who comprise the Canonical Leadership of the responsible public juridic person in governing authority in the healthcare corporation. The scope of the powers reserved to the Members in the corporate Articles of Incorporation and Bylaws seek to enable them to exercise their canonical responsibilities for the apostolate. The decision about the breadth of these reserved powers is the result of the legal analysis of local counsel and a canonist working in specific fact situations.

Current canonical praxis uses the public charitable corporation which, through the operation of charitable corporation law, establishes the Catholic identity of the corporation and permanently dedicates the assets of the corporation to the use of healthcare, the apostolate in this instance. Therefore, the canonical discussion, from the perspective of "how the current legal structure works," needs to focus on the legal identity and purpose of a corporation—which is a statement *in secular legal terms* of the apostolate, and *to* the governance authority of Canonical Leadership of the responsible public juridic person in the related corporation.

In the context of Catholic health care, the canonically responsible public juridic person is either a religious institute or a newly created public juridic person erected to succeed to the canonical responsibility for health care organizations formerly the canonical responsibility of religious institutes. The creation of a public juridic person in the Church and the entrustment to it of its apostolate (its ministry) is done by a formal canonical process by competent hierarchical canonical authority. The responsible public juridic person and its legally enforceable governing authority (which includes control of the legal purpose) in the health care corporation is the formal connection creating or ensuring the continuance of Catholic health care as a ministry. This formal connection through the legal identity, purpose and governing authority of Canonical Leadership in the health care corporation creates the Catholic identity of the health care corporation which is the instrumentality used to carry on the apostolate.

Catholic identity, granted by the bishop, is altogether distinct, I suggest, from the traditional Catholic identity that derives from

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[10] 1983 CODE c.116, c.118, c. 677, c. 678, c. 731 (83 CIC cc. 116, 118, 677, 678, and 731).

the status of an apostolate related to a public juridic person. Importantly, it is not equivalent to the theological and canonical assumptions underlying the apostolate of a public juridic person. Competent authorities in the Church will make the value judgments on the ramifications of the separate issues of a) the essential importance of the canonical and theological relationship of an apostolate of a public juridic person and its connection to a civil corporation; and, b) the bestowal of Catholic identity in new equity structures based on civil law contracts. Clarification of language and the distinctions discussed herein, enhance the analysis of the theological and canonical issues underlying the issue of the choice of secular corporate structures.

The second distinction that needs to be clarified is the difference between a relationship that is an investment by one civil corporation in another, and a relationship that exists between a canonically responsible public juridic person and the civil corporation that carries on a work for which that specific canonical public juridic person is responsible in canon law. In the investment relationship, one corporation may be an equity owner or a manager or both in another corporation. In the canonical relationship, in the current structure, there is no equity ownership by the canonically responsible public juridic person in the assets of a charitable corporation.

Any analysis of alternative for-profit models for Catholic health care requires individual examination to determine the equity ownership in the non-charitable assets of the for-profit corporation. Given the distinction above, the equity relationship of one health care corporation in another is an investment relationship.[11] The current canonical rationale supporting the use of the Membership model which focuses on the apostolate of religious institutes[12] developed in the context of a public charitable corporation, in my judgment, does not apply to an investment or management relationship in the equity owned context.

The third distinction focuses on legal purpose of the corpora-

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11 As such, the word "sponsorship" obfuscates the canonical analysis if it is used either to describe the relationship of a Catholic health care corporation to the equity owned corporation; or to describe the relationship of the public juridic person to an equity owned corporation.

12 *See* NEW COMMENTARY ON THE CODE OF CANON LAW (J.P. Beal et al. eds., 2000); ADAM J. MAIDA & NICHOLAS P. CAFARDI, CHURCH PROPERTY, CHURCH FINANCES, AND CHURCH-RELATED CORPORATIONS: A CANON LAW HANDBOOK (1984).

tion. In current public charitable corporate law, the legal purpose in the corporation's Articles of Incorporation explicitly describes the *raison d'etre* of the corporation as that of a Catholic health care ministry. The assets of the corporation, the instrumental means of carrying out the apostolate, are permanently dedicated to health care for the public benefit. In the corporate documents of the for-profit models being proffered for consideration as an alternative structure for Catholic health care, the legal purpose may be simply health care. The use of assets for health care is the instrumental means of providing profit for shareholders which is the legal duty of directors of a for-profit corporation. The purpose of the for-profit corporation and the legal duty of directors uncouples the traditional unity of ministry (charitable purpose), the legal duty of the use of charitable corporate assets, and the governing authority of Canonical Leadership in the corporation—while retaining the Catholic identity for the for-profit corporation.

The fourth distinction concerns governance authority. In the current Membership model, Canonical Leadership has reserved powers controlling who governs and manages the corporation. In for-profit models, governance and management—who and how—is controlled by any number of private or public equity owners and a board of directors elected by shareholders of a controlling corporation.

The fifth distinction concerns "civilly valid methods" to protect Church interests. Catholic identity by contract (for-profit model) and Catholic identity by the legal purpose and governance structure of the corporation (nonprofit model) may appear to be closely related but they are enforced by different legal principles. The identification as Catholic is a judgment by one local bishop, in the for-profit context, that adherence to contract terms is sufficient to support his grant to the corporation of the right to use Catholic in its public identification. These distinctions need to be analyzed carefully in light of what protection secular law may give to each of these structures for adherence to the teaching of the Church. The current discussion on religious liberty illustrates the nature of this concern.

POTENTIAL IMPLICATIONS OF FOR-PROFIT FORM ON CANONICAL RELATIONSHIPS

With these distinctions as a context, I offer the following ob-

servations from a practitioner's perspective on how the transition to a for-profit model, on a practical level, may affect current canonical relationships and principles.

FIRST OBSERVATION: The exclusive rights of Members has provided the legal authority and control that allowed the growth of free-standing Catholic hospitals to regional and then national presence for Catholic health care systems that exists today. The flexibility of this form of governance and the control it invests in the present Membership structure is unlikely to survive in a for-profit model.

The growth from free-standing hospitals to the sizeable regional and national Catholic health care systems that we know today results from the placement of governance control in public juridic persons. The reserved powers allowed the Members in these situations to make fundamental reorganizational changes to the corporation without having to obtain board agreement. One may, of course, question whether such unilateral authority is appropriate. But the point of this observation is simply this: The ability of the canonical entity, acting through the Membership model, to drive the future direction of its related organizations (its ministries) is likely to change in the conversion to a for-profit model. The impact of such a change depends on whether a for-profit model is used for individual hospitals and/or for entire systems. The analysis of the question, however, if it is a valid one, is relevant to transactions involving individual acquisitions and system transitions.

SECOND OBSERVATION: While the focus of this Symposium has been narrow and practical—the implications of potential for-profit conversion of the Catholic hospital—larger and arguably more important questions hover: that is, how any transformation of Catholic ministries, simultaneous with the contraction of religious institutes, affects the civic role of the Church in the United States?

The focus of the conversations initiated at this Symposium has been on conversions and acquisitions of individual hospitals. System conversions or the systemic substitution of for-profit models to replace the use of the public charitable corporation as the dominant structure for the delivery of health care as an essential apostolate (ministry) of the Church has not been addressed specifically. However, it is helpful to note that the analysis related to single hospitals that comes out of this Symposium may also be appropriate

for business plans that may focus on for-profit growth or even, a system conversion.

This raises a broader issue related to the Church's perception of its apostolate in the modern world, as expressed in the teachings of Vatican II and recent encyclicals.[13] The size and scope of the health, education and social service corporations related to the Roman Catholic Church through public juridic persons extends throughout the United States. This significant presence was built through the joint efforts of many persons. However, it is the legal control of the Canonical Leadership in these corporations that has been essential to the stability and development of this presence as a major provider, employer, and significant participant in civic society. With the changing stability of religious institutes and the brief experience with new public juridic persons, the introduction of public or private equity ownership adds a new challenge to those whose focus may be on the role of the Church in American civic society. The essential role of these ministries to the Church is first a theological question. The change in legal control of corporate structures determines the future capacity of the Church to be a significant participant in this sector in the future. At the same time, the new models under consideration may offer new opportunities to influence the business sector.

THIRD OBSERVATION: Canonical praxis, because of the relationship to the religious institute, has deemed the property of the corporation as church property, because it is the instrumental means used to carry on the apostolate or ministry. The change in the legal use of the assets of a public charitable corporation to the legal use in an equity corporation raises a question concerning the capacity of the Church to maintain its current level of participation in the civic sector.

People and property are essential to the capacity of a public juridic person to act. The corporation provides a mechanism for the public juridic person to carry on an apostolate. The property of a public benefit corporation is permanently dedicated to its charitable purpose, even upon a sale or dissolution. Both canon law and

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[13] The recent encyclical of Pope Benedict XVI, *Deus Caritas Est*, is an excellent statement of the essential role of the public charitable ministries of the Church; *See* Pope Benedict XVI, *Deus Caritas Est*: *Encyclical Letter on Christian Love* (Dec. 25, 2005), *available at* http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est_en.html.

secular law protect the dedication of assets to their original charitable purposes. The Attorney General supervises the use of the proceeds resulting from a sale of a charitable corporation to a for-profit corporation, assuring that proceeds remain dedicated to charitable uses. The issue that becomes relevant to the notion of an active apostolate is whether the canonical entity sees its primary role as a provider of human services, and thereby having a use for a formal relationship to the health care corporation involved in the human interaction of ministry. Or, is funding health care provided by others also a valid expression of the apostolate of the public juridic person?

The proceeds of a sale of charitable assets may be held in a foundation controlled by the Members of the selling charitable corporation. Equity ownership in a for-profit health care corporation may provide profits to support existing Catholic facilities, but the notion of church property seems ill fitted to the for-profit structure. In the Foundation option, the charitable dedication of the assets remains. Presumably, the Canonical Leadership has authority in the Foundation and the assets may continue to be used for the apostolate. In this fact situation, the notion of "deemed church property" may still apply. If profits from the equity company are distributed to the charitable corporation, then the canonical characterization deeming the property of the charitable health care corporation as church property may still be appropriate.

FOURTH OBSERVATION: The responsible public juridic person acts in the name of the Church and in communion with the Church.

It is the essential characteristic of a public juridic person and the apostolate—that it act in the name of and in communion with the Church—that may be the most difficult to achieve in for-profit transactions. While the legal structures of governance, as described in the Membership model and the dedication of the property in a public charitable corporation to a Catholic purpose, may provide a method of control, acting in communion with the Church involves more than legal controls. It involves theological, ethical and cultural principles and beliefs that go far beyond prohibitions on the provision of particular clinical activities.

Corporations serving as the instrumental means to carry on the apostolate are expressions of the Church's perception of its ministry to the entire community. This is why it is important for the

corporation to have sufficient legal protection to operate in accord with Church teaching and to maintain an appropriate organic relationship to the ecclesial community. If the governors and managers of a related corporation lack an appropriately sophisticated understanding of the organic relationship to the Church and how this relationship should influence the corporate culture, even the Canonical Leadership's reserved powers as Members in a related corporation may have the potential to lose mutual understanding of the theological meaning of the work of the related corporation.[14] The transition to a contractual relationship that is built on honest good faith but not on an organic relationship to the Church may pose an even greater challenge to the label "Catholic."

On the other hand, a duplication of the leadership formation programs that are promoted by such organizations as the Catholic Health Association and many Catholic systems may provide an opportunity to inculcate the affirmative standards of Catholic Social Teachings in regard to the value of work, human dignity, just compensation as well as avoidance of prohibited clinical behaviors. It may be, that the presence of the Church in some of the proposed for-profit structures may provide a positive opportunity to influence corporate for-profit activity with values rooted in Catholic Social Teaching.

FIFTH OBSERVATION: The legal remedies for breach of any of the terms of the agreements in the proposed for-profit transactions need to be analyzed from a theological as well as a legal perspective.

The teaching authority of the bishop, his exercise of discretion and prudential judgment in the application of Church teaching, must not be subject to a third party limitation or control. Interpretation and application of terms of a contract may be subject to neutral principles of law if an enforcement issue arises among the parties. Requirements of confidentiality and a fact-finding process prior to an exercise of the bishop's authority may be appropriate. However, special care needs to be given to the potential impact of arbitration provisions, court review, evidentiary rules and burdens of proof on theological principles that may be relevant to the exercise of typical contract remedies.

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[14] *See generally id.* at Part II.

CONCLUSION

These observations are not meant to suggest any judgment for, or against, the use of for-profit structures. It is my hope that they simply stimulate the discussion of short- and long-term consequences to the use of a for-profit structure from a canonical perspective. While I do not intend to suggest a judgment on the resolution of the Symposium question, I do want to urge the careful use of terms with canonical significance as I suggested in the Introduction and discussion of language and distinctions herein. I believe that focusing on the notion of the canonically responsible person for an apostolate; the difference between an investment between civil corporations and a canonical relationship to a corporation carrying on an apostolate; and the difference between a formal relationship to a canonical entity arising from the apostolate of the canonical entity and permission to call a corporation Catholic; will help to provide a context for the evaluation of these observations concerning the potential impact of the use of the for-profit structure through contractual or equity ownership models.

