

Truth or Consequences:

*Using Consumer
Protection Laws to Expose
Institutional Restrictions
on Reproductive and
Other Health Care*

The National Women's Law Center is a nonprofit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families, including health and reproductive rights, employment, education, and family economic security. Elena N. Cohen is Senior Counsel and Alison Sclater was a fellow at the Center when the report was written.

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by
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INTRODUCTION AND EXECUTIVE SUMMARY

Women are facing growing obstacles to receiving affordable, quality health care. One particularly significant barrier is created when health care providers restrict their services because of religious beliefs. Public opinion polls show that these restricted services are indeed important to women and that protecting people's health care needs is more important than protecting a health care entity's freedom to follow its religious beliefs. Nevertheless, hospitals, nursing homes, managed care companies, and insurers often refuse to provide or pay for services to which they have a religious objection.

The most significant bans are imposed through the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* ("the *Directives*"), which govern the delivery of care at Catholic health care institutions. An alarming trend that began in the 1990s has continued in the new millennium: as religious health care providers merge, purchase, or otherwise affiliate with secular ones, they impose religious restrictions on the health care services of their new partners. Nowhere are these limits more keenly felt than in the arena of women's reproductive health.

Despite the pervasiveness of these restrictions, many health care consumers do not know about them. Women's health suffers as a result, since women might have made more informed health care decisions had they known. For example, pregnant women who may want to have a tubal ligation during the same hospital stay as their delivery would not select an obstetrician who can only deliver at a hospital that prohibits that practice. Women who delivered at hospitals with such bans would face additional surgery at a later point and the attendant health risks and

additional financial costs that result.

Women in their reproductive years who want the option of contraception, infertility treatments, or abortion might select obstetricians and gynecologists who can provide care at hospitals without restrictions. They might select health insurance from a company that pays for services, regardless of the company's religious tenets. This choice could provide substantial savings for the consumer for needed services or could avoid the risk of having to forgo these services altogether because of the inability to pay for them. And sexual assault survivors need to know immediately whether they can get emergency contraception at the emergency room where they are taken, so that they can try to get the treatment elsewhere during the limited time period that emergency contraception effectively prevents pregnancy.

Over the years, the National Women's Law Center and others have used several legal tools to reduce the negative impact of institutional religious restrictions. The defense of health care consumers' rights has taken center stage in the national health care dialogue. Health care providers, government officials, and the public at large all have encouraged improved communication between the health care industry and its customers. Therefore, the time is ripe for advocates to add to their legal arsenal another potential tool: consumer protection laws.

The notice provisions contained in consumer protection laws allow health care consumers and their advocates to demand *truth* or *consequences*. Health care institutions that restrict services must warn consumers about the limitations in a clear, accurate, and timely way or face legal sanctions. Use of notice provisions in consumer protection laws to expose these religious bans is largely

Religious restrictions are widespread and have serious consequences for women's health—advocates can use consumer protection laws to fight back.

Federal and state disclosure rules can be used to expose limitations on services.

untested. Nevertheless, the extensive federal and state legal disclosure rules offer significant potential for exposing these bans.

A.

Consumer Protection Laws and How Advocates Can Use Them

This report first describes consumer notice requirements and then provides advocates with strategies for using them to help ensure that health care entities warn consumers about religious restrictions. The report describes four types of law that advocates should consult when mounting a challenge to an institution's lack of adequate notice. They include:

- provisions in federal and state “refusal clauses” (laws that allow health care providers to refuse to render care based on religious or moral objections) explicitly requiring health care institutions to disclose their use of such institutional religious restrictions;
- other notice requirements governing health care entities (federal Medicare and Medicaid rules, various state rules, and national accreditation standards);
- notice provisions contained in unfair and deceptive practice laws that concern any type of entity (not only health care entities), with particular emphasis on state laws, which generally offer greater protection than do the federal laws; and
- other legal protections that may be useful in specific circumstances. These include common law fraud or misrepresentation, nonprofit corporation law, charitable trust law, antitrust law, and tax law.

Advocates should evaluate each of these types of laws when seeking to challenge a particular notice practice. Each offers different protections, depending on the facts surrounding the transaction and the law in a particular state. Many states do not have all of the laws. Other states may have a specific law, but it may not cover the practice at issue. States also vary in the resources and effort devoted to enforcing these laws.

The types of laws themselves also have different benefits and disadvantages. For example, a hospital's failure to warn patients about a sterilization restriction might clearly violate the notice requirements in the state refusal clause, but it might be harder to show that the conduct violates the state unfair and deceptive practices law. However, if advocates successfully argue that the conduct is covered by the unfair and deceptive practices law, they may be able to seek stronger remedies under that law than under the refusal clause.

Armed with knowledge of these disclosure requirements, advocates can adopt several strategies to encourage entities with restrictions (or contemplating adopting restrictions) to relax the bans, decide not to adopt them, or provide appropriate notice. Advocates can use these tools to: negotiate directly with health care entities; report entities that are not complying with the laws to governmental and accrediting agencies; and bring (or help bring) lawsuits to require appropriate notice and other remedies. Advocates can argue that the refusal to expose restrictions not only makes bad medicine and bad community relations, but also possibly violates the law.

As a general matter, the agencies with the greatest legal authority to enforce the notice requirements are: state health or insurance departments, state attorney general offices, Medicare and Medicaid officials (at the national, regional, or state levels), and national private accrediting

entities (e.g., Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance).

Depending on the facts of the particular situation, other governmental agencies could also be useful. For example, the Federal Trade Commission could be useful if the offending entity is considered a for-profit. Governmental ombuds (consumer health assistance program) offices can also help resolve complaints, but in some states, they only exist for long-term care facilities or seniors. And federal, state, and local legislators may also be willing to put pressure on enforcement entities and the institutions, hold hearings on the issue, or propose stronger legal protections against religious restrictions.

Advocates can enlist other allies to complain directly to the health care facility or to the enforcement entities just described, and to publicize the problem. Depending on the particular law about which they are complaining and what remedies they are seeking, they also may be able to file lawsuits (either individually, or as part of a class action). These important allies may include (either individually or as a group): actual health care consumers (e.g., current or former patients), potential health care consumers (e.g., prospective patients or residents of the community), advocacy groups, donors to the facility, competing health care institutions, health care practitioners whose practices are limited by restrictions, and the press.

B.

The Structure of the Report

This report begins by examining the nature and scope of the problems created by the spread of religious restrictions and the public's unfamiliarity with them (Section I). Section II describes the four types of laws that can be used to warn consumers about institutional religious restrictions on health care. Section III discusses the strategies advocates can use to expose an institution's notice practices concerning its religious restrictions.

The report also includes a checklist to help advocates gather relevant information for a possible consumer protection challenge (Appendix A); a list of government agencies that enforce consumer protection laws (Appendix B); a sample letter alerting an enforcement agency of a possible violation of consumer protection laws (Appendix C); a list of possible allies to enlist in challenging notice practices (Appendix D); and a glossary of some terms as used in this report (Appendix E).

Advocates can work with a broad array of allies—state agencies, state attorney general offices, Medicare and Medicaid officials, accrediting bodies, and consumer groups.

SECTION I

The Problem:

Little-known Religious Restrictions Severely Reduce Access to Reproductive and Other Health Care Services

Certain sectarian health care institutions have long prohibited the provision of reproductive and other key health care services based on religious principles. These entities usually impose the bans on nonsectarian institutions that merge or otherwise affiliate with them. However, health care consumers often do not know about these limitations. This section describes the types of services that may be restricted, the trends causing the spread of these bans, and the public's unfamiliarity with the limitations.

A.

The Ethical and Religious Directives for Catholic Health Care Services and Other Similar Policies Limit the Availability of Health Care

Because of certain religious tenets, sectarian health care entities sometimes have special rules about the services they will provide. Catholic entities generally impose the most detailed and rigid limitations on the provision of women's reproductive and other health services. The U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* ("the Directives")

govern the delivery of care at Catholic health care institutions.¹ This report focuses on these restrictions because of their broad scope and the substantial nationwide role of the Catholic health care system. However, other sectarian entities limit health care services based on religious or moral beliefs as well.²

Catholic health care entities must follow the *Directives* as policy. All administration, medical and nursing staff, and other personnel are required to adhere to the *Directives* as a condition of employment and of medical privileges, and they must receive appropriate instruction as to the application of the *Directives*.³

The *Directives* explicitly and implicitly prohibit several specific services and treatments, including: medical and surgical abortions;⁴ certain treatment of ectopic pregnancies;⁵ sterilization, the most commonly used form of contraception in the United States⁶ (with *Directives* revisions in 2001 that further restrict sterilization practices);⁷ contraceptive services (including contraceptive prescriptions) and counseling;⁸ counseling about the use of condoms by HIV-positive patients (or patients with other sexually transmitted diseases) to prevent disease transmission;⁹ certain infertility treatments;¹⁰ and research or therapy using fetal tissue or embryonic stem cells.¹¹

Some health care institutions prohibit services based on religious principles, and impose these bans on nonsectarian institutions that merge or affiliate with them.

Although Catholic hospitals often provide needed

health care, Catholic Directives prohibit vital services, including:

- abortion
- emergency contraception
- sterilization
- contraceptive services
- counseling on condom use to reduce the risk of HIV/AIDS
- infertility treatments
- research and therapy using fetal tissue or stem cells
- certain end-of-life care

The *Directives* also limit the provision of emergency contraception, even in cases of rape, although some Catholic entities interpret the *Directives* to allow its use in certain circumstances.¹² The *Directives* affect end-of-life care, for example, by indicating that preferences of pregnant patients or patients who want to reject artificial feeding should be ignored in some instances.¹³ Furthermore, the teachings of the Catholic church affect health care for gay, lesbian, and transsexual patients.¹⁴ They also prevent health care professionals from informing patients about certain treatment alternatives and making treatment referrals.¹⁵

B.

The Catholic Health Care Industry, a Major Health Care Force, is Expanding through Mergers, Purchases, and Other Affiliations

The impact of the *Directives* is far-reaching, due to the strong presence of Catholic health care providers in the U.S. health care market. In 2002, five of the ten largest health care systems were Catholic-owned.¹⁶ Sixteen percent of all community hospital admissions in the nation are to Catholic institutions.¹⁷ In many rural areas, Catholic hospitals are the sole health care providers.¹⁸ There are numerous Catholic-sponsored managed care plans, including many serving Medicaid recipients.¹⁹ And Catholic-sponsored outpatient clinics include facilities that customarily provide reproductive health care.²⁰

It is not solely the Catholic health care entities themselves that are constrained by the *Directives*. The *Directives* permit affiliations with non-Catholic

entities, but caution the Catholic entity in such an arrangement to “limit its involvement” in activities that contradict Church teaching.²¹ As a result, Catholic providers typically condition arrangements with non-Catholic entities on the new partner’s agreement to comply with the *Directives*, which often results in the elimination of key women’s reproductive and other health services.²² The practices of one significant hospital purchaser are particularly troubling. Tenet Healthcare Corporation, a for-profit nonsectarian system, has bought several Catholic hospitals. Tenet has signed sale agreements that not only require Tenet to abide by the *Directives*, but also require that Tenet obtain adherence to the *Directives* from any subsequent purchaser.²³

In addition, Catholic-owned medical office buildings sometimes require physicians to whom they lease to honor the *Directives* in those private physician offices, even though the physicians do not have any other relationship with the Catholic entity.²⁴ Although some recent developments offer potential for reducing the negative effects of Catholic-secular partnerships,²⁵ the restrictions on access to care remain severe.