Animating a Catholic Health Care System, Managerial Organizations, and Communion with the Church

*T. Dean Maines**

Our final session focuses upon the issues of animating a Catholic health care system, managerial organizations, and communion with the Church. My colleague, Robert Kennedy, and I will offer a few reflections on the conversations of the past two days in light of these topics. We hope that our reflections will serve as a spur to further discussion.

I want to begin by combining the first two topics within a single question: From a managerial perspective, what does it mean to "animate" a Catholic health system? I want to suggest that every organization's decisions and activities are shaped by a set of moral values or principles, whether those standards are adopted by default or design. These principles guide the organization's operations, what it chooses to do or not do, as well as how it undertakes specific initiatives. For Catholic health care institutions, the challenge is to place certain essential principles rooted in the Catholic moral tradition—the essential principles that Michael Naughton and I outlined in the symposium's opening session—in a position of authority so they can decisively influence how the organization performs its work, how it produces and delivers its distinctive suite of services, with an eye toward the ultimate goal of enfleshing Christ's healing work.

Our colleague, Kenneth Goodpaster, has identified three tasks that leaders must undertake to give moral principles that kind of authority within a managerial organization, to enable moral principles to animate the firm's operations.[1] First, leaders must *orient* their firms towards those moral standards. They must identify the principles that will serve as their organization's moral touchstone and they must communicate them, explaining the principles' general implications for the firm's work and its stakeholders. Johnson

* M.S., President, Veritas Institute of the Opus College of Business, University of St. Thomas.

[1] Kenneth E. Goodpaster, *Ethical imperatives and corporate leadership*, *in* ETHICS IN PRACTICE 212–28 (Kenneth R. Andrews, ed., 1989).

& Johnson's *Credo*, which we explored yesterday, is an example of an attempt to orient a firm towards a particular set of moral principles. Mission standards, value statements, and codes of conduct also help with this task.

Second, leaders must *institutionalize* principles. They must ensure that moral principles are integrated within the policies, processes, and practices that guide how the organization operates. For example, the principles need to be embedded within selection processes for critical leadership roles, within the organization's performance management system, within its compensation and recognition structures, as well as within the processes and procedures the organization follows to produce its goods or services. Vernon Byrd, Executive Director of Johnson & Johnson's Center for Legal and Credo Awareness, provided us with examples of this yesterday—how Johnson & Johnson's performance management and reward systems draw upon the *Credo*, and how other clinical and administrative processes do so as well. A few years ago, the vice president for finance at a Catholic health care system outlined for me her organization's attempt to formally integrate its guiding principles within its capital allocation process. That is another example of institutionalizing a moral principle.

Third, leaders must *sustain* these principles. They must ensure their continuity over time. Most importantly, they must pass the principles along to the next generation of leaders. They must help their successors internalize these moral standards. Both Sr. Doris Gottemoeller and Sr. Sharon Holland have commented on the importance of formation programs here at this Symposium. Formation programs directly support this task: They support the transmission and inculcation of moral principles.

Much more could be said about each of these tasks. However, I want to emphasize two points about Goodpaster's framework. First, from a managerial perspective, this threefold agenda—to *orient, institutionalize,* and *sustain* the principles which inform an institution—applies equally to for-profit and not-for-profit organizations. It is common to both. In other words, corporate structure does not affect the basic leadership tasks associated with animating a foundational set of moral principles within an organization. This certainly has been our experience at the Veritas Institute. Goodpaster's model lies at the heart of the Institute's ethics

assessment and improvement tools, and both for-profit and not-for-profit firms have employed these tools fruitfully.

So the journey towards animating a Catholic health system or hospital with the essential principles for Catholic health care will follow the same guideposts, whether that institution utilizes a for-profit or a not-for-profit structure. This leads to my second point: Of itself, a not-for-profit structure offers no guarantee that a leadership team will do a better job than their for-profit peers on the tasks of orienting, institutionalizing, and sustaining moral principles. As some presenters have noted, scandals have emerged within not-for-profit organizations—for example, charities and universities—as well as for-profit ones. Also, some for-profit organizations have done a good job of consistently making ethics part and parcel of how they do business, even if they have failed to do so perfectly, as all institutions inevitably must. Johnson & Johnson is one of these organizations. So too are Herman Miller, the furniture maker, and Cummins, the Indiana-based diesel engine manufacturer for which I worked for many years.

I want to turn to the more specific question before us: Is a for-profit structure conducive to animating a Catholic health care system or hospital with the seven principles we reviewed yesterday morning? What challenges might arise from combining a for-profit structure with principles such as holistic care, solidarity with the poor, respect for life, the dignity of work, subsidiarity, creating and justly distributing wealth, and acting in communion with the Church? In thinking about these challenges, we should attend to Michael Naughton's counsel concerning practical wisdom. In particular, we need to exercise foresight, a vital dimension of practical wisdom, to identify unintended consequences that might accompany the adoption of a for-profit organizational form.

Animating a for-profit Catholic health system or hospital with the seven principles for Catholic health care is by definition a leadership task. So who occupies the leadership roles within these firms will influence how well the principles are woven into the organization's fabric. And I believe challenges to Catholic identity could arise on this particular front.

For example, how will a for-profit structure influence the desired profile of talents, skills, and experiences for a hospital's CEO and his or her executive team? That is, how will it affect the skills, the knowledge, the abilities, and experience that will be viewed as

necessary or preferable in candidates for these roles? Furthermore, since every leadership role spans a range of tasks, it requires a range of skills. Rarely are candidates equally strong across that spectrum, so tradeoffs inevitably are made during the selection process. What priority will be assigned to each of the desired qualifications?

Could leadership experience in the for-profit sector eventually be deemed an essential, or even necessary, qualification for a leadership role within a for-profit Catholic health care hospital, particularly in instances where the hospital may be in severe financial distress due to poor cash flow, thin operating margins, or severe competitive pressures? If that is the case, what priority would that experience be given relative to experience with issues of Catholic identity or formation in the Catholic moral tradition? Could a concern for for-profit experience and "hard" management skills lead to an effective, if unintentional, de-emphasis of the latter? If so, what might be the long-term impact of this de-emphasis upon an executive team's commitment to the task of animating the hospital with the essential principles for Catholic health care, as well as its comfort addressing that particular task? Could this lead to a situation where issues surrounding Catholic identity are delegated *in toto* to the hospital's mission leader, while the CEO and the rest of the leadership team attend solely to the hospital's "real" business?

Implicit in this last scenario is a perspective that sees Catholic identity as extrinsic to the hospital. That is, Catholic identity is viewed as something that is "added" to a hospital's operations, as opposed to being intrinsic, the organization's *anima*, the soul that shapes both what is done and how it is done. Speaking from the Veritas Institute's experience helping Catholic hospitals utilize the *Catholic Identity Matrix,*[2] such a perspective is inimical to the development of a robust Catholic health ministry.

Now the picture I am painting here suggests there is a bright line between the skill sets required in the for-profit and the not-for-

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[2] The Catholic Identity Matrix (CIM) helps a Catholic health system or hospital assess and enhance the degree to which it has integrated the six Catholic moral principles within its operating policies, processes and practices. The first use of the process took place within Ascension Health in 2006. The CIM was subsequently improved through a partnership between Ascension Health and the Veritas Institute of the University of St. Thomas Opus College of Business (formerly known as the SAIP Institute). More information about the CIM is *available at* http://www.stthomas.edu/business/centers/veritas/assessments/cim.html.

profit realms. Of course, things are not that clear cut. There are leaders who have come into Catholic health systems and hospitals from for-profit firms, and who are making important contributions to Catholic health care. At the same time, based on what I've experienced within Catholic health care organizations, the entry of executives from the for-profit realm has not been without its tensions. And many of these tensions have revolved around the role of mission, the central role played by the essential principles for Catholic health care.

So a shift to a for-profit structure raises a set of questions around leadership selection and formation. For example, if a for-profit structure is adopted, and experience in a for-profit environment is deemed preferable or essential, what might Catholic health systems and hospitals need to do differently in the selection process to ensure that successful candidates for executive roles are predisposed and prepared to fully address challenges around Catholic identity, as well as business or clinical challenges? How might the leader's responsibility to help bring the principles for Catholic health care "to life" within the organization be stressed throughout the selection process, so candidates are clear about this expectation and have an opportunity to explore concretely what this responsibility entails? How should formation programs be modified or adapted to account for the backgrounds and experiences of these new leaders, to help prepare them to undertake their distinctive duties around the health ministry's identity? Finally, what performance management structures should be put in place to reinforce the executive's responsibility to address the leadership tasks of orienting, institutionalizing, and sustaining the essential principles for Catholic health care? What structures should be put in place to help prevent the wholesale delegation of responsibility for the organization's Catholic identity to the mission department?

A second challenge concerns the institutionalization of the seven essential principles. My hunch is that the for-profit structure will influence how institutionalization takes place, how the principles are driven into a health system's or hospital's operating policies, processes, and practices. The full scope and precise nature of that impact remains unclear to me at this point. However, in considering the potential for unintended consequences, there is one question I would like to explore briefly: Could the contractual ar-

rangements that surround for-profit Catholic health care organizations inadvertently foster a kind of moral minimalism?

All of the legal structures and arrangements that we explored yesterday contain provisions that require the for-profit hospitals within their purview to observe the *Ethical and Religious Directives for Catholic Health Care Services*.[3] But what exactly does it mean to observe these standards? The *Ethical and Religious Directives* can be viewed from different perspectives. For example, they can be seen as a set of moral thresholds for Catholic health ministries. Fulfilling these thresholds is essential, but they ultimately beckon Catholic health systems and hospitals toward a rich and prophetic witness to the dignity of a human person within the realm of health care and medicine. In other words, the *Ethical and Religious Directives* can be viewed as impelling Catholic health ministries towards moral excellence, towards the full embodiment of the principles for Catholic health care and ultimately towards Catholic health care's *telos*, incarnating Christ's healing work. Alternatively, they can be read as a compliance checklist: Don't do abortions, don't do sterilizations, perform some charity care, distribute benefits to the community in a variety of ways, etc. That is, the document can be read as establishing a set of moral minimums that every Catholic health system or hospital must meet—and nothing more.

One reason for concern on this point is the history of how corporate ethics programs within the United States have evolved. Since the advent of the Defense Industry Initiative[4] during the 1980s, and the emergence of the *Federal Sentencing Guidelines for Organizations*[5] during the 1990s, these programs have focused increas-

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[3] U.S. CATHOLIC CONFERENCE OF BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

[4] DII is a non-profit association of U.S. defense companies committed to conducting business affairs at the highest ethical level and in full compliance with the law. Its membership comprises the professional ethics officers, CEOs and senior officials of 85 top defense and security companies serving the United States military. More information on DII is *available at* http://www.dii.org/.

[5] The United States Sentencing Commission produced sentencing guidelines for organizations (corporations) in 1991 that include factors that can positively and negatively affect a corporate sentence for criminal behavior. The existence of an effective corporate ethics and compliance program has received significant attention with respect to whether it actually influences corporate culture to behave ethically. More information on the Organizational Guidelines is *available at* http://www.ussc.gov/Guidelines/Organizational_Guidelines/index.cfm.

ingly on legal compliance. They tend to emphasize legal minimums, not moral excellence. Now moral minimalism is always a danger within organizations, whether not-for-profit or for-profit. Unfortunately, legal contracts tend to foster a compliance mentality. Thus, I think the danger of a kind of moral minimalism emerging within Catholic hospitals under certain for-profit arrangements is particularly acute. This possibility certainly warrants our attention and vigilance. It is out of step with what the *Ethical and Religious Directives* call Catholic health care to become. Much more than moral minimalism is needed if Catholic health care is to incarnate the healing ministry of Jesus in the world today.

Animating Catholic Health Care: Communion with the Church

*Robert G. Kennedy**

I have been asked to address Catholic health care and communion with the Church and, perhaps more specifically, the implications of for-profit structures for this vital communion.

I want to begin with a question and an observation.

First, the question: Why are we, as Christian disciples, consciously and deliberately engaged in providing health care as a ministry or apostolate of the Church? We clearly do not offer health care only to members of the Church, so is it a recruiting effort or something much more than that? What is our rationale and what is our objective?

I pose this not so much to provoke an explicit answer as to suggest that the answer we do give—or have implicitly already given—to this question will shape our response to the possibility of embracing for-profit structures.

And then my observation: Health care is different from professional medical care. When we speak about "health care" in the context of this conference and the questions it addresses, we are almost always speaking about professional medical care.