C.

Health Care Consumers’ Lack of Knowledge about Religious Restrictions Threatens Their Health Care

Health care consumers’ unfamiliarity with religious restrictions in health care further exacerbates the lack of access to women’s reproductive and other health services. In a nationwide survey of 1,000 women in early 2000, almost half said that if they were admitted to a Catholic

hospital, they believed they would be able to get medical services that may go against Catholic teaching.²⁶ Even women who thought services might be limited did not know how broad the restrictions were. While 62 percent identified abortion when asked to name services that are contrary to Catholic teaching, only 43 percent named birth control, and less than seven percent were able to identify any other restricted services, including emergency contraception, sterilization, or infertility treatment.²⁷

Women's health care is threatened when they must make decisions about their care without knowing about these restrictions. They may make different health care decisions once they know about those bans. For example, pregnant women who may want to have a tubal ligation during the same hospital stay as their delivery might not select an obstetrician who only has privileges at a hospital that prohibits that practice. Women who delivered at hospitals with such bans would face additional surgery at a later period, with the attendant health risks and financial costs that result.

Women in their reproductive years who want the option of contraception, infertility treatments, or abortion might select obstetricians and gynecologists who have affiliations at non-Catholic hospitals. They might select health insurance from companies that do not have religious restrictions on covered services and treatments. This choice could provide substantial savings for the consumer for needed services or could avoid the risk of having to forgo these services altogether because of the inability to pay for them.

Furthermore, a sexual assault survivor needs to know immediately whether the emergency room to which she is taken will provide emergency contraception. She needs to find care elsewhere within the time frame that emergency contra-

ception is most likely to be effective. Women and their family members with chronic or fatal illnesses (e.g., HIV/AIDS,²⁸ Parkinson's Disease, Alzheimer's Disease) are also affected. They might want to choose a physician affiliated with an institution without religious restrictions so they are more likely to receive appropriate information about disease management. Religious rules sometimes prohibit HIV risk-reduction counseling, experimental treatment (e.g., therapies involving embryonic stem cells), and certain end-of-life care (e.g., forgoing artificial feeding).

Also, when a community hospital that offers comprehensive reproductive health services is contemplating a merger with a Catholic system, consumers who want to take action need notice of the plan to do so. With notice, they could challenge the merger, work toward a solution that ensures reproductive services are not restricted if the merger proceeds, or work to ensure that hospitals provide appropriate warnings of the restrictions to patients and prospective patients.

Women's lack of information is understandable and traceable to the providers themselves. Health care facilities that restrict services often provide little or no notice or information about those restrictions. Consumers, therefore, do not know about the bans. For example, the facilities may not make any written or oral statements about their restrictions. They may represent that they provide comprehensive primary care or comprehensive women's health services²⁹ when in fact they do not. They may claim to advocate for universal health care coverage,³⁰ while in practice they ban access to services to which they have religious objections.

Hospital marketing brochures may state that their health care practitioners fully inform patients so that the patients can make their own health care decisions

Health care facilities that restrict services often provide little or no notice or information about restrictions, leaving consumers in the dark.

after learning about medically appropriate alternatives, when in fact the hospital stops practitioners from providing patients with information about religiously objectionable health care alternatives. Similarly, hospitals may state that practitioners on their medical staff make decisions about what is best for their patients regardless of institutional policies, while in practice those policies restrict communication or provision of service.

Hospitals may trumpet their commitment to open and honest communication with the community,³¹ while at the same time failing to inform community members about religious restrictions. They may make accurate statements about the scope of religious restrictions, but not in highly accessible or visible places.

Public opinion polls show that these restricted services are indeed important to women and that protecting people's health care needs is more important than protecting a health care entity's religious freedom to follow its religious beliefs. In one nationwide poll conducted in 2001, more than eight out of ten people surveyed believed that it is more important to protect the rights of people seeking medical care than to protect the religious freedom of religious hospi-

tals to follow their religious beliefs.³²

Over three quarters of those surveyed said they opposed "giving hospitals an exemption from the law allowing them to refuse to provide medical services they object to on religious grounds."³³ Indeed, more than 80 percent of those polled believe that, despite religious objections, hospitals should not be allowed to deny: HIV risk-reduction counseling, abortion when a woman's life or health is threatened, emergency contraception to prevent pregnancy resulting from rape, or birth control and voluntary sterilization procedures for men and women.³⁴ And almost 90 percent opposed other types of entities (insurance companies, pharmacies, and employers) being able to claim religious exemptions.³⁵ Other surveys have yielded similar results.³⁶

Women seeking reproductive and other health services—and health care consumers generally—should not be kept in the dark about religious bans by the institutions that serve their community. As discussed further in this report, the notice requirements in various types of consumer protection laws can be used to require that health care entities with religious restrictions warn the public about them in a clear, accurate, and timely way.

SECTION II

Federal and State Notice Requirements Can Help Challenge Improper Warnings about Institutional Religious Restrictions

A number of legal tools have been used to reduce the negative impact of institutional religious restrictions.³⁷ However, legal theories based on consumer protection laws have largely been ignored. The time is ripe for advocates to turn their attention to these laws. The protection of health care consumers' rights has taken center stage in the national health care dialogue. Health care providers,³⁸ government officials,³⁹ and the public at large all have encouraged improved communication between the health care industry and its customers. Advocates are encouraged to use the notice provisions contained in consumer protection laws to demand *truth* or *consequences*. Health care institutions that restrict services must provide appropriate notice about them (i.e., information that is clear, accurate, and timely) or face legal sanctions.

Use of notice provisions in consumer protection laws to expose religious bans on the provision of health care services is largely untested. Nevertheless, the extensive federal and state legal disclosure rules offer significant potential for exposing these bans. Sometimes the rules clearly apply to warnings about institutional religious restrictions, and only require that advocates and government officials make enforcement

a priority. Other rules may not explicitly address religious restrictions, but are reasonably interpreted to apply to them.

The legal instruments discussed in this report vary dramatically by jurisdiction. They also vary in the scope of their coverage and in the remedies they offer. This section describes four types of notice protections that advocates should consult when mounting a challenge to an institution's notice practices. They include:

- provisions in federal and state refusal clauses (laws that allow health care providers to refuse to render care based on religious or moral objections) explicitly requiring health care institutions to disclose institutional religious restrictions;
- other notice requirements governing health care entities;
- notice provisions contained in unfair and deceptive practice laws that concern any type of entity (not only health care entities); and
- other legal protections.

Advocates can use notice provisions in consumer protection laws to demand truth or consequences—appropriate notice or legal sanctions.

Some institutional refusal clauses explicitly require that health care consumers be warned of any service limitations.

A.

Notice Requirements in Institutional Refusal Clauses

Several federal and state laws allow those who assert religious or moral objections⁴⁰ to be exempt from providing⁴¹ reproductive and other health services.⁴² These refusal clauses (sometimes referred to as “conscience clauses”) typically allow individual practitioners to refuse to provide certain care. This report, however, focuses on those laws that allow health care *institutions* to assert objections. These are referred to in this report as “institutional refusal clauses.”⁴³

The restrictions on services permitted by institutional refusal clauses create barriers to care. As noted earlier, these limits can be especially harmful when consumers do not know about them. In recognition of this fact, some refusal clauses also require that health care consumers be warned of any resulting limitations of services. These provisions, referred to in this report as “notice” or “disclosure” requirements, at least help to ensure that health care consumers have the information they need to make informed decisions about their care. These notice requirements may apply to different types of health care services or health care entities. Their form and content may vary as well.

1. Health Care Services Covered

Institutional notice requirements can apply to several different types of services. These include:

- health care services generally⁴⁴
- abortion⁴⁵
- family planning services generally⁴⁶

- contraceptive insurance coverage⁴⁷
- sterilization⁴⁸
- infertility treatment⁴⁹
- advance directives (living wills and health care proxies)⁵⁰

2. Health Care Entities Covered

There may be different notice requirements for different types of health care entities. For example, advocates should examine institutional refusal clauses to determine whether they apply to hospitals, nursing homes, managed care organizations, insurers, pharmacies, and employers.⁵¹ They should also determine if the notice requirements apply only to those entities receiving Medicare or Medicaid reimbursement, and/or also to those entities that are privately funded.⁵²

3. Nature and Content of Notice

Notice requirements vary greatly concerning the nature and content of the notice, with some general and others very detailed. Specific issues that notice requirements might address include:

a. Location of Notice: Some laws mandate that notices in hospitals be posted in a conspicuous place open to the public.⁵³ Some specify that the warning must appear in the entity’s marketing material (at least one explicitly states that notice of excluded services must appear in all health plan materials).⁵⁴ Other laws do not specify where the notice must appear, but require that it be in writing.⁵⁵ Some laws do not state whether the notice must be oral or written, but do require that people be “informed.”⁵⁶

Some specify that the description of religious restrictions must also appear in contracts or other important documents (e.g., by-laws, mission statement, charter, code of ethics, or vote of governing

body).⁵⁷ As a practical matter, disclosures even in these important documents do not effectively inform consumers, since most patients and prospective patients do not see this material. Nevertheless, information in these documents can help advocates mount a challenge to institutional notice practices. For example, if the refusal clause only grants legal immunity to institutions that reflect their policy in certain formal documents, institutions would not receive legal immunity if they did not put the mandated statements in the material. Furthermore, minutes documenting the process for adopting the policy could serve as evidence that the failure to publicize the restrictions was intentionally misleading. This argument could be particularly effective when relying on unfair and deceptive practices law (as discussed later in the report).

b. Those Entitled to Notice:

Some laws explicitly require that the entity warn both current and prospective health care consumers; other laws require only that notice be provided to people actually receiving care at the facility or already covered under insurance.⁵⁸

c. Timing of Notice: Some laws merely state the notice must be “reasonable” and “timely,” or “prompt;” others specify that the notice must occur at or before hospital admission or insurance enrollment.⁵⁹

d. Content and Form of Notice: Some laws specify the content of the notice. For example, some require that the notice specify the reason for the objection.⁶⁰ Some require that the legal basis authorizing the refusal be included.⁶¹ Some specify the typeface size.⁶² In California, managed care plans (private sector and Medicaid) and disability insurers must also provide a very detailed notice that hospitals and other health care entities accepting insurance through these plans may not provide a full range of reproductive health services.⁶³

e. Who Must Provide Notice:

Under federal law governing Medicaid managed care, the state (but not necessarily the managed care entity) must provide notice at specified times and in specified ways to potential or enrolled Medicaid recipients.⁶⁴ In addition, some states require the restrictive entity to provide notice,⁶⁵ but these requirements vary.⁶⁶

In summary, when considering a challenge to an institution’s notice practices, advocates should consult federal and state law to see if there are refusal clauses that apply to institutions. If such laws exist, they should be examined for notice requirements. Any such rules must then be analyzed to assess whether they apply to the treatment and type of facility at issue (for example, whether they apply to hospitals and to sterilizations). If the notice requirements apply, advocates should carefully review the institution’s written and oral statements and their dissemination (see Appendix A for possible sources to consult for statements). If the statements do not comply with the refusal clause’s notice requirements, there may be several remedies to pursue, as discussed later in the report.