Let me explain. I think of providing health care as what my wife and I do when one of our children is ill and has to stay home from school. Health care is what we provide when one of our grandchildren is ill, cannot go to day care and instead comes over to our home for a "Grandma Day." Neither of us is professionally trained in medicine but we have a great deal of experience in providing health care. So did Mother Teresa, who took the dying off the streets of Calcutta and gave them a place to die with genuine dignity. That is a kind of health care but it is not professional medical care. The member organizations of the Catholic Health Association, by contrast, are engaged in providing professional medical care. This implies a need for resources, for trained professionals, for expensive facilities and so on that would not otherwise be the case for health care more broadly considered.

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So, with this in mind I must revise my question. Why do disciples of Christ consciously and deliberately engage in providing *professional medical care* as a ministry or apostolate of the Church? Hold this in mind for a moment while I turn to some observations about the Church and the meaning of communion.

I do not need to tell this audience that when I speak of the "Church" I do not mean simply the leadership of the Church, the hierarchy, or even just the clergy. When we speak about the Church we speak of the people of God, of the whole body of Christian disciples who are members of the Catholic community and who, as a consequence of that membership, share in one way or another in the mission of Jesus.

In his first encyclical, *Deus Caritas Est*,[1] Pope Benedict XVI spoke about the activities that define the Church. "The Church's deepest nature," he said, "is expressed in her threefold responsibility (*munus*)." The Latin word he used for responsibility, "munus," does not easily translate into English. Since the Second Vatican Council it seems to have taken on a formal meaning and is often used carefully in official documents to speak about the activities that are distinctive and proper to specific persons and organizations in a community. "Responsibility" or "duty" or "task" really do not capture the force of the term. When Benedict says that the Church has three related *munera*, he expects us to understand that these three activities not only belong to the Church but that they are part of what makes the Church what it is and that the Church *must* pursue them.

He went on to say that these three activities are:

1. the *munus* of "proclaiming the word of God (*kerygma/martyria*)"
2. the *munus* of "celebrating the sacraments (*leitourgia*)" and
3. the *munus* of "exercising the ministry of charity (*diakonia*)."

None of these activities is expendable. In his words, they "presuppose each other and are inseparable. For the Church, charity is not a kind of welfare activity which could equally well be left to others but is a part of her nature, an indispensable expression of her very being."[2]

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1 Pope Benedict XVI, *Deus Caritas Est: Encyclical Letter on Christian Love* (Dec. 25, 2005), *available at* http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est_en.html.

2 *Id.* at No. 25a.

The Church cannot abandon this ministry of charity without suffering a sort of mutilation. At the same time, whether it acknowledges this or not, society loses something if the Church is not actively engaged in this area. I am reminded of an incident that occurred in the 1930s, as the New Deal was first being implemented. There was a discussion among the bishops of the United States about whether they ought to participate in, to advocate for, to support, to oppose, some of the New Deal programs. At one of their meetings a bishop—I think, in fact, it was the Bishop of Fort Wayne-South Bend—stood up and expressed some reservations about the new government programs. He was not sure that these programs would be good because, as he famously said, "the poor belong to us." His concern was that these programs would replace or supplant or squeeze out Church programs, and particularly that the Church would lose its connection with working men. But more than this alone was at stake. Government can do certain things and ought to do certain things, but there are some things that the Church can do for which there is no substitute. As Benedict reminds us, a government program can pursue justice but it is very unlikely to manifest charity.[3] Perhaps we need to keep that in mind.

In February (2012), at the consistory at which Archbishop Dolan of New York was made a cardinal, he was invited to speak to the College of Cardinals about the New Evangelization. Permit me an extended quotation from his comments:

> The Way of Jesus is in and through His Church, a holy mother who imparts to us His Life. "For what would I ever know of Him without her?" asks De Lubac, referring to the intimate identification of Jesus and His Church. Thus, our mission, the New Evangelization, has essential catechetical and ecclesial dimensions. *This impels us to think about Church in a fresh way: to think of the Church as a mission. As John Paul II taught in Redemptoris missio*, the Church does not "have a mission," as if "mission" were one of many things the Church does.
>
> No, the Church *is* a mission, and each of us who names Jesus as Lord and Savior should measure ourselves by our mission-effectiveness. Over the fifty years since the convocation of the Council, *we have seen the Church pass through the last stages of the Counter-Reformation and rediscover itself as a missionary enterprise.*

3 *Id.* at No. 28a.

> In some venues, this has meant a new discovery of the Gospel. *In once-catechized lands, it has meant a re-evangelization that sets out from the shallow waters of institutional maintenance, and as John Paul II instructed us in Novo millennio ineunte,* puts out "into the deep" for a catch.
>
> In many of the countries represented in this college, the ambient public culture once transmitted the Gospel, but does so no more. *In those circumstances, the proclamation of the Gospel—the deliberate invitation to enter into friendship with the Lord Jesus—must be at the very center of the Catholic life of all of our people.* But in all circumstances, the Second Vatican Council and the two great popes who have given it an authoritative interpretation are urging us to call our people to think of themselves as missionaries and evangelists. (emphasis added).[4]

Cardinal Dolan reminds us that the Church is missionary in its very nature. Sharing the Gospel is not simply one thing that the Church does; it is part of the very reason for the Church's being. This can and must be done at several levels. One level is to proclaim, to announce, the good news of Jesus Christ but another level is to bear witness to God's love through ministries of charity. In our own time and culture, we have too often taken for granted that people know this good news and so perhaps we have become indifferent witnesses to it. The remedy is for us to consider anew how our ordinary activities in the world can once again be the signs they were meant to be.

With these thoughts in mind, perhaps we can return to the question I posed as I began: Why are we engaged in providing health care to the community? The answer, I think, is that we do it because it is a critical element of the *ministerio caritatis* of the disciples of Christ, and as such it is something that we cannot simply delegate to others.

Very broadly, the mission of Christ is to restore to creation the order intended by the Creator. More particularly, it is to heal humanity and to repair the relationship of the human community and each of its members to God. There is, to be sure, a spiritual dimension to this healing—it is this dimension that civil authority

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[4] Timothy Cardinal Dolan, Archdiocese of New York, The Announcement of the Gospel Today, Between *missio ad gentes* and the New Evangelization, Address to Pope Benedict XVI and College of Cardinals at the Day of Prayer and Reflection of the College of Cardinals, Vatican (Feb. 17, 2012), *at* http://cnsblog.wordpress.com/2012/02/17/cardinal-designate-dolans-address-to-pope-benedict-and-the-college-of-cardinals/ (Feb. 17, 2012).

is least well-equipped to address—though just as human persons are not souls trapped in bodies but integrated wholes, so there are also social and physical dimensions of healing. I submit to you that as it continues the mission of Christ, the Church is called to work to heal the whole person. The ministry of charity, therefore, must attend to every dimension of the human need for healing.

The work of health care, not just personally but also institutionally, thus has an important role to play in the life of the Church. But does this also extend to providing professional medical care, as I have distinguished it from health care in general?

I think in fact that it does but there are challenges. Because the three *munera* of the Church are integrally related, none can be neglected but at the same time none can be emphasized to the great diminishment of the others. Though there have been times and voices in the history of the Church that have tended to prefer one *munus* or another to the integration of the three, the clear message of the Second Vatican Council and of Pope Benedict is that all three must be pursued. Indeed, they support one another like the three legs of a stool. As a practical matter, this requires prudence and balance.

So, one question concerning the Church's activities and the provision of professional medical care has to do with whether we can assemble the resources to offer such care to the extent, and at the level of quality, we believe is necessary. Given the costs and the requirements for personnel, this has led us to consider whether some elements of Catholic health care operations could adopt a for-profit structure in order to respond to these demands. In fact, of course, some have already done so, in whole or in part. For them, and for other organizations that might consider this direction, the pressing question is not only whether a for-profit structure will provide the resources needed (it may or may not), but whether an operation with such a structure can remain in communion with the Church.

As a practical matter, what would this mean? In the sense that concerns us here, I suggest that to be in communion with someone is to *think* with them and to *act* with them.

Permit me to be more specific. To *think* with the Church requires us to embrace the Church's self-understanding of its nature (including its hierarchical structure), its missionary character and its vision of the nature, destiny and dignity of the person. To reject

any of these elements will inevitably undermine communion and provoke conflict. As a consequence, there is a persistent need in Catholic institutions (and not only health care facilities) to renew and sustain an understanding of what the Church genuinely thinks.

To *act* with the Church, as many of you have observed at this conference, requires more than passive acquiescence or minimal compliance with the ERDs. Genuinely to act in communion is to internalize the mission and vision of the Church and to manifest these in the policies and practices of the organization. We are not simply facilities that seek to have a pleasant Catholic flavor. We seek to do more than that; we seek to make the Church in its full nature active in the ministry of charity that is health care.

I will not rehearse with you all of the challenges that make it difficult for Catholic institutions to remain in communion with the Church. Many of you know them better than I. But I would like to speak for a moment about one challenge that several of you have mentioned. This is the working relationship of Catholic health care institutions with the local bishop.

In an earlier life I spent several years working for a small diocese. I was chief of staff to the bishop there and because it was a small diocese I wore several hats. One of the hats I wore was as the bishop's liaison to the Catholic health care organizations in the diocese, of which there were several. So I have looked at some of these problems, if you will, from the other side of the desk.

As successors of the apostles, bishops have the *munera*, that word again, of sanctifying, teaching and governing the Church. In many cases, they have, let's say, not as much practical preparation for these roles as we would like them to have. Many new bishops are quite surprised at their appointment and, if truth were told, quite apprehensive about their readiness to assume the office. In sharp contrast with most other professions, there is very little formal training available.

As a result, I can tell you that especially with regard to health care, the bishops with whom you work are often not well acquainted with the problems and challenges that you face. They are not quite sure how they should respond to you or relate to you. So, I want to challenge you to think about what the bishops need to know that only you can tell them. What do the bishops need to do that they cannot do without you? How can you support the very

lonely job that they have? How can you facilitate and sustain a relationship where—if I may put it this way—they may be more apprehensive of you than you are of them?

Over the past couple of days, I have heard several speakers acknowledge the ultimate authority of the bishop. Fair enough, but I want to challenge you with this: Do you provide avenues for a bishop to engage with you on important questions? Or have you allowed your relationship with the bishop to be structured in such a way that he is either a passive observer or an opponent? You have a role to play in ensuring that your relationship with the bishop is not an uneasy peace but a genuine collaboration. Given how important this is, or ought to be, to your institutions, the principal responsibility for shaping this relationship will fall on you rather than the chancery.

Finally, let me turn briefly to the question of whether a for-profit organization can be committed to the truths and values of the Catholic tradition. In principle I do not see why it cannot but I acknowledge that a number of speakers have raised questions about how practical this might be.

Let me put the question a bit differently. Can a for-profit organization embody a genuine Catholic apostolate? Now this word "apostolate" is one that we have not used but I would like to introduce it to the discussion. We have been accustomed to speak of all of the activities associated with Catholic health care as "ministries."

As the Second Vatican Council struggled to find language to express its vision of the Church and the relationship of the various offices and roles of its members, it made some halting steps toward defining ordinary words more precisely. In many cases, though not in every instance, it tended to use the word "ministry" for those activities that had to do with the functions of teaching, sanctifying and governing the Church. That is, it preferred to use "ministry" for the work of the clergy. For those activities in which the Church is engaged with the wider, secular world, the Council preferred to use the word "apostolate" (from the Greek word, *apostello*, which means "to send out"). This distinction of language was not preserved in translation and ultimately in English "ministry" came to be used as a generic term for almost any activity associated with the Church.

I think something has been lost here. The distinction between ministry and apostolate is a perfectly good one. In the context of

what the Council had to say about the universal call to holiness, the distinction does not imply that ministries are more noble than apostolates but that each in appropriate ways are operations of the Church. However, to speak of all of the activities associated with Catholic health care as ministries may be misleading. Some of these activities certainly are ministries, but many may be more appropriately apostolates—in which members of the Church (particularly the laity) seek to bring the Gospel to secular professional practice.

I am thinking here specifically of animating professional practice with a Catholic vision of the dignity and destiny of human persons. If I read the Council rightly, this is not strictly speaking a ministry but is instead an apostolate—and a very valuable one. It is not clear to me why such an apostolate cannot be carried on within a for-profit structure (though, again, I acknowledge that there can be special challenges).

In many ways we face an uncertain future, not just in health care but in many other areas of professional activity. And I do think that uncertain futures call for imagination and creativity. Could we not craft for-profit structures that may be less subject to the pressures of capital markets and that might enable us to do the things that we need to do? Could we think about for-profit health care initiatives as morally sound investment opportunities for Catholics who are looking for something other than IBM and General Motors and Johnson & Johnson?

In the end, though, we must be careful what we wish for. Historically, material success has been the nemesis of both ministry and apostolate. There are many stories to be told about the medieval papacy and other eras (including perhaps our own) in which wealth was accompanied by corruption. If we are really successful financially, there may be dangers to our identity. We ought to ask ourselves what the real motivations are for growth. Even a nonprofit institution can be infected by a sort of business disease, in which the goal of growth obscures every other objective.

From the perspective of faith, our real goals are to witness to the truth of the Gospel, to bring the love of God to every person we encounter, and to prepare material for the Spirit to use in shaping the Kingdom of Heaven. The final test of any structure is whether it helps us to do this in communion with the Church.

APPENDIX

Pre-conference Questionnaires About Corporate Structure with Responses from Ascension Health Care Network, Vanguard Health Systems and Ardent Health Services

Ascension Health Care Network

Is a For-Profit Structure a Viable Alternative for Catholic Health Care Ministry?
Presentation Questions for Representatives of Each For-Profit Model

Thank you for taking the time to provide this information about your model. The other speakers on the program will rely on these responses in preparing their Symposium remarks. AH required hospital in these questions means the for-profit Catholic hospital.

Please answer the following set of questions in no more than seven single spaced pages using a 12-pt font, preferably Times New Roman. If a question does not apply to your model, please write NA. If any information is not requested which you consider important to the fair presentation of your model in view of the topic of the symposium, please provide that information while maintaining the seven-page limit.

You are welcome to provide two attachments *in addition* to these seven pages: a diagram of your ownership structure and a diagram of your management structure, if you believe it will be helpful to the Symposium speakers.

Introductory Information

1. Name of For-Profit Model: Ascension Health Care Network.

2. What is the City, State or Region in which the model has hospital(s): None at this time.

3. Website Address: ahcn.com

4. Does the model include:
   a. A Parent Holding Company? YES
      If yes, what is the name and date incorporated? Ascension Health Care Network, incorporated December 22, 2010.
   b. An Acquired Hospital(s)? NO
      If yes, what is the name and date incorporated?
   c. Other for-profit hospital(s)? NO

5. Are there other affiliated entities in the business enterprise of your model? (Please describe) See addendum below which describes the relationship with Ascension Health Alliance.

6. Briefly describe the legal structure of the entities described in questions 4 and 5.

   a. Closely-held corporation ______________________________
   b. Publicly-traded corporation ___________________________
   c. Limited liability company _____________________________
   d. Partnership ____
   e. Nonprofit corporation ________________________________
   See addendum below.

7. Briefly describe the relationship between equity owners and the owned entities in your model. See addendum below.

8. Do you have a management agreement with any entity described in question 4?
   YES NO If so, identify the managed entity and the manager.
   See addendum below.

Corporate Structure

1. Does the legal purpose in the organizational documents of the following entities include the identification as "Catholic"?

   a. Parent Holding Company YES
   b. Acquired Hospital YES
   c. Other affiliated entity YES

2. Does the legal purpose in the organizational document of the Acquired Hospital include the statement that the hospital operates in accordance with the teachings of the Roman Catholic Church and its Ethical and Religious Directives for Catholic Health Services (ERDs)? YES

3. Where is the decisional board with fiduciary duties to the Acquired Hospital located? In the parent holding company or in the Acquired Hospital? Ascension Health Care Network Board

   a. Is a Catholic party with legally enforceable rights in regard

to Catholic identity a voting member of this fiduciary board? YES

b. Does this board have a role in monitoring the implementation of the elements of Catholic identity? YES If so, please describe the monitoring process: See addendum below.

c. What is the composition of this board?
6 members appointed by Oak Hill Capital Partners; 4 members appointed by Ascension health Alliance and the CEO of Ascension Health Care Network

d. Are these board members compensated? YES NO 3 outside directors are compensated.

4. Is there an advisory board to the fiduciary board? YES

a. What is the composition of the advisory board? Please list, for example, Church representatives, health care professionals, members of the community, etc. See addendum below re the Congregational Advisory Council.

b. Who appoints the members of the advisory board? Ascension Health Care Network.

c. What is the function of this advisory board? See addendum below.

d. Are these board members compensated? YES

Management

1. Is the Acquired Hospital managed by the owner? See addendum below. It is managed through a Management Agreement with Ascension Health Alliance.

2. Is the Acquired Hospital managed by employees of the managed hospital? YES – with accountability to Ascension Health Care Network.

3. Who hires and evaluates the executive leadership of the Acquired Hospital? Ascension Health Care Network.

4. Is the Acquired Hospital managed through a management

contract with a non-affiliated or affiliated entity in your model? An affiliated entity.

a. Who is the contracted manager? Ascension Health.

b. Who are the parties to the management contract? Ascension Health Alliance and Oak Hill Capital Partners.

c. Are the executive leadership and/or staff members of the Acquired Hospital employees of the Acquired Hospital or of the management company? (circle one) A variety of approaches will be used depending on the circumstances.

d. Does the party with the legally enforceable rights in regard to Catholic identity have any legal rights in the management agreement? Yes – Subject to the rights of the local Ordinary, Ascension Health Alliance has sole authority over all elements of Catholic Identity in perpetuity. See addendum below.

Catholic Identity and Stewardship/Sponsorship

1. Is there is a stewardship/sponsorship agreement? YES NO
   See addendum below.
   If there is both a stewardship/sponsorship agreement and a management contract, how do they differ? (Stewardship agreement in this context means the agreement that sets forth the obligations of the "elements of Catholic identity.")

2. Describe the legal rights/remedies of the parties in the stewardship agreement. N/A

3. Identify the elements of Catholic identity that are set forth in the legal documents of your model: Promotion and Defense of Human Life and Dignity; Promotion of Common Good; Participatory Community of Work and Mutual respect; Solidarity with those who live in Poverty; Stewardship; Holistic Care; and Acts in Communion with the Church. See addendum below.

   a. Does your model identify quantifiable benchmarks of performance of each element? YES, through the Catholic Identity Matrix. See Addendum below.

   b. Does your model incorporate the elements of Catholic

identity into the strategic business/financial and executive leadership plan of the Acquired Hospital?
YES

c. Does your model identify who is responsible for assessing whether the elements of Catholic identity are observed and implemented in a way that is consistent with Catholic teaching? YES; see addendum below.

d. Is there a legal remedy for noncompliance with the elements of Catholic identity?
YES How, when, and by whom can it be exercised? See addendum below

4. How are the compensation incentives for the management of an Acquired Hospital aligned with the "elements of Catholic identity" defined in your model? N/A – have not yet acquired a hospital.

5. Is Catholic identity used in the marketing materials of the model? YES If so, how? Logo; Mission, Vision and Values; Catholic Identity is described in all presentation materials.

6. Does the Acquired Hospital or the parent holding company have a relationship to a canonical entity in the Roman Catholic Church through the governance structure of either the Acquired Hospital or the parent holding company? YES. See addendum below.

7. Do you use the word "sponsor" in relation to the Catholic identity of the hospital in your marketing or public relations materials? YES NO Have not yet acquired a hospital.

8. Does your model use the word "ministry" in relation to the delivery of health care? YES. If so, in what sense is the word "ministry" used? Ascension Health Alliance defines itself as a ministry of the Catholic Church in the following way: "Our Ministry is an active service done on behalf of the Church in Jesus' name, with and in the community, as an expression of God's presence on earth – we are a *ministry* of the Catholic Church, committed to continuing the *healing mission of Jesus.*" See addendum below for additional explanation.

9. How does your model, in structuring the delivery of its services, balance profitability with community need? We have not yet acquired a hospital. Hospitals that become part of Ascension Health Care Network will be managed in the same manner as the 70+ hospitals that make up Ascension Health today.

10. How does your model provide for the identification of community need? See response to question 9 above and addendum below.
11. How does your model specifically address the core elements of the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* in the development of its business and clinical practices and the selection and formation of the executive leadership of the corporation that has the governance and management control of the Acquired Hospital? Please address each Part of ERDs specifically. See response to question 9 above and addendum below.
    a. Part One (Social Responsibility) ____________________
    ____
    b. Part Two (Pastoral and Spiritual Responsibility of Catholic Healthcare) ____________________
    ____
    c. Part Three (The Professional-Patient Relationship) ____
    ____
    d. Part Four (Issues in Care for the Beginning of Life) ___
    e. Part Five (Issues in Care for the Seriously Ill and Dying)
    ____
    f. Part Six (Forming New Partnerships with Healthcare Organizations and Providers) ____________________
    ____

12. Please include any additional information about your model that you think is relevant to the Symposium topic and that has not been included in the above questions. All answers to the questions must be limited to seven pages.

Addendum

ASCENSION HEALTH CARE NETWORK

Ascension Health Care Network (AHCN) is a Catholic health system that is Sponsored by Ascension Health Ministries, a public juridic person, the Participating Entities of which are the Congregation of the Sisters of St. Joseph of Carondelet, the Congregation of St. Joseph, the Daughters of Charity of St. Vincent DePaul, Province of St. Louise, and the Alexian Brothers of the Immaculate Conception Province – American Province.

AHCN was incorporated as a stock corporation organized under the General Corporation Law of the State of Delaware on December 22, 2010. The shareholders of AHCN are: OHCP III AHCN, LLC, a Delaware limited liability company, OHCMP III AHCN, LLC, a Delaware limited liability company (collectively, the "Oak Hill Shareholder") and Ascension Health Ventures, LLC a Missouri limited liability company ("Ascension Shareholder"). The sole member of the Ascension Shareholder is Ascension Health Alliance, a Missouri nonprofit corporation that is listed in the Official Catholic Directory. Ascension Health Alliance is the member of Ascension Health, a Missouri nonprofit corporation that is also listed in the Official Catholic Directory. Ascension Health directly or indirectly owns approximately 70 Catholic hospitals across the United States. The Oak Hill Shareholders own approximately 80% of the issued and outstanding stock of AHCN; and, the Ascension Shareholder owns approximately 20% of the issued and outstanding stock of AHCN.

AHCN became operational in the first quarter of 2011. AHCN does not currently own any hospitals but intends to acquire Catholic hospitals across the United States. These Catholic hospitals will retain their Catholic identity post-acquisition and will likely be organized as limited liability companies. AHCN will directly or indirectly own each of these limited liability companies. It is anticipated that each acquired hospital will have its own governing board that will be responsible for a variety of matters including: (i) participating in the adoption of a vision, mission, and values statement for the hospital consistent with the hospital's Catholic Identity; (ii) participating in the development and review of operating and capital budgets and facility planning and advising AHCN with respect to the same; (iii) participating in periodic evaluations of the hospital

CEO; (iv) monitoring performance improvement at the hospital; (v) granting medical staff privileges and, when necessary and taking disciplinary action consistent with the medical staff bylaws; (vi) assuring medical staff compliance with Joint Commission requirements; (vii) supporting physician recruitment efforts; and (viii) fostering community relationships and identifying service and education opportunities.

AHCN is managed by an employed CEO appointed by the Board of AHCN. The Oak Hill Shareholder and the Ascension Shareholder each have an independent right to terminate the CEO of AHCN with or without cause. AHCN acquired hospitals will each be managed by a local management team.

The foundational legal documents for AHCN require AHCN and its acquired Catholic hospitals to adhere to specific Catholic Identity Standards ("Catholic Standards"). These Catholic Identity Standards include those operations, programs, policies, characteristics and services that support recognition by the Roman Catholic Church that AHCN and each of its acquired Catholic hospitals is a Catholic organization, including mission, vision, values, activities and practices that are in accord with the teachings, philosophy, mission, values and norms of the Roman Catholic Church, adherence to the Ethical and Religious Directives by AHCN and each hospital acquired by AHCN, policies and procedures related to charity care and community benefit, and those operations, programs, policies, characteristics and services relating to the Catholic Identity of AHCN as a healing ministry of the Roman Catholic Church. The AHCN Catholic Identity Standards are organized in five broad categories: Mission, Ethics, Sponsorship, Promoting Human Dignity and the Common Good, and Canon Law and Church Relations. The essential elements of Catholic Identity that are set out in the AHCN legal documents include: Promotion and Defense of Human Life and Human Dignity, Promotion of Common Good, Participatory Community of Work and Mutual Respect, Solidarity with those who live in Poverty, Stewardship, Holistic Care, and Acts in Communion with the Church.

Under the AHCN legal documents, the Ascension Shareholder has the sole authority to interpret the Catholic Identity Standards and may legally enforce these Catholic Identity Standards should

AHCN or any AHCN acquired Catholic hospital not be operated in a manner consistent with such Catholic Identity Standards.