B.

Other Notice Requirements Specifically Concerning Health Care

The previous section examined notice requirements contained in institutional refusal clauses. Notice requirements can also be found in other laws that regulate health care entities. These are described below. They include federal Medicare and Medicaid rules, various state laws, and national accreditation standards.

Entities receiving Medicare and Medicaid payments must provide patients with clear written statements about institutional objections to honoring advance directives.

I. Medicare and Medicaid Notice Requirements for Health Care Entities

Health care entities receive a significant portion of their income from Medicare and Medicaid payments. Religiously sponsored health care entities are no exception. In 1998, combined Medicare and Medicaid payments accounted for half the revenues of religiously sponsored hospitals nationwide.⁶⁷ To receive Medicare and Medicaid payments, entities must satisfy federal requirements called “conditions of participation.”⁶⁸ There are different conditions of participation for hospitals, nursing homes, managed care organizations, and other entities. The following conditions of participation, however, generally apply in some way to most entities receiving Medicare and Medicaid.

The conditions of participation that most clearly apply to notice requirements of institutional religious restrictions concern advance directives. These federal rules are the most detailed of all institutional refusal notice rules. The federal Patient Self-Determination Act (PSDA) requires that most entities receiving Medicare and Medicaid payments inform adult patients about state law regarding the rights of patients to accept or reject treatment and to formulate advance directives.⁶⁹ The regulations implementing the PSDA require that written policies include “a clear and precise statement of limitation if the [provider] cannot implement an advance directive as a matter of conscience;” clarify the difference between institution-wide and individual objections; identify the state legal authority permitting objections; and describe the range of medical conditions or procedures affected by the refusals.⁷⁰ Health care entities with religious objections to honoring advance directives are not exempted from providing community education about advance directives.⁷¹

Other conditions of participation that do not expressly address religious restrictions still could be used to compel notice of institutions’ refusal to provide services because they require the entities:

- not to engage in misleading advertising⁷² (i.e., they cannot mislead consumers into thinking they provide all services when they do not);
- to honor a patient’s right to make informed decisions regarding his or her medical care⁷³ (i.e., informed consent protections, as discussed in more detail below);
- to provide services in a timely manner or to give prompt referrals and follow up to ensure that patients receive requested services (sometimes called “continuity of care” provisions)⁷⁴ (i.e., they cannot refuse to give referrals for services to which they object);
- to provide notice of these and other rights in advance of providing or discontinuing patient care whenever possible;⁷⁵
- to have relevant state licenses necessary to provide care;⁷⁶ and
- to comply with all applicable federal, state, and local statutes, laws, rules and regulations.⁷⁷ This requirement can be interpreted to mean that they must comply with the refusal clause notice requirements, as well as other notice provisions discussed in other sections of this report.

2. State Notice Requirements for Health Care Entities

State laws governing health care entities contain a wide variety of notice provisions. These provisions address marketing and advertising, patients’ rights generally, informed consent, statutory

counseling requirements, certificates of need, conversion laws, community benefits, and licensing rules generally.

a. Marketing and Advertising:

Some state laws explicitly prohibit false, deceptive, and misleading statements in health-related marketing material (this is in addition to similar prohibitions contained in unfair and deceptive acts and practices law, discussed later). This requirement helps to ensure that prospective patients will not be misled into thinking that they can get services that they cannot. Most of the rules about marketing and advertising are aimed specifically at managed care organizations. Some cover all managed care companies, while others are limited to specific types of managed care companies.⁷⁸

b. Patients' Rights Generally:

Many states have patients' rights statutes and regulations that are similar to those contained in the Medicare and Medicaid conditions of participation. Although almost all states have nursing home and managed care patients' rights laws, some patients' rights laws also apply to hospitals.⁷⁹ State laws vary not only in the type of entities covered, but also in the scope of the protections.⁸⁰

Some patients' rights provisions have procedural requirements about how and when these rights must be communicated to patients. In New York, for example, every patient must be given a copy of the hospital's Patient Bill of Rights, a hospital staff member must meet with a patient and/or his or her representative after admission to explain the rights, and staff must be designated to answer any questions for emergency service patients or outpatients.⁸¹ Some state laws include notice provisions about advance directives beyond the federal Medicare and Medicaid requirements discussed above.⁸²

c. Informed Consent and the Need to Explain Alternatives to Care:

It is well established in law⁸³ and medical ethics⁸⁴ that providing medical care to patients without their informed consent is impermissible. Most informed consent protections derive from court cases and state statutes or regulations.⁸⁵ The exact formulation of informed consent rules varies by state and by type of treatment, but generally, the law requires that patients be told about the nature and consequences of the proposed treatment, as well as the risks, benefits and *alternatives* to treatment.⁸⁶

Failure to warn patients about religious restrictions in a clear and timely way may well violate these legal rules, since patients are not being informed about reasonable medical alternatives to the treatment to which the facility objects. These institutional restrictions therefore limit practitioners' ability to act solely based on appropriate standards of medical practice and in consideration of their patients' needs.⁸⁷ Indeed, they may subject the individual practitioners to further legal liability for failure to obtain informed consent.

Courts have supported this analysis in several cases involving religious restrictions on abortion, emergency contraception, and end-of-life care. A few cases support the proposition that health care providers violate informed consent requirements when they fail to provide information about abortion as an alternative to pregnancy when there is evidence of fetal abnormalities, notwithstanding providers' religious objections to actually performing abortions.⁸⁸

There are also a few statutes and cases that explicitly address the issue of informing sexual assault survivors about emergency contraception. All require that the information be provided, even in the face of such religious or moral objections to doing so.⁸⁹ In one California case, the court stated that medical malpractice for lack of informed

Failure to warn patients about religious restrictions may violate informed consent rules, since patients are not being informed about some reasonable medical alternatives.

consent could arise from an institution's failure to disclose information about emergency contraception.⁹⁰

There are a few court cases in which seriously ill patients were admitted to hospitals without receiving notice that the hospitals restricted patients' rights to forgo life-sustaining treatment. The patients requested that their wishes be honored and the institution refused on the grounds of institutional religious objections. In such instances, courts generally have held that, when there is a conflict between patient preferences and institutional religious views, the patient preferences prevail; in particular, judges note that their conclusion was supported by the fact that the institutions did not provide appropriate, clear, and timely notice of the restriction before the patients were admitted.⁹¹

d. Statutory Counseling

Requirements: Some states have specific counseling requirements concerning care forbidden under the *Directives*. For example, New York requires that women who are booked for delivery in hospitals must receive information about the availability of postpartum family planning services, defined as "planning and spacing of children by medically acceptable methods to achieve pregnancy or prevent unintended pregnancy."⁹² Accordingly, New York hospitals must provide maternity patients with written information about the availability of these services, even if they do not provide the services themselves.

Furthermore, several states have statutes requiring health care providers to educate HIV positive patients on ways to prevent transmission of HIV, the virus that causes AIDS.⁹³ Some states also require that information be provided to sexual assault survivors about emergency contraception, as noted above.

e. Certificates of Need (CON) or Other Requirements about Reducing Services:

States typically adopt laws to ensure that a health care entity's structure fulfills community needs while containing costs.⁹⁴ Several states have Certificate of Need (CON) requirements that are designed to ensure there is a demonstrated need for a service that a health facility is proposing to provide. In addition, some states have CON and related requirements for institutions proposing to *limit* services (these are sometimes referred to as "reverse CON" provisions).⁹⁵ For example, Massachusetts has detailed requirements for hospitals contemplating closing an "essential service," which is defined to include "outpatient reproductive health services."⁹⁶ One requirement of these laws is that assessments of need be made public and that the public have an opportunity to provide input at hearings before a CON is issued.⁹⁷

Advocates can cite the public notice requirements in CON, reverse CON, and related laws to ensure that entities that are considering restricting services clearly communicate these plans to the public. Before relying on these provisions to mount a challenge to institutional notice practices, however, advocates should determine whether there are exemptions for "religious" entities and what types of entities are deemed to be included in the exemption.⁹⁸

f. Conversion Laws:⁹⁹ Several states have "conversion" laws that apply when a nonprofit hospital "converts" into a for-profit entity. These provisions include protections to ensure that needed health services are maintained when a nonprofit hospital is purchased by, or otherwise transfers some or all of its assets or control to, a for-profit hospital or system.¹⁰⁰ Although these laws focus primarily on nonprofit hospitals converting to *for-profits*, many of these laws also govern a nonprofit affiliating with *other nonprofits*.¹⁰¹ Since most religiously

owned hospitals are nonprofits, these *nonprofit-to-nonprofit* conversion provisions are important tools because they offer opportunities for public notice and input. Some conversion statutes apply to nonprofit health care plans and HMOs as well.

Although conversion laws do not require specific notice to patients or prospective patients about limitations in service, they do serve other important notice functions. Conversion proceedings typically require that those advocating for the conversion show how they will continue to meet community needs (or provide “community benefits”),¹⁰² and/or what impact the conversion will have on health care access for underserved populations.¹⁰³ Conversion laws also include more specific notice and public hearing requirements,¹⁰⁴ such as hiring an independent monitor to ensure that health care access is preserved once the conversion occurs.¹⁰⁵ Such a provision can be used more specifically to ensure that a converting facility, as a condition of conversion approval, adhere to notice and referral requirements for restricted services.

g. Community Benefits: As a condition of state approval in various contexts (e.g., conversion, CON, or other contexts), hospitals and other entities provide certain benefits to the community. These requirements are sometimes referred to as “community benefits,” “indigent care,” “charity care,” or “free care” requirements.¹⁰⁶ These benefits include care that is free or at a discounted rate. Some of these community benefits provisions also include explicit notice requirements. For example, Massachusetts requires that all acute care hospitals and other entities provide notice about eligibility for free care, with very specific requirements about what must be included in the notice, where the notice must appear, and when it must be provided.¹⁰⁷ Advocates should

review the notice requirements in the community benefits laws, as well as institutional compliance. The hospital’s notice may indicate that it is providing comprehensive health care when in fact it refuses to provide some basic primary care.

h. Licensing Rules Generally:

The most powerful weapon that states have for ensuring that all notice requirements are being met is state licensing of health care entities. Generally, states require hospitals, nursing homes, insurers, managed care companies, clinics, and other health care entities to receive licenses and other state approval before the entities can provide services.¹⁰⁸ Licensure is contingent on an entity complying with all applicable state statutes, rules, and regulations.¹⁰⁹ Thus, failure to comply with state institutional refusal clause notice requirements or any other notice provisions above could be viewed as a failure to comply with these licensing standards.¹¹⁰

As is evident, there are many state health laws that address notice requirements, forming an important part of the network of consumer protections available. Advocates can use these laws to ensure that notice requirements are being met.

3. Notice Requirements for Accreditation

Private entities “accredit” different types of health care entities. The two main accrediting entities are Joint Commission on Accreditation of Healthcare Organizations (JCAHO)¹¹¹ and the National Committee for Quality Assurance (NCQA).¹¹² Accreditation is important because it often means that an accredited entity is “deemed” to have met federal Medicare/Medicaid¹¹³ and state licensing requirements.¹¹⁴ Thus, accreditation problems can have serious implications for facilities.

Failure to comply with state refusal clause or other notice requirements could be viewed as a failure to comply with licensing standards.

Both JCAHO and NCQA have accrediting standards that can be interpreted to require notice of institutional religious restrictions. Both organizations require that the entities operate according to a code of ethical behavior that governs marketing practices, admissions, and transfers.¹¹⁵ NCQA standards, for example, require that managed care organizations ensure that communications with prospective members “correctly and thoroughly” represent the benefits and operating procedures of the organization; NCQA also requires that *all* organizational materials and presentations accurately describe, among other things, “noncovered benefits” and “potential restrictions.”¹¹⁶ NCQA requires that an organization “systematically” monitor new member understanding of its procedures to ensure that marketing communications are accurate and to improve communication when necessary.¹¹⁷

Accrediting groups impose patients’ rights standards on the entities they accredit. Among the rights that must be addressed are the right to informed consent (including the right to have all medically appropriate alternatives fully explained and referrals offered for services that cannot be provided); the right of patients to be involved in decision-making; the right to have their individual needs and values respected; and the right to have ethical conflicts resolved.¹¹⁸

For example, NCQA requires that a managed care organization advise members of their right to receive information about the organization and its services, as well as their right to a “candid discussion of appropriate or medically necessary treatment options for their conditions.”¹¹⁹ Accrediting standards also require that entities have a mechanism for resolving patient complaints and getting patient input.¹²⁰ NCQA requires that managed care organizations distribute their policy on members’ rights and responsibilities to existing and new members¹²¹ and have policies for

complaints and appeals processes.¹²²

NCQA requires that organizations provide each subscriber with information necessary to understand benefit coverage, including written information that addresses “benefits and services included in, and excluded from, coverage;” methods for obtaining primary and specialty care; and procedures for voicing complaints.¹²³ JCAHO has requirements similar to many of these NCQA standards.¹²⁴

In summary, those individuals and groups considering a challenge to an institution’s notice practices about its religious restrictions should consult the federal, state, and private accreditation notice requirements that apply specifically to health care entities.

C.

Laws Prohibiting Unfair and Deceptive Conduct

The previous section examined notice requirements solely in the health care context. There are also federal and state consumer protection laws that apply more broadly. These apply to most consumer transactions, including in the provision of products or services. They are aimed at preventing consumer deception and abuse in the marketplace. Advocates could argue that entities violate these laws when those entities impose restrictions but make misleading statements or omit information about the scope of their services in advertising or marketing materials, admissions materials, statements in media interviews, signs or posters at the facility. State unfair and deceptive acts and practices laws (referred to in this report as UDAP laws) generally offer more comprehensive protections than those at the federal level.¹²⁵ However, advocates will have to determine whether state UDAP laws actually apply in the health care context, as discussed below.

1. State Unfair and Deceptive Acts and Practices (UDAP) Laws

State unfair and deceptive practices statutes serve to protect consumers' "right to be informed."¹²⁶ These laws can protect consumers when they receive fraudulent or misleading information about products or services, and when they have not received disclosure of material facts regarding the products or services. Advocates considering using the state UDAP laws to challenge an institution's notice practices need to examine these state laws for their requirements about the definition of "unfair" or "deceptive" practices, the definition of "trade or commerce," intent, and injury or "ascertainable loss." Some states also require a plaintiff to establish that an action is "in the public interest," although interpretation of this requirement varies.¹²⁷

a. Definition of "Unfair" or "Deceptive" Acts or Practices:

The first element that must be shown for a practice to be covered under the UDAP law is that the health care entity's conduct is unfair or deceptive. This element includes an entity's failure to disclose material information as well as its use of false or misleading statements.¹²⁸ In evaluating whether an act or practice is unfair or deceptive, courts sometimes consider whether a less experienced or vulnerable consumer would be misled, not whether a sophisticated consumer would be misled; some evaluate whether a "reasonable" or "ordinary" consumer would be misled.¹²⁹ Some courts have found that when a first contact is made through a deceptive advertisement, a violation has occurred even if subsequent disclosures are made or if the consumer does not actually purchase goods or services.¹³⁰

Reported court decisions applying unfair and deceptive practices rules to a health care entity's marketing and admis-

sion materials are rare. Nevertheless, advocates can use the few that exist to argue that a health care entity's failure to provide notice of religious restrictions is unfair or deceptive.

For example, "crisis pregnancy centers" have been found to engage in unfair or deceptive practices concerning the scope of their services. The goal of crisis pregnancy centers (sometimes referred to as "CPCs") is to prevent women from obtaining abortions.¹³¹ They typically hold themselves out as offering free pregnancy tests, as well as complete and accurate information about the range of options available to women facing unintended pregnancies. In fact, however, they refuse to counsel about abortions as an alternative to pregnancy. In several situations, CPCs have been required to disclose that they do not counsel about abortion. They have also been prohibited from representing that they provide comprehensive pregnancy-related services.¹³²

At least one court implied that there may be a claim for deceptive acts and practices against a religious hospital that refuses to provide warnings about religious restrictions to a rape survivor concerning emergency contraception. That California decision suggested that hospitals might be liable for unfair trade practices if they fail to notify rape survivors that they do not offer emergency contraception.¹³³ Although the court denied the plaintiff rape survivor's UDAP claim, it based its conclusion on the evidence that the emergency room physician who treated her advised her to see her personal doctor within two days and told her that the hospital did not offer emergency contraception.¹³⁴ It therefore implied that there could be a cause of action under the state's UDAP law if the doctor and/or hospital failed to provide notice that the hospital did not provide emergency contraception.

In a similar context, a consumer group sued a managed care company (Kaiser Permanente), alleging violations of

State unfair and deceptive practices laws protect consumers' "right to be informed."

Undisclosed institutional prohibitions on providing services mislead consumers into believing that physicians make independent medical decisions based on the best medical care for the patient, when in fact they are constrained by institutional policies.

California's UDAP statute.¹³⁵ The group alleged that Kaiser engaged in misleading advertising in its membership drive by fraudulently claiming that doctors rather than administrators were in charge of health care decisions. The consumer group argued that, in fact, Kaiser's cost-cutting policies interfered with physicians' independent medical judgment; as a result, the health care services the customers received were worth less than those advertised by Kaiser.¹³⁶ The parties settled the lawsuit, with Kaiser agreeing to publish on its website disease clinical treatment guidelines that doctors use, as well as other company practices and policies to assist consumers in making decisions about their health care.¹³⁷

Advocates facing institutional religious restrictions could make an analogous argument. They could assert that undisclosed institutional prohibitions on providing services mislead consumers into believing that physicians make independent medical decisions based on the best medical care for the patient, when in fact they are constrained by institutional policies. Just as Kaiser's cost-cutting policies interfered with physicians' medical decisions, institutional religious restrictions affect health care practitioners' medical advice.

b. Definition of "Trade or Commerce": The second condition that must be met for UDAP protection to apply is that the conduct must occur in the course of "trade or commerce."¹³⁸ Many states define this phrase broadly. For example, some states define it as "the sale of assets or services, and any commerce directly or indirectly affecting the people [in the state]".¹³⁹ This definition can clearly be interpreted to include a health care entity's marketing practices.

Indeed, courts have found that UDAP laws cover unfair and deceptive conduct of health care providers when the conduct concerns: misrepresentations about

the nature of services provided;¹⁴⁰ purchase of health care services from a private nursing home;¹⁴¹ statements in advertising and marketing material;¹⁴² provider's qualifications, experience, or success rates;¹⁴³ lack of informed consent;¹⁴⁴ and fraudulent billing for medical services and false supporting documents (e.g., injury reports).¹⁴⁵ Advocates can look to these precedents to argue that an entity's misleading statements about the scope of its religious restrictions, designed to attract customers, clearly fulfill the "trade or commerce" requirement.

Before making these arguments, however, advocates should determine whether certain exemptions may apply. If the conduct is exempt, it is not subject to the UDAP rules. First, in some states, conduct related to "professional services" is not considered service provided in "trade or commerce."¹⁴⁶ Conduct related to medical malpractice or negligence could also fall under this exception.¹⁴⁷ Second, exemptions sometimes apply when the state otherwise regulates the conduct.¹⁴⁸ For example, UDAP laws may not apply to conduct regulated by the state insurance or health departments.

Finally, a few states exempt nonprofit entities from their UDAP statutes, although the vast majority do not.¹⁴⁹ In their interpretations of "trade or commerce" provisions, some courts have exempted nonprofits from their UDAP laws merely because their transactions take place outside a private commercial business context, focusing solely on the charity's public, nonprofit purpose.¹⁵⁰ Some courts have given weight to the fact that a nonprofit does or does not receive payment for its services in determining whether the nonprofit is engaged in "trade or commerce."¹⁵¹ Others find the issue of payment irrelevant and focus instead on marketing practices and their adverse effects on consumers.¹⁵²

c. Intent: Most states do *not* require proof that a deceptive act was “intentional” or “willful.”¹⁵³ Where a statute does require intent, evidence might include statements that administrators were concerned that notices of religious restrictions would drive away customers. Advocates might find evidence of such intentional deception in inconsistencies between public and internal documents (e.g., hospital and medical staff by-laws). For example, intent to deceive might be established if the restrictions are clearly identified in the documents that patients typically do not receive (such as in hospital and medical staff by-laws) but are not even mentioned in public materials on the facility’s website or in the patients’ rights brochure or other materials that the patients do receive. Minutes from a hospital’s board of trustees meetings that reflect a decision not to warn patients because it could drive them away could also help establish intent to mislead.

d. Injury or “Ascertainable Loss”: Most state UDAP laws offer protection only if plaintiffs can show that they are “aggrieved”¹⁵⁴ or suffered some injury or “ascertainable loss” as a result of the unfair or deceptive conduct. These terms usually mean a measurable financial loss.¹⁵⁵ Consumers may be able to show financial loss for additional medical appointments, insurance co-payments, travel and telephone expenses, and lost wages as a result of an unanticipated delay in obtaining treatment because they were not informed of their hospital’s restrictions on services and therefore had to seek additional care.¹⁵⁶ States vary, however, about whether their UDAP statutes include recovery for physical injury¹⁵⁷ or mental anguish, distress, and humiliation.¹⁵⁸ Some states recognize that even minor injuries satisfy UDAP requirements.¹⁵⁹ A few states do not require plaintiffs to show that they have suffered an injury to bring a lawsuit.¹⁶⁰

A handful of states have a second UDAP law that allows individuals to sue without showing that they have been injured by a violation, requiring only a showing that plaintiffs are “likely to be damaged” by the unfair practice, though their recovery is limited in most states to injunctions and attorneys’ fees.¹⁶¹ These statutes would be useful in situations where plaintiffs wanted the court to order a hospital to halt its deceptive advertisements and to affirmatively provide notice to patients of its restrictions.