In addition, AHCN has entered into a Management Services Agreement with Ascension Health. Under this agreement, Ascension Health, as a manager of AHCN, is required to provide programs and services to AHCN in manner consistent with the Catholic Identity standards. These programs and services include, Mission Integration, Governance and Leadership Formation, Ethics, Workplace Spirituality, and oversight of charity care and community benefit programs. As manager, Ascension Health will also employ the Ascension Health Catholic Identity Matrix to assess how well AHCN Catholic hospitals live out their Catholic Identity. The **Catholic Identity Matrix** uses A Shared Statement of Identity for the Catholic Health Ministry, developed by the Catholic Health Association, and the Ethical and Religious Directives, to assess the elements of Catholic Identity (described above) by an evaluation and assessment provides involving the following six aspects of organizational development: planning, alignment, process, training, measurement and impact. The assessment tool includes a quantitative scoring process based on Malcolm Baldridge-like metrics. The assessment will be reported annually to Ascension Health Ministries, the canonical Sponsor of AHCN.

In furtherance of its commitment to maintain the Catholic Identity of the hospitals it acquires, AHCN has created a Congregation Advisory Council AHCN has established the AHCN Congregational Advisory Council ("CAC") to serve as an advisory body to Ascension Health as Ascension Health carries out its duties and responsibilities to oversee and maintain the Catholic Identity of Catholic hospitals owned by AHCN. Among its responsibilities, the CAC will provide advice and counsel to Ascension Health, in its role as manager of AHCN, on the implementation of Catholic Identity elements within AHCN Hospitals and on the integrated and comprehensive approach used to sustain and express Catholic Identity. The CAC will also be responsible for preparing an annual report on the "State of Catholic Identity within AHCN," which report will be presented to the Board of Directors of AHCN at its annual meeting.

The CAC will also be responsible for:

A. Reviewing and monitoring the progress of AHCN toward

achieving Catholic Identity Matrix objectives through established programs.

B. Making appropriate recommendations for creating and maintaining a positive organizational culture for AHCN consistent with Catholic Social Teaching.

C. Reviewing and providing advice, counsel and planning assistance to efforts throughout AHCN to promote a Mission-focused, values based organization.

D. Reviewing the overall performance of AHCN in developing and implementing the elements of Catholic Identity.

CAC council members will include religious women and men who have served as historical canonical sponsors of Catholic hospitals acquired by AHCN. The CAC will meet on a regular basis but no less frequently than once each quarter. CAC members will receive an annual stipend for their participation on the CAC.

Please return to Sister Melanie DiPietro, S.C., J.D., J.C.D., Director, Center for Religiously Affiliated Non-Profit Corporations, Seton Hall University School of Law, One Newark Center, Newark, NJ 07102-5210;
Melanie.dipietro@shu.edu

Vanguard Health Systems

1. ***Name of For-Profit Model:***
   Vanguard Health Systems
2. ***What is the City, State or Region in which the model has hospital(s):***
   Worcester, MA
3. ***Website Address:***
   http://www.vanguardhealth.com
4. ***Does the model include:***
   a. ***A Parent Holding Company?*** Yes
      If yes, what is the name and date incorporated?
      Vanguard Health Systems, Inc. - 1997
   b. ***An Acquired Hospital(s)?*** Yes
      If yes, what is the name and date incorporated?
      Saint Vincent Hospital at Worcester Medical Center
      Incorporated - 1898
      Acquired - December 31, 2004
      In 2000, Saint Vincent Hospital moved to the new facility at Worcester Medical Center
   c. ***Other for-profit hospital(s)?***
      Yes
5. ***Are there other affiliated entities in the business enterprise of your model? (Please describe)***
   Yes, Vanguard owns a total of 28 hospitals in San Antonio, TX, Chicago, IL, Detroit, MI, Phoenix, AZ and Boston, MA, as well as health plans and various ambulatory facilities in our markets.
6. ***Briefly describe the legal structure of the entities described in questions 4 and 5.***
   All 100% owned facilities are wholly-owned subsidiaries. Two facilities are joint ventured facilities
7. ***Briefly describe the relationship between equity owners and the owned entities in your model.***
   The equity owners are equity owners in the Parent Company only. The hospital is a wholly-owned subsidiary of the Parent Company, which is the extent of the relationship between any equity owners and the owned entities.
8. ***Do you have a management agreement with any entity described in question 4?***
   No

Corporate Structure

1. ***Does the legal purpose in the organizational documents of the following entities include the identification as "Catholic"?***
   a. ***Parent Holding Company*** No
   b. ***Acquired Hospital***
      Yes, the organizational document (viz. The Catholic Covenant) includes the designation Catholic. This constitutes the stewardship/sponsorship agreement between the Roman Catholic Bishop of Worcester a corporation sole and the ownership of Saint Vincent Hospital, Worcester.
   c. ***Other affiliated entity*** No
2. ***Does the legal purpose in the organizational document of the Acquired Hospital include the statement that the hospital operates in accordance with the teachings of the Roman Catholic Church and its Ethical and Religious Directives for Catholic Health Services (ERDs)?***
   Yes
3. ***Where is the decisional board with fiduciary duties to the Acquired Hospital located? In the parent holding company or in the Acquired Hospital?***
   The parent holding company
   a. ***Is a Catholic party with legally enforceable rights in regard to Catholic identity a voting member of this fiduciary board?***
      No
   b. ***Does this board have a role in monitoring the implementation of the elements of Catholic identity?***
      No
      If so, please describe the monitoring process:
   c. ***What is the composition of this board?***
      CEO of Vanguard Health Systems and seven other board member representatives from the financial and health care industries
   d. ***Are these board members compensated?***
      Yes
4. ***Is there an advisory board to the fiduciary board?***
   Yes
   a. ***What is the composition of the advisory board? Please list, for example, Church representatives, health care professionals, members of the community, etc.***

The AC board of trustees has 16 members. Four are physicians, three are representatives of the Diocese of Worcester, eight are community leaders one is the CEO of the hospital.

b. ***Who appoints the members of the advisory board?***
A nominating committee recommends candidates to the advisory board which votes at its annual meeting for those they wish to serve on the board.

c. ***What is the function of this advisory board?***
The Advisory Board has responsibility for medical staff privileging and patient safety.

d. ***Are these board members compensated?***
No

Management

1. ***Is the Acquired Hospital managed by the owner?***
Yes
2. ***Is the Acquired Hospital managed by employees of the managed hospital?***
Yes
3. ***Who hires and evaluates the executive leadership of the Acquired Hospital?***
The parent company hires the CEO and evaluates his/her performance. The CEO hires those reporting to him/her and is responsible for evaluating their performance.
4. ***Is the Acquired Hospital managed through a management contract with a non-affiliated or affiliated entity in your model?***
No
   a. ***Who is the contracted manager?*** N/A
   b. ***Who are the parties to the management contract?*** N/A
   c. ***Are the executive leadership and/or staff members of the Acquired Hospital employees of the Acquired Hospital or of the management company?*** N/A
   d. ***Does the party with the legally enforceable rights in regard to Catholic identity have any legal rights in the management agreement?*** N/A

Catholic Identity and Stewardship/Sponsorship

1. ***Is there is a stewardship/sponsorship agreement?***
Yes

If there is both a stewardship/sponsorship agreement and a management contract, how do they differ? (Stewardship agreement in this context means the agreement that sets forth the obligations of the "elements of Catholic identity.")

N/A

2. ***Describe the legal rights/remedies of the parties in the stewardship agreement.***
   - The RCB of Worcester has the right to be a member and trustee in his civil individual as opposed to his corporate capacity. In addition, the President of the Sisters of Providence of Holyoke, a successor congregation or if the Sisters abrogate their right to a seat (which they have), the Bishop may appoint a second member to the board and he controls three (3) seats on the hospital's community board.
   - Oversight management committee to monitor and support compliance with the Ethical & Religious Directives for Catholic Health Care Services (ERD)
   - Board membership will be selected from nominees acceptable to the Bishop
   - "The business and affairs of SV. . ..shall continue to be managed and operated on a basis consistent and in accordance with the tenets and practices of the Roman Catholic Church"
   - The Bishop and he alone has the authority to interpret the ERDs which must be complied with in their entirety—both letter and spirit
   - The Department of Pastoral Care will be maintained and duly-appointed chapel safeguarded; members of the department must have the Bishop's approval. The chapel will be regarded as a "chapel of ease" for the use of the staff of SVH and other participants in the liturgical life of the Church

   Resolving disputes:
   - While at the time of the agreement, compliance with the ERDs was agreed upon, due to the evolving nature of medical practice and governmental policies "a process [is established] for the identification of conduct within such facilities which either of the parties may believe to be other than in accordance with the operational conduct described in Article III above"

- Proposed Changes or Additions in Medical Services with Moral Valences
    - Uncertain conduct requires written notification be given to the Bishop that describes the proposed conduct in detail listing no more than three persons with whom they will discuss the conduct with the Bishop's designee
    - Thirty days later, the Bishop's Determination will be given as to: (1) conduct may be performed without violating the agreement; (2) may not be performed indicating the reasons for such a refusal; or (3) requires further study to determine whether the conduct under consideration may be undertaken. In matters (2) and (3), the Bishop designates an equal number of persons with whom discussion must occur as SVH does.
    - This group must render a written report (viz. The Report) within sixty days of the Bishop's Determination and issued concurrently to both parties.
    - If the content of the written report determines the disputed conduct may occur, then SVH may undertake these medical practices.
    - Following receipt of The Report, however, if the Bishop determines such conduct incompatible with Article III, the conduct must not be undertaken. This will be communicated to SVH within thirty days after the request and will be marked the Final Determination. It will include a reasonably detailed explanation of why the conduct would be violating the agreement.
- Word-of-mouth Information of Conduct under consideration or being performed at SVH the Bishop believes violates the articles of agreement requires him to notify SVH in writing entitled the Bishop's Notification which describes the conduct in reasonable detail and designates the person(s) the Bishop wants SVH to discuss the matter with.
    - Thirty days after receipt of the Bishop's Notification, SVH will respond in writing indicating (1) Disputed conduct violates Article III and will either cease or not be undertaken; (2) does not violate the

article and why; or (3) requires further study to determine whether it does or not. The hospital will designate the person(s) with whom discussion is needed, along with an equal number appointed by the Bishop

- ◦ If matters reach two or three, good faith discussion will take place to determine whether or not the conduct may continue. Within sixty days, the Report is completed whether or not the conduct does violate the covenant and issued concurrently.
- ◦ The Bishop will issue the Final Report within thirty days determining whether or not the conduct violates the mission.

- If the Bishop's Final Determination is that the proposed conduct (or omission) violates the agreement, such conduct will not be performed at SVH. In the event the hospital, after the Final Determination that it violates the agreement, will still be performed, "prior to so doing it shall ceased doing business under and refrain from all future use of the name and style of "Saint Vincent" and will apply to all entities and facilities.
  - ◦ If after undergoing the process agreed upon and, after having issued the Final Determination, declaring such conduct incompatible with the moral mission of SVH and in the event the Bishop "believes such conduct is imminent, he may in his absolute sole discretion withdraw the designation of Catholicity from SVH. . .by giving written notice of such withdrawal to SVH. . . which withdrawal will be effective immediately
  - ◦ Within no more than six months, the hospital will cease doing business under the name and refrain from future use of the name SVH. The disputed conduct will only be undertaken or omitted until such cessation has occurred. The hospital and its related organizations will "refrain from holding themselves out as a Catholic institution". The hospital will notify the Bishop of the effective date of the cessation. All membership, policy making rights and operational conduct requirements, along with the

Process and Dispute Resolution process would be terminated.

- ◦ Costs incurred in the pursuit of agreement will be assessed and paid for by the facility at which the disputed conduct took place or was omitted.

- Catholicity disputes are mutually agreed upon to be ill-suited for civil courts of law and the resolution process is the exclusive manner by which those issues should be resolved.
- This does not preclude a court of competent jurisdiction from assisting one party from obtaining performance by the other party of Article IV (par 1-3) of questionable practices when the Bishop has determined such action to be a violation of the moral mission prior to cessation of the use of the name SVH. Breach of the ERDs that prohibit certain conduct would be the reason for immediate irreparable harm and, so, the Bishop may seek injunctive relief, without proving monetary loss to enforce the agreed-upon cessation of the name, before and after it has occurred.
  - ◦ Disputes between RCB of Worcester and owners of SVH will be confidential and no disclosure of dispute to a third-party while resolution is occurring.

3. ***Identify the elements of Catholic identity that are set forth in the legal documents of your model:***
   a. ***Does your model identify quantifiable benchmarks of performance of each element?***
      Yes
   b. ***Does your model incorporate the elements of Catholic identity into the strategic business/financial and executive leadership plan of the Acquired Hospital?***
      Yes
   c. ***Does your model identify who is responsible for assessing whether the elements of Catholic identity are observed and implemented in a way that is consistent with Catholic teaching?***
      An Oversight Committee is envisioned of 5-7 people, the majority members being appointed by the Bishop and the remainder from SVH administration. Committee's responsibilities include:
      - Education for committee members regarding the ERDs: their theological and ethical bases

- State standards, identify objective criteria
- Establish mechanism and systems controls to monitor compliance with the ERDs
- Notify the RCB of Worcester of areas of concern or disagreement
- Mark recommendations to the Bishop of Worcester
- Issue an annual report to the Bishop
- Design educational programs and processed to make Board, staff, Physicians and employees aware of the ERDs.

d. ***Is there a legal remedy for noncompliance with the elements of Catholic identity?***

Yes

How, when, and by whom can it be exercised?