In summary, the best UDAP laws for a notice challenge in the context of religious restrictions are those that have: a broad definition of unfair or deceptive practice, a broad definition of trade or commerce that expressly includes or has been interpreted to apply to the health care services at issue, no intent requirement, and no (or minimal) injury or ascertainable loss requirement.

2. Federal Laws Prohibiting Unfair or Deceptive Acts or Practices

The Federal Trade Commission Act (FTC Act) and the Lanham Act are federal statutes that protect against unfair and deceptive acts and practices. It should be noted at the outset, however, that these laws have limited application in the context of religious restrictions on health care. First, consumers cannot sue (i.e., have no private right of action) under either statute; only the FTC may enforce the FTC Act.¹⁶² Furthermore, only individuals with a commercial interest, rather than a private consumer interest, may raise claims under the Lanham Act.¹⁶³ Also, the FTC Act applies to non-profit organizations, including religious entities, only under limited circumstances.¹⁶⁴

a. Federal Trade Commission (FTC) Act: The FTC Act prohibits “unfair or deceptive acts or practices in or affecting commerce.”¹⁶⁵ Under the

A practice is considered deceptive if it contains a representation or omission that is likely to mislead consumers, to their detriment; actual deception is not required.

FTC Act, an act or practice is “unfair” when it offends public policy and when the act or practice is immoral, unethical, oppressive, unscrupulous, or causes substantial injury to consumers.¹⁶⁶ An act or practice is considered “deceptive” under the FTC Act if it contains a representation or omission that is *likely* to mislead consumers acting reasonably under the circumstances, to their detriment; actual deception is not required.¹⁶⁷ Thus, failure to disclose material information may be deceptive under the FTC Act, even though the advertisements or marketing brochures do not make false statements.¹⁶⁸

An institutional health care provider's failure to disclose its restrictions on reproductive or other health care, therefore, may be considered a material omission that violates the FTC Act. Courts have also ruled that when contact with consumers is established through a deceptive advertisement, the law is violated even if subsequent disclosures are made before a contract is formed.¹⁶⁹ Therefore, if an institutional health care provider states in its promotional materials that it provides “comprehensive women's health care services,” the law may be violated even if a patient is later informed by her doctor or other provider that an institution does not provide certain services.

Nothing in the FTC Act prohibits its application to health care entities' advertisements or marketing materials about the scope of the services they provide. In fact, federal courts have repeatedly indicated that the FTC Act's prohibition on “unfair methods of competition,” which is found in the same subsection as its prohibition on “unfair or deceptive acts or practices,” applies to commercial aspects of the medical profession.¹⁷⁰

Because the FTC Act does not generally apply to nonprofit organizations, however, it may apply only to a small group of Catholic entities. It generally extends to nonprofit organizations only

if the nonprofits are organized to carry on business for the profit of their members, which would include trade associations such as the Catholic Health Association.¹⁷¹ Because some Catholic managed care plans operate as for-profit entities, it seems likely that the FTC Act would apply to them.¹⁷² Whether the FTC Act applies to nonprofit health care entities after they are sold to or become affiliated with for-profit groups will depend on whether the nonprofit entity's status changes (i.e., whether it retains its nonprofit status or becomes a for-profit entity) after the sale or affiliation. For example, when Catholic hospitals are sold to or affiliate with for-profit entities on the condition that the new owners retain the religious restrictions but do not provide adequate notice to consumers, the for-profit entities may violate the FTC Act.¹⁷³

b. Lanham Act: The Lanham Act prohibits, among other things, any person from using in commerce any false or misleading description of fact which in commercial advertising or promotion misrepresents the nature, characteristics, or quality of his or her or another person's goods, services, or commercial activities.¹⁷⁴ Unlike the FTC Act, the Lanham Act applies to nonprofit and for-profit entities alike, so long as the advertising or promotion at issue is conducted for commercial or business purposes.¹⁷⁵ Therefore, it seems likely that the Lanham Act would apply to nonprofit hospitals and institutional health care providers because they engage in the business practice of advertising and promoting their services to attract health care consumers.

Lanham Act challenges to health care entities' conduct are rare because generally only business competitors of the health care entity can sue under the Lanham Act; government representatives and consumers cannot. Nevertheless, advocates may be able to use the Lanham Act protections by enlisting

either competing hospitals or even individual health care practitioners to challenge conduct by the restricting entity that misrepresents the scope of its services (as discussed in Section III of the report).

To support a cause of action for misleading advertisements under the Lanham Act, plaintiffs must establish five elements: 1) the defendants made false or misleading statements of fact concerning their own product or service, or another's; 2) the statement actually deceives or tends to deceive a substantial portion of the intended audience; 3) the statement is material in that it will likely influence the deceived consumer's purchasing decisions; 4) the advertisements were introduced into interstate commerce;¹⁷⁶ and 5) some causal link exists between the challenged statements and harm to the plaintiff.¹⁷⁷

Although the Lanham Act does not explicitly require affirmative notice of religious restrictions, it prohibits a hospital from making misrepresentations about the nature of its services (e.g., proclaiming to provide comprehensive women's health services, when in fact it does not provide certain reproductive health services). Such misrepresentations could occur in mass advertisements and promotional materials, as well as private letters and internal memoranda.¹⁷⁸ A competing hospital may have a successful Lanham Act claim if it can establish that it has sustained damages from the other hospital's misrepresentations.

The type of proof of harm required under this law depends on whether the plaintiff is seeking injunctive relief or damages and whether the advertisement/advertising statement is literally false. A plaintiff who is merely asking a court to halt a defendant's true but misleading statement is only required to show that the defendant's advertisement has a tendency to deceive consumers; to obtain monetary damages, a plaintiff

must establish actual deception.¹⁷⁹ A plaintiff may establish actual deception by showing either that the challenged statements are literally false, or that they are true but misleading to consumers. If the statements are literally false, it is not necessary to prove that the statements actually misled consumers; rather, deception is presumed.¹⁸⁰ If the statements are true but misleading to consumers, the plaintiff must prove actual deception, which is often established through consumer surveys.¹⁸¹ Further, the plaintiff is not required to establish the defendant's intent to mislead or deceive consumers.¹⁸²

In summary, state (and federal, to a lesser extent) statutes that generally protect against unfair and deceptive practices when delivering services are yet another tool that advocates should examine to mount a challenge to a health care facility's failure to provide clear and timely warnings to consumers of its religious bans on health care services.

D.

Other Notice Requirements that May be Useful

The requirements discussed earlier in Section II provide the strongest support for requiring notice of religious restrictions. Advocates, however, should also consult several other types of laws for their notice provisions. These include common law fraud or misrepresentation, nonprofit corporation law, charitable trust law, antitrust law, and tax law.

I. Common Law Fraud or Misrepresentation

Advocates may consider raising claims based on common law fraud or misrepresentation. The elements of a cause of action for common law fraud

vary from state to state, but they generally include intent to deceive, actual knowledge of the falsehood, reliance on the deception by consumers, and injury due to the deception.¹⁸³ Because state UDAP statutes generally do not require proof of all of these elements, advocates may be more successful basing their claims under those statutes instead. In fact, states began passing UDAP laws because traditional common law fraud theories did not adequately address the problem of deceptive advertising practices.¹⁸⁴

Advocates should also consider claims of negligent misrepresentation. Such claims require proof that the entity issued a statement that was misleading, that it failed to exercise ordinary care in obtaining or communicating the statement, and that it intended that plaintiffs receive and be influenced by the statement where it was reasonably foreseeable that plaintiffs would be harmed by incorrect or misleading information.¹⁸⁵ Fraudulent misrepresentation, on the other hand, creates a greater burden for a plaintiff to prove by requiring an untrue statement, proof that defendant made the statement recklessly or with knowledge that it was false, and an intent to deceive the plaintiff.¹⁸⁶

2. Nonprofit Corporation Law¹⁸⁷

State nonprofit corporation laws sometimes require nonprofits to notify the government and/or obtain governmental approval when they change their structure significantly (e.g., selling or merging). Sometimes the law requires notice of the changes in proposed services to the attorney general and other interested groups or individuals. Advocates can argue that nonsectarian facilities that plan to restrict services when they merge with a religious system must disclose this limitation during the approval process. As a result of these disclosures, the transaction might not be

approved, or the approving entity might condition the approval on appropriate warnings to consumers of the change in services and of alternative sites for obtaining restricted services.

3. Charitable Trust Law¹⁸⁸

If an entity is a “charitable trust,” it is intended to benefit the community at large or some specified portion of the community. State charitable trust law protects these community assets by mandating review of certain changes in the trust’s actions. Sometimes this review includes informing the community of proposed changes in the trust’s charitable mission before the change occurs. If a nonsectarian hospital providing comprehensive primary services is considering affiliating with a religious institution that restricts care, this can constitute a change in charitable mission. Advocates should consult the charitable trust law in their state to determine whether such proposed changes mandate a public notice about the scope of the proposed changes and opportunity for public input.

4. Antitrust Law¹⁸⁹

Federal and state antitrust laws aim to preserve vigorous competition between rival producers of goods and services to ensure consumer choice. Some proposed hospital mergers must be reported to the federal antitrust enforcement authorities in advance for their review and approval.¹⁹⁰ If the government authorities determine that the merger would result in substantially reduced competition in the relevant market, they may deny “pre-merger clearance” and ask a court to stop the transaction from moving forward. In some instances, the federal authorities may deny this clearance to proposed mergers that threaten to decrease access to health care services. Federal authorities may also challenge consummated hospital mergers if the merging

entities promised during the pre-merger review process that the merger would yield broader access, but the merger actually results in more limited access to services.¹⁹¹

If, therefore, a hospital without religious restrictions is planning to cut back its services as a result of a merger, it should disclose its intentions during the pre-merger review process. This disclosure might lead government authorities to deny pre-merger clearance or to approve the merger on the condition that the hospital either continue offering the services it intended to eliminate or that it provide consumers with appropriate notice that the services are being eliminated.

5. Tax Law

Most hospitals are nonprofit institutions that are exempt from local, state and federal taxes. As such, they can solicit tax-deductible donations. The financial benefits of tax exemption are intended to allow these entities to provide needed goods and services to the community. The amount of money tax-exempt health care facilities save

because of these exemptions can be sizable. For entities to maintain their tax-exempt status, they must show that they are providing community benefits. Hospitals often qualify for tax-exempt status because of the charity care or the community benefits they provide. In these situations, the Internal Revenue Service examines whether the hospital broadcasts the terms and conditions of its charity care policy to the public.¹⁹² For example, if hospitals broadcast that they provide comprehensive services to low-income people when in fact they refuse to provide certain services, it could be argued that they are violating this broadcasting requirement. These arguments are similar to the community benefit requirements in state law mentioned above.

Armed with knowledge of the disclosure requirements described in this section, advocates can adopt several strategies to encourage entities with restrictions (or proposed restrictions) to relax the bans, decide not to adopt them, or provide appropriate notice. These approaches are discussed in the next section.

If a hospital without religious restrictions is planning to cut back its services as a result of a merger, it should disclose its intentions during the pre-merger review process.

SECTION III

How to Bring a Challenge for Improper Notice: Allies and Available Remedies

This section provides advocates with strategies for using the laws discussed in Section II (see Appendix A for an advocate's checklist for mounting a challenge). This section addresses allies to enlist and remedies to seek.

An initial step in challenging an entity's notice practice is to appeal directly to the health care entity to change its practice. Advocates should emphasize to the facility's leadership the harm caused by the practice and the fact that the facility may face penalties for its failure to provide appropriate warnings. They can use potential penalties as a negotiating tool to have restrictive practices changed or to ensure that adequate notice of any restrictions is provided. Advocates can also encourage entities that are currently providing comprehensive services not to agree to restrict services when negotiating a merger or other affiliation with a religious entity. Nonsectarian facilities might prefer to continue to provide the services at issue than to face the potential negative publicity and loss of patients that would occur should they have to publicize their restriction of services.

Advocates can also use consumer protection laws to encourage religious entities to provide certain services (e.g., emergency contraception for rape survivors) when the entities are unclear about whether provision of the service

at issue is permissible under the religious tenets. This option may be more appealing to the entity than either providing the notice or facing the legal consequences if notice is not provided. And even in situations where service provision is unlikely (e.g., a Catholic hospital with a long-standing practice of prohibiting post-partum sterilizations), advocates can urge the entities to provide appropriate notice or face the legal consequences.

If this direct negotiation is not successful in restoring restricted services or securing appropriate notice of restrictions, advocates can enlist other individuals and groups in their efforts, and pursue other strategies. They can report noncomplying health care entities to governmental and accrediting agencies, and bring (or help bring) lawsuits to require appropriate notice and secure other remedies.

This section first describes the groups and individuals who may seek action and the laws they most likely will find successful. It then summarizes the types of remedies they can pursue, as well as which of these groups and individuals are most likely to succeed at obtaining each of the remedies.

A facility may face harsher penalties if it fails to respond appropriately to complaints, so advocates should not bypass the facility and should not complain only to enforcement entities.

A.

Allies: Governmental and Accrediting Entities, Private Groups, and Individuals to Enlist in a Challenge to Institutional Notice Practices

Advocates should consider a broad range of groups and individuals to enlist in a challenge to institutional notice practices. Governmental and accrediting officials are central to consider, as are other advocates and consumers.

I. Governmental and Accrediting Agencies

Advocates can petition federal and state authorities to enforce existing notice requirements or impose other penalties on health care entities that restrict services. As a general matter, the enforcement entities with the greatest legal authority to enforce notice requirements are state health or insurance departments, state attorney general offices, Medicare and Medicaid officials, and accrediting organizations. See Appendix B for contact information for these agencies and Appendix C for a sample letter to them. It is important, however, to be aware of the agency's sympathies for a challenge against a religious entity (e.g., whether they are pro-choice, pro-consumer, etc.).¹⁹³

■ State health or insurance

departments: As noted earlier, state health departments or equivalent entities (e.g., insurance departments that license insurers) are responsible for licensing or otherwise approving the provision or financing of health services. These offices can threaten to revoke, restrict, or deny a license if an entity

does not provide appropriate notice. The most applicable notice requirements in this context are those contained in refusals clauses and in other state notice requirements specifically concerning health care.¹⁹⁴ For example, some states' patients' rights provisions expressly include the right to complain about care to the state licensing entity and require that the health care institutions provide patients upon admission with written notice of this right and the relevant telephone number for lodging a complaint.¹⁹⁵ Several states tabulate and publicize the nature of complaints against health care facilities.¹⁹⁶

Some states also have government-generated report cards that rate licensed facilities on several different components. Rated components include the scope of services, success rates on certain procedures, and performance on patients' rights measures (e.g., communication with patients).¹⁹⁷ Advocates are advised to: consult these reports to determine if they monitor facilities' notice and disclosure concerning religious restrictions, make complaints through recommended avenues about lack of appropriate warning, and encourage the inclusion in any state surveys or report cards of questions about notice concerning religious restrictions as one of the components they are measuring.

Health care consumers and advocates should complain to appropriate governmental entities when the required notice is not being provided. This approach not only encourages the enforcement entity to take action, but also raises consumer awareness of restrictions when the complaints are publicized. It may also result in different con-

duct by the facilities that are the focus of the complaint (e.g., they might either make notice clearer or eliminate the restriction).¹⁹⁸

■ **State attorney general offices:**

State attorney general offices have authority to enforce notice requirements or pursue other remedies pursuant to several types of notice laws. State attorney general offices also usually have responsibilities for enforcing legal requirements concerning consumer protection, charities, antitrust, and health care issues generally (including issues related to conversions), although sometimes the state consumer protection office is housed outside the attorney general office.¹⁹⁹

■ **U.S. Department of Health and Human Services:**

The U.S. Department of Health and Human Services is the main enforcer (at the national, regional, and state levels) of the Medicare and Medicaid rules and can threaten to take corrective action if health care entities fail to provide appropriate notice under the Medicare/Medicaid rules.²⁰⁰ Since Medicare and Medicaid certification also requires compliance with all applicable laws, any of the other tools mentioned can also be helpful. The federal government provides some avenues for people to complain about health care entities that receive Medicare and Medicaid payments but do not comply with the programs' requirements.²⁰¹ In addition, federal law requires that certain types of complaints be made public.²⁰² As noted above, such publicity serves the dual role of informing the public and possibly changing institutional practice.

■ **Accrediting organizations:**

Advocates and their allies should also report to the accrediting entities. Accrediting groups (e.g., JCAHO and NCQA) can threaten to revoke or restrict a facility's accreditation if the accreditation standards concerning notice are not met.²⁰³ Accrediting entities have several mechanisms that enable patient and community representatives to report accreditation violations and recommend improvement on accreditation standards.²⁰⁴

The agencies above are the most likely ones to have authority to enforce the notice requirements. The following offices, however, also should be considered:

■ **Federal Trade Commission:**

Advocates should also consider filing a complaint with the Federal Trade Commission about a health care entity's advertising or marketing practices. Because no private right of action exists under the FTC Act, advocates will need to notify the FTC of their concerns, but the FTC ultimately decides whether or not to pursue any particular remedy.²⁰⁵

■ **State's attorney, district attorney, or prosecuting attorney:**

Some state UDAP laws grant authority to the office of the state's attorney, district attorney, or prosecuting attorney (in addition to the attorney general) to enforce the UDAP requirements.²⁰⁶

■ **State consumer protection office:**

Sometimes these offices are within the attorney general's office, but sometimes they are a separate entity.

An entity's failure to comply with any applicable laws may jeopardize Medicare and Medicaid payments.

Advocacy groups can use their networks to encourage people to complain to a facility and enforcing agencies about notice practices, and publicize the problem to the press.

■ **Consumer health assistance programs (sometimes referred to as “ombuds” or “ombudsman” programs):**

These programs are devoted to resolving individual disputes and otherwise helping consumers obtain quality health care at the policy level. Some apply to particular health care settings (e.g., long-term care, hospitals, insurers); some apply to particular populations (e.g., Medicare or Medicaid beneficiaries, privately insured).²⁰⁷

■ **Legislators:** Finally, federal, state, and local legislators may be willing to put pressure on enforcement entities, hold hearings, or propose stronger legal protections.

2. Private Individuals or Other Groups

A variety of important individuals and groups can work with advocates to expose institutional restrictions on care. They can help publicize the problem. Depending on the particular law that they are using and the remedies they are seeking, they also may be able to file lawsuits (i.e., have standing to sue). The individuals and groups most likely to serve as allies include:

■ **Health care consumers (e.g., current or former patients, either individually or as a group):** Most state UDAP and informed consent protections allow people in this group to sue. As noted above, state laws vary as to the type of injury the consumer must have suffered to sue. This injury requirement may also vary if the consumer is seeking monetary damages or an injunction to have the notice requirements enforced. The majority of courts grant limited standing under the Lanham Act to parties with commercial (as opposed to personal) interests.²⁰⁸

Therefore, consumers are unlikely to succeed with a Lanham Act claim. As noted above, consumers do not have standing to sue under the FTC Act.

■ **Potential health care consumers (e.g., prospective patients or residents of the community):** Potential health care consumers are most likely to be able to sue under state UDAP laws that do not require a showing of actual harm (typically when they are requesting that the notice requirements be enforced, rather than money damages).

■ **Advocacy groups:** Advocacy groups can use their networks to encourage people to complain to a facility about its notice practice. They can also complain to the enforcing agencies and publicize the problem to the press. They can address the issue of religious restrictions in any relevant report cards they issue.²⁰⁹ Sometimes the groups themselves may have standing to bring a lawsuit on behalf of their members (e.g., consumers).²¹⁰ They can also identify individuals who could file a lawsuit (possibly help create a class action). Appendix D lists national advocacy groups to consider enlisting.

■ **Donors to the facility:** Donors may be able to challenge the notice practices especially under charitable assets theories as discussed above. For example, they could assert that they gave money based on the hospital's representations that it was providing comprehensive primary care and women's health care to the community. They may argue that, in refusing to provide certain reproductive and other health services, the hospital is failing to fulfill its charitable mission.

■ **Competing health care institutions:** These entities most likely could seek relief under the Lanham Act and some state laws. The Lanham Act confers standing to sue upon “any person who believes that he or she is likely to be damaged” by a violation.²¹¹ Most courts have not required a plaintiff to be a defendant’s business competitor to have standing, although they usually require that plaintiffs demonstrate a reasonable interest to be protected against false advertising and look for some level of competition or commercial interest.²¹² As noted earlier, some states also have special unfair trade practices laws that limit recovery to injunctions and attorneys’ fees. Competing health care entities could argue that the restrictive entity’s false advertising lured potential customers away because the customers thought they could get comprehensive care when, in fact, they could not. Therefore, advocates should consider approaching other facilities in their communities that may be harmed by another hospital’s false advertisements regarding its reproductive health services.

■ **Health care practitioners (either individuals or groups) whose practices are limited by the restrictions:** Individual health care practitioners with hospital privileges, or who participate in managed care, may also face practice limitations as a result of an institution’s religious restrictions. These practitioners might be able to assert that the entity’s prohibition against providing certain information or referrals is hurting their practices outside the hospital and exposing them to lawsuits for lack of informed consent. The laws that apply to competing health care institutions discussed in the preced-

ing paragraph, as well as informed consent principles, are tools that could support these claims.²¹³

■ **Individuals with a legal obligation to ensure that the hospital complies with applicable laws (also known as corporate fiduciaries, e.g., hospital trustees):** Even if hospital trustees are unaware of the entity’s restrictive practices and its failure to provide notice about them, they could face legal sanctions for failing to fulfill their fiduciary responsibilities to ensure that the facility complies with all applicable laws.²¹⁴ Advocates should, therefore, inform trustees of their concerns regarding the hospital’s practices. In light of this potential legal exposure and their fiduciary obligations, trustees could put pressure on the rest of the hospital’s leadership to provide appropriate notice.