- There is an internal dispute mechanism that is agreed upon to resolve disputes in regard to clinical practices that are inconsistent with the medico-moral practices of the Roman Catholic Church.
- Civil court action is eschewed, except in the in-between time when wherein the Bishop has withdrawn his endorsement of the facility as Catholic and the hospital must cease using the name and identifying itself as a Catholic facility.

4. ***How are the compensation incentives for the management of an Acquired Hospital aligned with the "elements of Catholic identity" defined in your model?***

Pillar goals for the organization include service, quality, employee engagement and community outreach. These pillars align with the Catholic Directives. Management receives incentive compensation for achieving/exceeding the metrics of the pillar goals.

5. ***Is Catholic identity used in the marketing materials of the model?***

Yes

If so, how?

The name of the entity is Saint Vincent Hospital, which on its own represents the affiliation with the Catholic Church. Brochures and patient information materials proudly promote the Catholic mission of the hospital.

6. ***Does the Acquired Hospital or the parent holding company have a relationship to a canonical entity in the Roman Catholic Church***

through the governance structure of either the Acquired Hospital or the parent holding company?

Yes, through the Hospital

7. ***Do you use the word "sponsor" in relation to the Catholic identity of the hospital in your marketing or public relations materials?***

   No

8. ***Does your model use the word "ministry" in relation to the delivery of health care?***

   No

   If so, in what sense is the word "ministry" used?

9. ***How does your model, in structuring the delivery of its services, balance profitability with community need?***

   Vanguard recognizes that health care is local to its hospitals and uses community health status to determine the medical and wellness needs of the community. To be recognized as a strong business citizen, Vanguard encourages its entities to be cognizant of community need and to help meet these without substantial impact on the profitability of the corporation. For example, maintaining some services that are not profitable is not uncommon within the hospital if the demand in the community requires consideration for operating. At this entity, an example of such a service would be the inpatient psychiatric service.

10. ***How does your model provide for the identification of community need?***

    Through its Advisory Board, community health status research, and government or payer data

11. ***How does your model specifically address the core elements of the U.S. Conference of Catholic Bishops' Ethical and Religious Directives for Catholic Health Care Services in the development of its business and clinical practices and the selection and formation of the executive leadership of the corporation that has the governance and management control of the Acquired Hospital? Please address each Part of ERDs specifically.***

    a. ***Part One (Social Responsibility)***

       - St. Vincent Hospital has a Health for Life Community Benefits Program

    b. ***Part Two (Pastoral and Spiritual Responsibility of Catholic Healthcare)***

       - In keeping with the Catholicity Covenant, SVH

wholeheartedly supports the Department of Pastoral Care: three (3) priest-chaplains, two (2) Sister-chaplains, and Clinical Pastoral Education (CPE) with an ACPE-endorsed supervisor

- The Bishop of Worcester has direct oversight of the department and the appointment of Catholic clergymen (priests and/or deacons), especially the Director of Pastoral Care, require his approval and endorsement
- Duly consecrated chapel, placed under the patronage of Our Lady of Providence, is staffed and maintains a full liturgical schedule

c. ***Part Three (The Professional-Patient Relationship)***

- Mission – Vision – Values Statements highlight the core values of dignity and reverence, cooperation, respect, trust, honesty, and heritage.
- Patient-Centered Care Team established to zero in on the personal and individualized aspects of care

d. ***Part Four (Issues in Care for the Beginning of Life)***

- Center for Women and Infants is a recognized department providing ob/gyn services:
    - No direct sterilization whether male or female
    - No direct abortion
    - CWI delivers 2000 infants annually
    - Childbirth Education Programs
- SVH Family Assistance Program at Pernet Health in Worcester: To help ensure proper prenatal care for underserved populations

e. ***Part Five (Issues in Care for the Seriously Ill and Dying)***

- Palliative Care Consult Team to properly care for end-of-life patients and to provide pain management
- Schwartz Rounds often cover the non-clinical elements of end-of-life care
- SVH Ethics Committee

f. ***Part Six (Forming New Partnerships with Healthcare Organizations and Providers)***

- St. Vincent and Vanguard Health Systems have continued to act as a responsible corporate citizen both

during the initial transaction and for the more than seven years following the transaction.

12. ***Please include any additional information about your model that you think is relevant to the Symposium topic and that has not been included in the above questions. All answers to the questions must be limited to seven pages.***

Please return to Sister Melanie DiPietro, S.C., J.D., J.C.D., Director, Center for Religiously Affiliated Non-Profit Corporations, Seton Hall University School of Law, One Newark Center, Newark, NJ 07102-5210; Melanie.dipietro@shu.edu

Ardent Health Services

Presentation Questions for Representatives of Each For-Profit Model

Introductory Information

1) **Name of For-Profit Model**
What is the City, State or Region in which the model has hospital(s)?
Model proposed; not operational
2) **Website Address:**
Since only a "proposed" model, no website has been developed. However, you can review the Ardent Health Services' website at http://www.ardenthealth.com.
3) **Does the model include:**
   a. A Parent Holding Company?
   Yes—Proposed model not yet incorporated.
   b. An Acquired Hospital(s)?
   Yes—Proposed model not yet incorporated.
   c. Other for-profit hospital(s)?
   Yes
4) **Are there other affiliated entities in the business enterprise of your model?**
Since this is a proposed model, actual entities utilized will depend on the market needs. The proposed model has:
   a. Equity infusion from Private Equity provider—either directly or through Ardent.
   b. A for-profit and not-for-profit forming Newco, a Catholic for Profit entity.
   c. Ownership in Newco would depend on value contributed or could be a 100% sale.
5) **Briefly describe the legal structure of the entities described in questions 4 and 5.**
Closely-held corporation.
6) **Briefly describe the relationship between equity owners and the owned entities in your model.**
Equity owners would be shareholders who would have to acknowledge and consent to the operation of the organization as a Catholic entity and agree to follow the Catholic purposes of the organization as a fiduciary duty.

7) **Do you have a management agreement with any entity described in question 4?**
   Yes—There would be a management agreement, but the Catholic partner would have input on executive selection and retention of senior management of the operating entities.

<u>**Corporate Structure**</u>

1) **Does the legal purpose in the organizational documents of the following entities include the identification as "Catholic?"**
   a. Parent Holding Company—Yes—as in the proposed model
   b. Acquired Hospital—Yes
   c. Other affiliated entity—Yes
2) **Does the legal purpose in the organizational document of the Acquired Hospital include the statement that the hospital operates in accordance with the teachings of the Roman Catholic Church and its Ethical and Religious Directives for Catholic Health Services (ERDs)?**
   Yes
3) **Where is the decisional board with fiduciary duties to the Acquired Hospital located?**
   In the parent holding company or in the Acquired Hospital?
   In the Newco Parent
   a. Is a Catholic party with legally enforceable rights in regard to Catholic identity a voting member of this fiduciary board? Yes
   b. Does this board have a role in monitoring the implementation of the elements of Catholic identity? If so, please describe the monitoring process.
      Yes
      1. The corporate purposes will contain language designating the organization as Catholic and all Board members will have fiduciary duty to follow purposes.
      2. There will be a monitoring committee made up of board members, senior management, and outside experts who will review operations for compliance.
      3. There will be an Ethics Committee to monitor procedures performed at Newco and related entities.
      4. The composition of these Committees will be approved by Catholic partner and will have ex-officio places for canonical stewards.

5. Committees will report findings to board, Catholic partner and the local Bishop.

c. What is the composition of this board?
See above—items 2 and 4.

d. Are these board members compensated? No

4) **Is there an advisory board to the fiduciary board?** No.
Since the Newco board members have fiduciary duties, to maintain the Catholic identity of Newco, and there is a monitoring mechanism established, there is no need for an Advisory Board. Open to discussion of the establishment of an Advisory Board if merited.

a. What is the composition of the advisory board? Please list, for example, Church representatives, health care professionals, members of the community, etc.
b. Who appoints the members of the advisory board?
c. What is the function of this advisory board?
d. Are these board members compensated?

Management

1) **Is the Acquired Hospital managed by the owner?** Yes
2) **Is the Acquired Hospital managed by employees of the managed hospital?**
Yes, as Newco employees.
3) **Who hires and evaluates the executive leadership of the Acquired Hospital?**
Executive team selected and changed with input from Catholic Partner; other evaluations done in accordance with policy depending on level of employee. For example, the CEO of the local Catholic hospital would be evaluated by local board, Newco board, and senior executives of the management company.
4) **Is the Acquired Hospital managed through a management contract with a non-affiliated or affiliated entity in your model?** Affiliated

a) Who is the contracted manager?
Ardent Health Services
b) Who are the parties to the management contract?
Ardent Health Services and Newco
c) Are the executive leadership and/or staff members of the

Acquired Hospital employees of the Acquired Hospital or of the management company? Acquired Hospital

d) Does the party with the legally enforceable rights in regard to Catholic identity have any legal rights in the management agreement?
There would be legally enforceable rights regarding Catholic identify relating to management selection and retention; also in the contract between Newco and the Special Purpose Vehicle relating to employment if that model was chosen by the Catholic partner.

Catholic Identity and Stewardship/Sponsorship

1) **Is there a stewardship/sponsorship agreement?** Yes
If there is both a stewardship/sponsorship agreement and a management contract, how do they differ? (Stewardship agreement in this context means the agreement that sets forth obligations of the "elements of Catholic identity.")
Stewardship or Catholic identity requirements would be in the organic documents of Newco and all contracts with entities controlled by Ardent, which are providing services to or with Newco.
Depending on the circumstances, there also could be a Sponsorship Agreement that would be in situations where there is an independent hospital with a Sponsoring Congregation or a System that wants to assume that role. The Sponsorship Agreement would give standing to the Catholic partner to enforce provisions, but also would provide an opportunity for services to be rendered to Newco in Mission Effectiveness, Ethics Committee roles, Chaplaincy positions and education of Board and employees in relevant topics of interest to Catholic health care.
2) **Describe the legal rights/remedies of the parties in the stewardship agreement.**
There would be a right/obligation to monitor activities and to provide positive input into the operations of Newco.
Any breach by Newco or Ardent would be subject to a cure period (absent a dramatic scandal causing event) and assuming no cure provided there would be penalties and remedies, which could result in a wind up of the organization and/or a loss of Catholic identity.

3) **Identity the elements of Catholic identity that are set forth in the legal documents of your model.**
   a. Does your model identify quantifiable benchmarks of performance of each element? Yes
   b. Does your model incorporate the elements of Catholic identity into the strategic business/financial and executive leadership plan of the Acquired Hospital? Yes
   c. Does your model identify who is responsible for assessing whether the elements of Catholic identity are observed and implemented in a way that is consistent with Catholic teaching? Yes
   d. Is there a legal remedy for noncompliance with the elements of Catholic identify? Yes

   See introductory paragraph to answer this question.

4) **How are the compensation incentives for the management of an Acquired Hospital aligned with the "elements of Catholic identity" defined in your model?**

   The employees will be compensated on performance criteria which will include compliance and promotion of the Catholic identity of Newco.

5) **Is Catholic identity used in the marketing materials of this model?** Yes

   It is anticipated that the Catholic identity would be part of the marketing materials in a way that accurately portrays the status and nature of the Catholic relationship.

6) **Does the Acquired Hospital or the parent holding company have a relationship to a canonical entity in the Roman Catholic Church through the governance structure of either the Acquired Hospital or the parent holding company?** Yes

7) **Do you use the word "sponsor" in relation to the Catholic identity of the hospital in your marketing or public relations materials?** Yes (as proposed)

8) **Does your model use the word "ministry" in relation to the delivery of health care? If so, in what sense is the word "ministry" used?** See Below:

   It would be used in the context of the Catholic nature of the organization and the fact that it would be a ministry of the Church, but it would not be used beyond those aspects. It is anticipated that the Mission Statement and employee materi-

als would properly describe that nature of the hospital operations.

9) **How does your model, in structuring the delivery of its services, balance profitability with community need?**

Before entering into a transaction, an analysis of the community need and charity care would be taken into account. Ardent would then commit to providing at least the same level of charity care and the same percentage of resources assigned to meet community needs. It would be anticipated that with the input of a Catholic partner, new needs would be identified and services adjusted to meet those needs.

10) **How does your model provide for the identification of community need?**

At present, Ardent does have a process for identifying community need. It would adapt and adopt improved methods of determining community needs through its relationship with the Catholic partner.