■ **The media:** The media, especially local investigative journalists, can be helpful in mounting a challenge by publicizing both the problem and the appropriate notices.

B.

Remedies and Those Who May Seek Them

Advocates may not succeed through direct negotiations with religious entities in getting them to provide services or appropriate warnings about restrictions. In these cases, advocates should consider pursuing other avenues to accomplish these goals. More specifically, advocates can examine the laws and statutes described in the previous section to determine whether they provide for any explicit remedies to correct the abuses they identify. Where such remedies do seem to exist, advocates must determine what actions they must take to seek to

Restricting an entity's ability to operate or receive funding until appropriate notice is provided can be especially powerful when the facility needs governmental approval to merge with another facility.

have them imposed. Even when there are no explicit remedies, remedies can sometimes be implied.²¹⁵ Remedies outside the statute may be available, as long as the statute itself does not say that its remedies exclude all others.

Advocates can identify and pursue these remedies even while they are negotiating directly with a health care entity. Indeed, a facility may face harsher penalties if it fails to respond appropriately to complaints, than if advocates bypass the facility and complain only to enforcement entities.²¹⁶ Furthermore, some laws require that, before filing a lawsuit, a potential plaintiff must first notify the potential defendants of the alleged violations of the law and give the defendants an opportunity to remedy the situation.²¹⁷ Several statutes also provide for attorneys' fees and costs when either the government or private groups or individuals go into court and the court grants remedies for statutory violations.²¹⁸

The main remedies that advocates may be able to pursue are:

- requiring the entity to provide the restricted service or to provide warnings about the restriction;
- limiting the facility's ability to operate or to participate in the Medicare and Medicaid program or some other benefit, such as accreditation or tax exemption, until appropriate notice is provided;
- making the entity pay the enforcement bodies; and
- making the entity pay private groups or individuals.

Below is a summary of each of these remedies and a brief discussion of the laws most likely to help achieve them. The groups or individuals most likely to seek the remedy are identified below as well.

1. The Entity Must Provide Services at Issue or Appropriate Notice

If the entity does not voluntarily agree to provide either the service or appropriate notice of the restrictions after negotiations with advocates and others, it could be forced to do one or the other.²¹⁹ Governmental enforcement agencies sometimes can order compliance without any court involvement.²²⁰ In other situations, the enforcement agency needs to ask a court to order compliance.²²¹ Private groups or individuals can also ask a court for this remedy, although it is more common for governmental entities to do so. This private action is sometimes authorized under state UDAP or patients' rights laws.²²²

2. The Entity's Ability to Operate or Receive Funding is Restricted until Appropriate Notice is Provided

A facility that does not comply with notice rules could also face restrictions on its ability to operate or receive funding. These types of remedies can be especially powerful when the facility needs governmental approval to expand or restrict services, for example in the context of a merger.²²³ The most serious sanctions are exclusion from participation in Medicare and Medicaid, as well as loss or revocation of accreditation.²²⁴ These sanctions, however, are rarely imposed. More likely, the enforcing entities will permit facilities to respond and correct deficiencies.²²⁵

3 The Entity Must Pay the Government

Some laws require that noncomplying entities pay the government a fine or financial penalty for not obeying the law.²²⁶ These include Medicare and Medicaid laws,²²⁷ state licensure laws,²²⁸

conversion laws,²²⁹ state UDAP laws,²³⁰ and the FTC Act.²³¹

Usually, it is the enforcing agency that imposes these penalties or asks a court to do so. It is unlikely that private groups or individuals would successfully petition a court to order an entity to pay government penalties. However, private individuals and groups may have some authority to highlight Medicare and Medicaid violations under the False Claims Act (FCA). Under the FCA, a person may bring an action on behalf of the federal government against an individual or entity that has made a false claim to the federal government.²³² The FCA has also been used to hold health care institutions liable for substandard quality of care.²³³

Advocates could therefore assert that the false claim was the facility's certification that it complied with the Medicare and Medicaid rules, as well as other applicable laws, when in fact it did not satisfy the notice requirements.²³⁴ Advocates could similarly argue that failure to provide notice of institutional religious restrictions not only violates the Medicare and Medicaid rules, but may also constitute substandard care, depriving patients of informed consent.

The False Claims Act is an extremely powerful tool in particularly compelling circumstances because of the extensive remedies and severe penalties for a violation. Damages include a civil penalty of \$5,000 to \$10,000 for each false claim (arguably each patient who did not receive appropriate notice), plus a fine of three times the amount of damages suffered by the government.²³⁵ A private party bringing the suit on behalf of the government receives a share of these damages and a prevailing plaintiff is entitled to an award of reasonable attorneys' fees and costs.²³⁶ Some state false claims acts might offer additional remedies.²³⁷

4. The Entity Must Pay Private Individuals or Groups

Several laws allow for private individuals or groups to receive payment from entities that violate the law. These include informed consent rules, patients' rights statutes, the False Claims Act, state UDAP laws, and the Lanham Act.²³⁸

When patients suffer injury as a result of being treated without informed consent, monetary damages are the most likely remedy.²³⁹ In addition, individual health care practitioners who want to obtain appropriate informed consent but who are constrained by institutional restrictions may be able to take some action against the institution.²⁴⁰

Moreover, some patients' rights statutes provide explicit remedies for private parties. For example, the Massachusetts patients' rights statute, which applies to hospitals, clinics, and nursing homes, among other entities, expressly allows any person whose rights under the law are violated to bring a civil action.²⁴¹ The strongest remedies are typically found in *nursing home* patients' rights statutes or elder abuse statutes (as opposed to *hospital* patients' rights provisions). State patients' rights statutes and elder abuse statutes provide for actual and punitive damages or injunctive relief, litigation costs, and attorneys' fees; they also sometimes grant class action status.²⁴² These patients' rights provisions are clearly relevant when a nursing home is not providing appropriate notices about religious restrictions, but also could be helpful if the main issue is with a hospital that is part of a health care system that includes nursing homes.

And, as noted above, private parties may bring actions under the False Claims Act, and, if they prevail, can receive a share of the damages awarded, including damages for false Medicare or Medicaid claims submitted by health care providers.²⁴³ The False Claims Act could

All states (except Iowa) and the District of Columbia permit individuals to sue for damages for UDAP violations.

also be used to seek payment to individuals or groups for failure to provide appropriate notice.

All states (except Iowa) and the District of Columbia permit individuals to sue for damages for UDAP violations.²⁴⁴ They also allow the state attorney general to obtain restitution on behalf of injured consumers (i.e., the attorney general obtains the award and distributes it to consumers).²⁴⁵

The remedies available for Lanham Act violations include disgorging profits earned by the defendant from the conduct in violation of the Act (that is, from false or misleading statements) and any damages sustained by the plaintiff for Lanham Act violations.²⁴⁶ It is important to remember, however, that plaintiffs under the Lanham Act can generally only be individuals or entities with a commercial interest, not individual consumers or government representatives.

The amount of money damages available under UDAP laws varies from state to state.²⁴⁷ Approximately half of all state UDAP statutes provide for treble or other multiple awards of the damages actually suffered.²⁴⁸ Damages provisions are generally construed to authorize the broadest remedy possible, fulfilling the statutes' purpose of eliminating deceptive practices and protecting consumers.²⁴⁹

If advocates identify a number of individuals with similar claims against a hospital, they may want to consider bringing a class action lawsuit for damages. In certain circumstances, the advocacy organization itself may have standing to sue, especially if the organization is a membership organization.²⁵⁰ Some state UDAP statutes explicitly allow for class actions,²⁵¹ some explicitly prohibit the use of class actions,²⁵² and some are silent (in which case advocates would want to argue that class actions are permitted).²⁵³

C.

Examples of Successful Uses of Notice Provisions

Advocates have put pressure on enforcement agencies in several cases to condition certain state approval on the provision of appropriate notice of religious restrictions. For example, state officials in New York and Connecticut, prompted by women's health advocates and members of the community, used their power in reviewing CON applications to require notice of restrictions.

State conversion laws have also been especially helpful in two cases, one in California and one in the Connecticut case mentioned above. They both involved nonprofit hospitals converting; the California deal, however, involved conversion to a nonprofit, Connecticut to a for-profit. Both cases took advantage of notice provisions and opportunity for public input to identify the potential restrictions in reproductive and other health services; both resulted in state approval of the transactions at issue being contingent on having arrangements to ensure either that such services would not be restricted or that appropriate notice was provided where restrictions remained.

The New Hampshire case shows how a state's charitable trust laws can be used to ensure that the public receives notice of proposed limitations on care and then has an opportunity to provide input into the governmental approval process.

In all of these cases, advocates primarily focused on preservation of services in light of the religious restrictions. The cases are discussed in this report, however, because they also illustrate how notice provisions were used to ensure that the public received appropriate notice of any such limitations, both during the governmental approval process

and once the arrangements were finalized. These efforts illustrate basic ways in which notice provisions can reduce the negative impact of religious restrictions. They serve as a foundation on which to build even stronger consumer protections with greater emphasis on notice rules and their implementation.

Below is a summary of several situations in which various notice provisions in the laws summarized in this report helped preserve services or ensure that appropriate notice to consumers of the restrictions were provided.

1. Seton Health Systems (Leonard Hospital Outpatient Clinics and St. Mary's Hospital) (New York)

A sectarian and nonsectarian hospital wanted to merge into Seton Health Systems (Seton) and needed CON approval to do so. The state approved the CON on the condition that the newly created hospital would, at a minimum, refer patients requesting sterilization or contraceptive services to a state, county or local government agency from whom the person may obtain a list of providers offering the services requested.²⁵⁴ Several patients—including one who was denied family planning services—and reproductive health service providers filed suit against the New York State Department of Health and the Public Health Council.²⁵⁵ They challenged the conditional CON granted to Seton, alleging that permitting Seton to make only indirect referrals to government agencies, and only when patients request, violated several state laws and regulatory provisions.²⁵⁶ The parties then settled. Seton agreed to provide patients with a detailed and current list of reproductive health service providers in the area, rather than just to refer patients to a government agency, and to review the list with the patient to help determine the most appropriate provider. In addition, Seton agreed to provide this list not

only when asked, but also when avoiding pregnancy was medically indicated.²⁵⁷ Seton further agreed that when it was medically indicated, Seton would follow up with patients to ensure that services were obtained and to provide continuity of care. Advocates thus used the CON process first to try to get appropriate notice of restrictions, and then as leverage in a lawsuit to get better notice provisions.