11) **How does your model specifically address the core elements of the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* in the development of its business and clinical practices and the selection and formation of the executive leadership of the corporation that has the governance and management control of the Acquired Hospital? Please address each part of ERDs specifically:**

a. Part One (Social Responsibility)

The Corporate Purposes and Mission and Values Statement will adopt the principles of Part One. As a result of that action, the various aspects of the Hospital's operations and employment practices will be guided by those principles. More specifically, Newco will have:

i. Employment Policies and Practices that will stress non-discrimination, respect, justice and adherence to the teaching of the Church. This will extend to all employees including executives and clinical staff.

ii. There will be a commitment to the community outreach and charity care to reach the most vulnerable and needy in its service area

iii. Executives, Board, employees will have education sessions relating to CST and ERDs

iv. Employees, including executives, will have to be evaluated on how well they carry out the Mission that will include the expository and proscriptive aspects of the ERDs.

b. Part Two (Pastoral and Spiritual Responsibility of Catholic Healthcare)

The Ardent Model provides for a Mission Effectiveness Vice President as part of the Executive team of the Hospital. The Mission Effectiveness office will be fully funded.

The Newco hospital will have a robust Pastoral Care Department that will be operated in accordance with the Directives. It is expected that any Catholic clergy would serve with the approval of the local Bishop and coordinate with the patient's parish to provide spiritual support after discharge.

Catholic liturgy will be celebrated in a consecrated Chapel in the Hospital and televised to patients unable to attend.

The Monitoring Committee will review adherence to these requirements and its findings regularly reported to senior management, the Board, the Catholic partner, and to the local Bishop.

Adequate provision of these services will be one of the elements in the evaluation of the responsible executives.

Spiritual support and assistance to employees and clinical staff will be made available through these offices.

c. Part Three (The Professional-Patient Relationship)

The values described in Part Three of the Directives will be incorporated into the Purposes, Mission Statement and Policies of Newco. Ardent prides itself on promoting an atmosphere where the patient is treated with dignity and the patient-doctor relationship is respected. Ardent would work with a Catholic partner to create a corporate culture to provide its clinical services in accordance with the ERDs. Newco will have proper informed consent and Advanced Directives processes in place that are in conformity with the ERDs.

In addition, there will be a properly constituted Ethics Committee to assist with decision-making. The actions of the Ethics Committee would be subject to the review and reporting requirements of the Monitoring Committee.

d. Part Four (Issues in Care for the Beginning of Life)

In designing its Model, Ardent has been mindful and respectful of the services that violate the ERDs. Newco will offer none of the proscribed services.

As a way of assuring compliance with the ERDs, the Ardent Model has in place an Ethics Committee to deal with the issues as they arise and a Monitoring Committee to review completed activities. In both situations, the Catholic partner controls the composition of the Committees and Reports go to Catholic partner and other Church authorities.

In addition, Ardent proposes educational sessions for clinical and executive personnel so that there is a proper understanding and appreciation of the scope of proscribed services and the rationale for their prohibition.

e. Part Five (Issues in Care for the Seriously Ill and Dying)

In the Ardent Model, all the ERDs would be fully adopted and followed in Newco. This is facilitated by the incorporation of the principles in the Corporate Purposes, Mission and Values Statement and operating policies. This is especially important when dealing with the issues of seriously ill and dying. It is important that a culture by established and promoted which affirmatively supports the seriously ill patient and his/her family.

Ardent would require Newco to incorporate the principles in developing clinical policies and make certain adequate budget is allocated to those activities. The Mission Effectiveness VP would participate in all budgetary meetings. The Board, made up of Ardent and Catholic partner members, would approve the budget.

Compliance with the Directives would be supported by the Ethics Committee and reviewed by the Monitoring Committee.

Executives would be evaluated on the culture they create and compliance with the ERDs.

f. Part Six (Forming New Partnerships with Healthcare Organizations and Providers)

Before entering into any type of relationship with any facility, Ardent has a preferred process whereby each organization will conduct an internal analysis to determine the strategic goals and benefits prior to exploring a joint ar-

rangement. An essential part of that process is the benefit to the local community.

Once it is determined that there can be an alignment of the goals of the two organizations, a joint process to design a model to meet the parties' needs is undertaken. Once a preliminary model is designed, a review by Church experts in various fields would determine whether or not the proposed model is a viable solution for the Catholic partner.

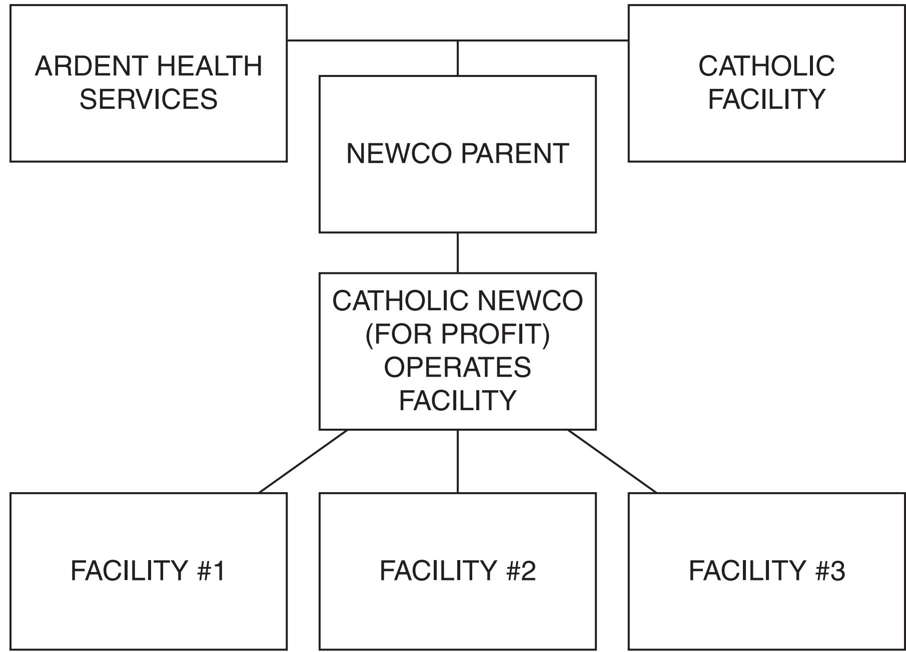
Ardent's Model assumes that the above process has been followed and there has been approval of the arrangement by the Catholic partner and appropriate Church authorities.

The proposed Ardent Model is designed to respect and continue the Catholic identity and purpose in an authentic manner. With the existence of various committees such as the Monitoring Committee, a mechanism is established to assure compliance and avoid problems or scandal. In the event there is a scandalous situation there are built in safeguards and escape provisions.

Future partnering of Newco would be subject to the approval of the Catholic partner.

12. **Please include any additional information about your model that you think is relevant to the Symposium topic and that has not been included in the above questions. All answers to the questions must be limited to seven pages.**

    Please see attached Model diagram and Narrative.


ARDENT HEALTH SERVICES
CATHOLIC FACILITY
NEWCO PARENT
CATHOLIC NEWCO (FOR PROFIT) OPERATES FACILITY
FACILITY #1
FACILITY #2
FACILITY #3

ARDENT'S CATHOLIC EQUITY MODEL NARRATIVE

1) **Assumptions:**
   a) A positive result from the internal and joint analysis aspect of the Process described in today's Presentation
   b) Relevant portions of the Patient Protection and Care Act ruled valid by Supreme Court
2) **Description of Model's characteristics:**
   a) Ardent and Catholic Partner form a new Catholic for-profit organization (Newco)
      i) Ownership interests determined by value of each party's contribution
      ii) Board representation reflects ownership interest
      iii) Newco's corporate purposes include provisions that:
         (1) It will be an officially recognized Catholic organization which will follow ERDs and CSTs relating to Healthcare
         (2) Every Shareholder and Director explicitly acknowledge Newco's Catholic nature and identity and their fiduciary duty to operate in accordance with that identity
         (3) Without regard to ownership interest, Catholic partner will have Shareholder rights to control the Catholic aspects of the organization
   b) Welsh Carson Anderson & Stowe (WCAS) and/or Ardent will provide equity either through Ardent or directly to Newco
      i) WCAS and/or Ardent will acknowledge the Catholic nature of Newco and will agree to participate or not participate on that bases
      ii) WCAS and/or Ardent will commit to certain amount of equity infusion and its terms and conditions prior to close of deal with Catholic partner
   c) Agreements and Corporate Documents will have provisions relating to Catholic identity including:
      i) Monitoring Committee with requirements to cure breaches
      ii) Reporting mechanism to Catholic System (if applicable), Sponsor and local Bishop

iii) Fully funded Mission Effectiveness VP Office and Chaplaincy program
iv) Ethics Committee
v) Education on Catholic issues for Board and senior Management
vi) Participation in CHA and local Catholic Health organizations if eligible
vii) Will have a commitment for charity care

d) Ardent will manage Newco with input from Catholic partner on senior executive selection and retention

e) No set exit date but a minimum time period when exit not permitted

f) Operational and financial performance criteria and remedies for non performance similar to existing tax exempt Bond industry covenants

g) Annual review of the operations of Newco with a special emphasis on the Catholic issues to see how to enhance the Catholic aspects of the organization.

Biographies

KATHLEEN M. BOOZANG, J.D., LL.M.
Professor of Law, Associate Dean for Academic Advancement and *Director,* Center for Religiously Affiliated Nonprofit Corporations, Seton Hall Law School

In addition to her university and law school administrative positions, Professor Boozang teaches Health Law, The Law of Death and Dying, and Pharmaceutical and Medical Device Marketing and Compliance. She founded the Seton Hall Law Center for Health & Pharmaceutical Law & Policy and its Healthcare Compliance Certification Programs. She serves on the Board of Directors of the American Health Lawyers Association and is a Fellow to The Hastings Center, an independent nonprofit bioethics research institute, as well as a Fellow to the American Bar Foundation. Professor Boozang is also a member of the American Law Institute and participates on the consultant group for the Principles of Nonprofit Law.

LEO P. BRIDEAU, FACHE
President and *Chief Executive Officer,* Ascension Health Care Network

Leo Brideau leads Ascension Health Care Network, a joint venture of Ascension Health, the nation's largest Catholic health system and Oak Hill Capital Partners, a prominent private equity firm. Prior to joining Ascension Health Care Network, Mr. Brideau was President and Chief Executive Officer of Columbia St. Mary's, Milwaukee, and served as the Ministry Market Leader for Ascension Health, responsible for its health care ministries in Wisconsin and Missouri. Before joining Ascension Health, Mr. Brideau served for 21 years at the University of Rochester Medical Center in various positions, including President of Strong Health Regional Network and as General Director and Chief Executive Officer of Strong Memorial Hospital, and was an Assistant Professor in the University of Rochester School of Medicine and Dentistry. Mr. Brideau has served on numerous national and state level boards and commissions. He chaired the American Hospital Association Payment Reform Task Force as well as the Wisconsin Hospital Association Health Reform Task Force. He also has served as a member of the Board of Trustees of the American Hospital Association, serving on

its Executive Committee and as a member of the AHA Commission on Workforce for Hospitals and Health Systems.

ANGELA CARMELLA, M.T.S., J.D.

John Courtney Murray Professor of Law, Seton Hall Law School

Having both a law degree and a master's in theological studies, Professor Carmella is a nationally recognized scholar in church-state issues with a particular regard for the intersection of religion and property. In addition to her teaching and groundbreaking scholarship, she has participated in numerous professional and scholarly conferences on the Religion Clauses of the First Amendment and their impact in the 21st century, including health/family issues, religiously affiliated corporations, and the complex issues that arise when religious institutions file for bankruptcy. Her publications include *Responsible Freedom under the Religion Clauses: Exemptions, Legal Pluralism and the Common Good*; *Religion as Public Resource*; and *Constitutional Arguments in Church Bankruptcies: Why Judicial Discourse About Religion Matters.*

DAVID M. CYGANOWSKI, M.B.A.

Managing Director, Kaufman Hall & Associates

As Managing Director of Kaufman Hall & Associates, a leading advisor to hospitals and health systems, Mr. Cyganowski is recognized as one of the nation's leading health care professionals. With nearly 30 years of senior experience in health care, Mr. Cyganowski brings specific expertise in both capital finance, and mergers and acquisitions. Previously, Mr. Cyganowski was the Managing Director and Co-Head of the Health Care Group at Citigroup Global Markets, with responsibility for working with nonprofit hospitals, health care systems and managed care organizations across the country. Prior to joining Citi, he managed the health care practice at Credit Suisse First Boston. Mr. Cyganowski has served as senior banker for mergers and acquisitions with an aggregate value of $15 billion and more than $35 billion of debt financings. He led the Citi team that represented eight nonprofit health care systems in their successful acquisition of 21 hospitals from Columbia/HCA for $1.2 billion, the largest-ever acquisition of assets by nonprofit entities.

SISTER MELANIE DI PIETRO, S.C., J.D., J.C.D.
Distinguished Practitioner-in-Residence, and *Director*, Center for Religiously Affiliated Nonprofit Corporations, Seton Hall Law School

Sister Melanie DiPietro is the Founding Director of Seton Hall Law's Center for Religiously Affiliated Nonprofit Corporations. Both a civil and canon lawyer, Sister Melanie's legal practice focused on the representation of religiously affiliated corporations in governance, transactional and litigation matters. In particular, Sister Melanie focused on joint ventures between Catholic and non-Catholic health care organizations. She is an elected member of the American Law Institute and serves on the consultant group for Principles of Nonprofit Governance. She currently serves as Special Legal Advisor & Counsel to Catholic Charities USA and is on the legal commission of Caritas Internationalis, Rome.

TIMOTHY P. GLYNN, J.D.
Miriam T. Rooney Professor of Law, Seton Hall Law School

Professor Glynn is one of the nation's foremost experts on employment law. In addition to teaching Business Associations, Employment Law and Comparative Corporate Law, Professor Glynn is an editor of WHITE ON NEW YORK CORPORATIONS and co-author of EMPLOYMENT LAW: PRIVATE ORDERING AND ITS LIMITATIONS, one of the top employment law case books for students. His recent scholarship focuses on the allocation of responsibility and decision-making authority within the corporation as well as the impact of choice-of-law doctrine and inter-jurisdictional competition on different corporate stakeholders. Thus, from a variety of perspectives, he addresses how prevailing legal norms in the corporate context affect not only shareholders and managers, but also employees, creditors, counsel and society.

SISTER DORIS GOTTEMOELLER, R.S.M., M.A., Ph.D.
Senior Vice President, Mission and Values Integration, Catholic Health Partners

Sister Doris Gottemoeller is the Senior Vice President for Mission and Values Integration at Catholic Health Partners, a multi-sponsored health care system headquartered in Cincinnati. A member of the Institute of the Sisters of Mercy of the Americas, she has lectured throughout the world on topics of ministry, ecclesiology

and religious life, and served in congregational leadership and on numerous health care and social service boards. She was the first president of the Sisters of Mercy of the Americas (1991-1999), a delegate to the International Union of Superiors General, and an auditor at the Synod on Consecrated Life convened by Pope John Paul II. She is a member of the steering committee for the Catholic Common Ground Initiative and of the Regional Council of the Christian Brothers Association for Mission. She chaired the boards of the Catholic Health Association and Sisters of Charity of Leavenworth Health System.

THOMAS (TIM) GREANEY, J.D.
Chester A. Myers Professor of Law and *Co-Director,* Center for Health Law Studies, St. Louis University School of Law

Professor Greaney is a nationally recognized expert in Health Law, Nonprofit Organizations and Antitrust Law who has spent the last two decades examining the evolution of the health care industry – and calling for reform. His extensive body of scholarly writing encompasses articles published in some of the country's most prestigious legal and health policy journals and includes articles such as *Antitrust and Hospital Mergers: Does the Nonprofit Form Affect the Competitive Substance?*; *Governance and Quality of Care in Nonprofit Hospitals Mission*; and *Margin and Trust in the Nonprofit Healthcare Enterprise* (with Kathleen Boozang). Professor Greaney has also authored or co-authored several books, including the leading health care law casebook, HEALTH LAW. He regularly teaches Health Law, Nonprofit Organizations and Antitrust and was named Health Law Teacher of the Year by the American Society of Law, Medicine and Ethics in 2007.

SISTER SHARON HOLLAND, IHM, J.C.D.
Department Head (Ret.), Congregation for Institutes of Consecrated Life and Societies of Apostolic Life

A member of the Sisters, Servants of the Immaculate Heart of Mary, Sister Sharon Holland, a canon lawyer, worked on the staff of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life at the Vatican from 1988 until 2009. After returning from Rome, she has continued to teach and serves as a consultant to religious congregations and their sponsored ministries in health care and education. She has published more than 30

articles, including two that appeared in THE CODE OF CANON LAW: A TEXT AND COMMENTARY. More recent publications examine the potential of the public juridic person as a canonical structure for the future of some systems of Catholic health care.

JOHN V. JACOBI, J.D.
Dorothea Dix Professor of Health Law & Policy and *Faculty Director*, Center for Health & Pharmaceutical Law & Policy, Seton Hall Law School

Professor Jacobi has been involved in health law, policy and practice from the private, academic and government sectors for decades. He is Faculty Director of Seton Hall Law School's Center for Health & Pharmaceutical Law & Policy and serves on the Board of the Greater Newark Healthcare Coalition and the North Jersey Community Research Initiative. Prior to joining the faculty at Seton Hall Law, where he teaches Health Law, Health Law Finance, Health Care Fraud and Abuse, and Mental Health Law, Professor Jacobi practiced with the New Jersey Office of the Public Advocate and held the Gibbons Fellowship in Public Interest and Constitutional Law, where he advocated in areas of Medicaid reform, disability rights, and prison health care. He served as Counsel to the former Governor of New Jersey in matters of health, human services, child welfare and insurance. His current work concerns the implementation of reform to the health care finance and delivery systems, particularly as they affect underserved populations.

ADAM KATES, M.B.A., J.D.
Director, Fitch Ratings

Adam Kates is a Director in Fitch Ratings' health care group. He is responsible for analyzing and rating hospital and long-term care credits. His experience in health care includes investment banking, consulting and treasury services. Prior to joining Fitch in 2011, he was the Senior Director of Treasury at NorthShore University Health System, where he was responsible for managing the tax-exempt bond portfolio, short-term investments and commercial banking activities. Prior to NorthShore, Mr. Kates worked in the health care investment banking group at Merrill Lynch and in health care consulting. At Merrill Lynch, he was involved in over $1 billion in tax-exempt financings for not-for-profit hospitals. His

health care consulting experience includes strategic planning and fair market valuations of mergers, acquisitions and divestitures.

ROBERT G. KENNEDY, M.B.A., Ph.D.
Co-Director, Catholic Studies, Terrence J. Murphy Institute for Catholic Thought, Law and Public Policy, University of St. Thomas

Robert Kennedy is Professor of Catholic Studies and Co-Director of the Terrence J. Murphy Institute for Catholic Thought, Law and Public Policy at the University of St. Thomas in St. Paul, Minnesota. He also holds a joint appointment (as professor of Ethics and Business Law) in the Opus College of Business, where he has served as Chair of the Faculty. Professor Kennedy's research and publications explore issues in professional ethics, especially concerning business and the military, and also elements of the economic dimension of the Catholic social tradition. Recent works include *Pope John Paul II and Business Practice*; *Spirituality and the Christian Manager*; *Ethics, Courage and Self-Discipline*; and THE GOOD THAT BUSINESS DOES.

JAMES LEBUHN
Senior Director, Fitch Ratings

James LeBuhn is a Senior Director and head of the not-for-profit health care group in Fitch Ratings' public finance department. He is responsible for analyzing hospital and long-term care credits as well as managing the personnel, policies and procedures within the department. Mr. LeBuhn has experience in all aspects of health care finance. Prior to joining Fitch in March 2005, he worked in the health care investment banking group at Cain Brothers & Company in Chicago. He was involved in the structuring of debt financings for hospitals and continuing-care retirement facilities, including a $70 million start-up financing for a senior living facility in the Midwest. Prior to joining Cain Brothers, Mr. LeBuhn was an institutional salesman at Ziegler Capital Markets Group in Chicago. He was involved in the structuring and pricing of over $5 billion in new issue underwritings, including many lower investment grade and non-investment grade health care borrowers.

T. DEAN MAINES, M.S.
President, Veritas Institute of the Opus College of Business, University of St. Thomas

Dean Maines is the President of the Veritas Institute at the University of St. Thomas' Opus College of Business. Immediately prior to assuming this role, Mr. Maines served within the Opus College as the Research Associate to the Koch Chair in Business Ethics. Previously, he was the Chief Human Resource Executive for the Worldwide Power Generation Group at Cummins, Inc., and President of the Columbus Occupational Health Association, a Cummins managed partnership. Mr. Maines was a Sloan Fellow at Stanford University's Graduate School of Business, where he earned an M.S. in management. He has contributed articles on corporate ethics to the JOURNAL OF CORPORATE CITIZENSHIP, THE BUSINESS AND PROFESSIONAL ETHICS JOURNAL, HEALTH PROGRESS, the SAGE ENCYCLOPEDIA OF BUSINESS ETHICS AND SOCIETY, and the PALGRAVE HANDBOOK OF SPIRITUALITY AND BUSINESS.

MICHAEL J. NAUGHTON, M.B.A., Ph.D.
Director, John A. Ryan Institute for Catholic Social Thought and *Alan W. Moss Endowed Chair in Catholic Social Thought,* University of St. Thomas

Professor Naughton is the Director of the John A. Ryan Institute for Catholic Social Thought and holds the Alan W. Moss Endowed Chair in Catholic Social Thought at the University of St. Thomas. His scholarly focus is on the interdisciplinary engagement between Catholic social thought and business, and he has written extensively on the subject of faith and its role in business and business management. He co-authored the book MANAGING AS IF FAITH MATTERED: CHRISTIAN SOCIAL PRINCIPLES IN THE MODERN ORGANIZATION, and has written and edited numerous other articles and books on entrepreneurship, corporate management, and Catholic social tradition, including *Bridging the Gap: Catholic Health Care Organizations Need Concrete Ways to Connect Catholic Social Principles to Practice.* He received the National Outstanding Course Award from the United States Association for Small Business and Entrepreneurship for his course entitled "Christian Faith and the Management Professions: An Entrepreneurial Perspective."

MEGAN NEUBURGER, M.P.A.
Senior Director, Fitch Ratings

Megan Neuburger is a Senior Director in the corporate finance group at Fitch Ratings. Her responsibilities include the analysis and

ratings of companies in the health care sector, including for-profit health care providers; pharmaceutical, medical device and life science tools manufacturers; drug distributors; and pharmacy benefit managers. Ms. Neuburger previously spent four years in the U.S. public finance group at Fitch, focusing on tax-supported ratings for local governments throughout the Eastern seaboard of the United States. In addition to her work on tax-supported credits, she has experience in credit analysis in water and sewer, and other revenue-supported areas. Before joining Fitch, Ms. Neuburger worked at the Environmental Finance Center of Syracuse University.

KEITH B. PITTS
Vice Chairman, Vanguard Health Systems

Keith B. Pitts has served as Vice Chairman, Vanguard Health Systems since 1999. Prior to joining Vanguard, Mr. Pitts was the Chairman and Chief Executive Officer of Mariner Post-Acute Network and its predecessor, Paragon Health Network. His career includes serving as OrNda HealthCorp's Executive Vice President and Chief Financial Officer as well as more than 15 years as a consultant to health care organizations, most recently as a Partner in Ernst & Young's Healthcare Consulting practice. He has significant experience in the acute care and managed care sectors of the health care industry as well as the long-term care, physician practice management and specialty services sectors. Mr. Pitts' experience covers the functional areas of mergers and acquisitions, development, strategic planning, organizational development, operations, finance and information systems.

ARNOLD T. STENBERG, JR., C.P.A.
Executive Vice President and *Chief Administrative Officer,* All Children's Hospital & Health System

Arnold Stenberg joined All Children's Hospital & Health System in 2000 as its Senior Vice President and Chief Financial Officer. Prior to joining All Children's, Mr. Stenberg was a Divisional Chief Financial Officer for the largest proprietary health care company in the United States and a Regional Partner in Charge of Healthcare Services for Deloitte & Touche. Mr. Stenberg has over 30 years of health care consulting and management experience. In October 2008, Mr. Stenberg became the Executive Vice President and Chief

Administrative Officer of the Health System responsible for all clinical, finance and information technology services. Mr. Stenberg played a key role in establishing the relationship that led to All Children's becoming a member of Johns Hopkins Health System in April 2011.

DAVID T. VANDEWATER, M.S.
President and *Chief Executive Officer*, Ardent Health Services

As President and Chief Executive Officer, Mr. Vandewater brings more than 30 years of health care management expertise to Ardent Health Services. He joined the company as Chairman of Behavioral Health Corporation, Ardent's predecessor company, in February 2001. Later that year, he was appointed President and Chief Executive Officer and expanded the company's focus to include acute care hospitals and health care systems. Prior to joining Ardent, Mr. Vandewater served as President and Chief Operating Officer of Columbia/HCA Healthcare Corporation. Under his leadership, the company grew to become the world's largest health care organization, with $20 billion in annual revenues and more than 340 hospitals, 130 surgery centers and 550 home health locations in 38 states and two foreign countries. During his career, he has served in executive positions ranging from Chief Executive Officer of Vista Hills Medical Center in El Paso to Executive Vice President and Chief Operating Officer at Republic Health Corporation. Mr. Vandewater is Past Chairman of the Federation of American Hospitals, which represents investor-owned and managed community hospitals throughout the U.S.