2. Sharon Hospital/Essent Health Care/St. Francis Arrangement (Connecticut)

In rural northwest Connecticut, for-profit Essent Healthcare sought state CON and conversion authorization to purchase the nonsectarian Sharon Hospital. One component of the sale involved an extensive tertiary care agreement between Essent and St. Francis Hospital in Hartford, a Catholic institution. Under the agreement, St. Francis was to provide advanced tertiary care to patients referred by Sharon Hospital for services unavailable at that institution. Reproductive health advocates were concerned about possible limits on services at St. Francis that could result from this agreement.²⁵⁸

Pursuant to state conversion laws, the Attorney General's office and the Connecticut Office of Health Care Access (OHCA) announced that they would examine the sale to ensure that community residents would have continued access to care at Sharon Hospital.²⁵⁹ Connecticut law also requires at least one public hearing prior to deciding whether to approve or disapprove a proposed sale.²⁶⁰ The process also allows individuals or groups to “intervene” in these proceedings when they demonstrate that participation is in the interests of justice and will not impair the orderly conduct of the proceedings.²⁶¹

In this case, the Connecticut Permanent Commission on the Status of Women (a state agency) and the Connecticut Coalition for Choice (a group formed to protect access to reproductive rights) intervened. They addressed the issue of whether the level of reproductive health services then being provided at Sharon Hospital would be reduced or eliminated after purchase by Essent and whether the proposed tertiary care relationship with St. Francis Hospital would adversely affect women's access to reproductive health services.²⁶²

Both the Attorney General and OHCA approved the sale in November 2001 with stipulations that Sharon Hospital fully inform any patients referred by Sharon Hospital to another facility about the range of services available at that facility.²⁶³ The final notice provision also required Essent and Sharon Hospital to make "best efforts" to educate doctors and staff about their obligations.

In February 2002, Sharon Hospital and Essent Healthcare submitted a CON application seeking authorization to transfer the hospital's ownership to Essent.²⁶⁴ As required by law, OHCA held a public hearing regarding the CON application. Once again, the Commission on the Status of Women was granted status as an intervener with limited rights and the Connecticut Coalition for Choice was granted status as an informal participant.²⁶⁵ In March 2002, the Attorney General and OHCA issued final approval for the sale.²⁶⁶ As a condition of state approval, Essent agreed to establish a tertiary care agreement with a health care provider that offers the full range of health care services that are legally permissible and available in Connecticut, including reproductive health services.²⁶⁷

Advocates in the Sharon Hospital case used both the CON and conversion process to strengthen notice provisions about religious restrictions and

to ensure that the full range of health care services remained available in the community.

3. St. John's Hospital and Catholic Health Services (New York)²⁶⁸

In Smithtown, New York, Episcopal Health Services ("EHS") decided to sell St. John's Hospital to Catholic Health Services ("CHS"), a New York-based regional operator. St. John's previously had no religious restrictions in the delivery of health care. Nonprofit corporation law required attorney general and court approval before the sale could be consummated.²⁶⁹ Advocates therefore brought their concerns about reductions in reproductive and end-of-life care to the attention of the Attorney General.²⁷⁰

The Attorney General ultimately conditioned approval of the sale on the hospital's agreement to notify the community of the new restrictions and to provide a toll-free hotline informing consumers about where these services could be obtained.²⁷¹ As a condition of approving the sale of the hospital, EHS was required to notify patients that the hospital's religious dictates may supercede patients' written requests regarding their end-of-life care, and also agreed to inform the community of reductions in reproductive health services.²⁷² In this case, advocates used both the nonprofit and the CON laws to force the state attorney general and health department to examine the transaction's impact on reproductive and other health services and to condition the transaction's approval on certain notice provisions about religious restrictions. The extent to which these disclosure requirements have been successfully implemented was unclear when this report went to press

4. Elliot Hospital/Catholic Medical Center/Optima (New Hampshire)²⁷³

Three years after the nonsectarian Elliot Hospital in Manchester, New Hampshire, merged with the Catholic Medical Center to form Optima Health, the Board of the new entity voted to severely restrict abortion services at all Optima hospitals, including Elliot Hospital. Charitable trust laws proved to be particularly effective in protecting the community's right to receive notice of, and be involved in, the merger between the two nonprofit hospitals. The New Hampshire Attorney General investigated the matter based on hospital and community members' complaints about the new policy. The Attorney General determined that Optima had failed to meet the law's requirement to inform and receive input from the public regarding the impact of the merger on each hospital and the community. After the Attorney General's report, the merger disintegrated and Elliott Hospital restored services. This case shows how advocates used the charitable trust law's notice requirements to focus the Attorney General on ensuring that Elliott Hospital's charitable mission was being followed.

5. Sutter Hospital and Mercy Hospital (California)

In California, the Catholic Mercy Hospital sought to take over the lease and business operations of the county-owned Sutter Hospital.²⁷⁴ California has a strong nonprofit-to-nonprofit conversion statute and regulations,²⁷⁵ which mandate attorney general pre-transaction review and community public hearings. Advocates used the community public hearings to gain assurances that certain reproductive services would not be eliminated at either hospital.²⁷⁶ The Attorney General approved the transaction only on the conditions that current reproductive health services would be maintained and that any proposed service reductions due to religious bans be subject to attorney general approval to ensure the continued availability of reproductive health services elsewhere.²⁷⁷ The conversion process thus allowed advocates to receive notice of the proposed changes, which in turn enabled them to seek assistance from the Attorney General in conditioning approval on continued access to services.

SECTION IV

Conclusion

The refusal of certain institutions to provide important health care services based on religious beliefs creates serious barriers to care. Health care consumers, particularly women, are at risk when these institutions do not provide notice of restrictions in a timely and accurate way. Federal and state laws can be used to protect consumers by requiring appropriate notice by health care entities. Although these legal tools have rarely been used in this context, they offer significant potential in helping health care consumers get the information they need to make informed decisions about their care.

APPENDIX A

An Advocate's Consumer Protection Checklist

This is a checklist for advocates or attorneys who might want to challenge a health care entity's notice practices about its religious restrictions on health care. The full report provides more detail on these items. The National Women's Law Center may provide help in specific cases (info@nwlc.org or 202-588-5180).

1. Find out as much information about the facility as you can, because different notice laws may apply depending on the following:

- What type of entity is it (e.g., hospital, nursing home, managed care organization, pharmacy)?
- Is it part of a larger system or affiliated with another entity?
- Is it owned or operated by a religious body and, if so, what is it?
- Is there a plan to change ownership or the way the hospital runs (e.g., merger, consolidation, other affiliation, reduction in services) that requires federal, state or local approval or review?
- Is the entity a for-profit or nonprofit organization?
- Is it tax-exempt?
- Is it a public or privately owned facility (generally, public entities cannot refuse to provide services based on religious or moral objections)?

2. Identify which services are (or will be) banned and how.

An entity may ban providing services, paying for services, counseling about services, or making referrals for services.

- Services
 - abortion (medical or surgical)
 - treatment of ectopic pregnancies with certain medications (e.g., mifepristone)
 - contraceptive services or counseling
 - HIV and STD risk-reduction counseling on the use of condoms
 - sterilization (e.g., tubal ligation, vasectomy)
 - emergency contraception ("morning-after" pills) for rape survivors or others
 - research or treatment involving embryonic stem cells or fetal stem cells, or clinical trials or research where participants need to take birth control to participate
 - infertility treatments
 - certain end-of-life care (e.g., withholding artificially administered food and drink, forgoing treatment for pregnant patients)
 - any other restrictions (describe)
- Restrictions on individual health care practitioners

- restrictions on health practitioners outside of restricted entity (e.g., services provided at a clinic or in private practice not associated with the entity)
- restrictions on health care practitioners who lease space from entity, even though space is not part of entity (describe)
- any other restrictions (describe)

3. Identify institutional notice

practices. The following questions regarding the entity's notice practices should be answered:

- Nature of notice
 - What is the form of notice (e.g., typeface, language)?
 - To whom is notice provided (e.g., patients or prospective patients, legally authorized representative, enrollees, prospective enrollees)? If prospective, how is "prospective" defined?
 - How often and/or when is notice provided (e.g., at admission, preadmission, application for coverage, annually)?
 - Is the notice clear, or is it inconsistent, misleading, or confusing compared to other notices the entity provides? Is there any evidence that hospital staff, patients, or public at large was confused about notice practices? For example, are there specific individuals who have said they are confused or are there patient surveys showing confusion about the notice? Does the notice leave out important information needed to make informed decisions about an individual's health care?
 - How responsive is the institution to complaints about or requests for more information about its religious restrictions?
- What was the process for adopting the notice practice? For example, was there any opportunity for input from community, hospital employees, or medical staff?
- Location of notice. How are patients informed of the restrictions?
 - posted notices (e.g., are they posted where everyone can see them, inside or outside of the facility or on a bulletin board in an area patients never see?). Are they posted in admissions and waiting areas for inpatient admissions, outpatient services, emergency room, clinics, business offices?
 - advertisements (e.g., print, television, radio, website, phone book) and/or marketing material
 - press releases, community newsletters and/or community education programs
 - admissions material
 - patients' rights brochures
 - statements made in public (e.g., interviews, in court and administrative hearings or agencies, speeches by hospital administrators, anniversary commemorations, dedications and statements at other types of ceremonies)
 - fundraising material and charity drives
 - insurance contracts and other insurance documents
 - independent investigative reports (e.g., newspaper, advocacy groups)
 - governing or legal documents that patients or prospective patients might not usually see (these may include evidence that the entity was purposely misleading con-

sumers about restrictions).¹

Examples of these documents are: the entity's mission statement, constitution, corporate by-laws, medical staff by-laws, policy and procedures manual, articles of incorporation, code of ethics, contracts, applications for government approval or funding, annual report, and court papers.

- Types of misleading statements that advocates can use as a basis to challenge notice practices when religious restrictions exist. The following are some examples of the kinds of phrases, assertions, or omissions that could be considered misleading depending on the nature of the restrictions:

- providing comprehensive women's health care
- providing comprehensive primary care
- addressing community needs and patients' needs
- not mentioning religious affiliation
- commitment to honest and open communication with community
- honoring patient preferences as long as they are consistent with religious teaching (but entity does not tell patients about religious guidance or potential conflict with patients' needs)

4. Build support on your side. The information above will help you build both community and government support to address your notice

concerns. Listed below are possible allies to consider:

- Advocacy organizations at national (see Appendix D), state, and local level, including grass-roots organizers
- Governmental enforcement agencies (see Appendix B). Support for reproductive health care is only one factor in deciding how to approach governmental officials.² Officials' statements on preventive health care, access to care, disparities, consumer protection, managed care, and health care reform are all useful in encouraging agencies to act on this issue.

National level (or local counterparts, depending on structure)

- U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS)
- U.S. Federal Trade Commission and Department of Justice
- accrediting entities (e.g., JCAHO, NCQA)
- U.S. senators and representatives (to put pressure on government enforcement entities, to hold public hearings on the problems, to advocate for more protective legislation)

State level

- attorney general office (may have charities, health, consumer protection divisions)

¹ Federal and state freedom of information laws allow advocates and others access to government documents that could help mount a challenge to notice practices. For specific federal and state freedom of information provisions, see the website of the National Freedom of Information Coalition (NFOIC), available at <http://www.nfoic.org/web/index.htm>. For more examples of these types of documents, see also Elena N. Cohen & Jill C. Morrison, Nat'l Women's Law Ctr., Hospital Mergers and the Threat to Women's Reproductive Health Services: Using Charitable Assets Laws to Fight Back, Appendix B (2001).

² For the views on reproductive health of selected state officials, see NARAL Pro-Choice America, Who Decides? A State-by-State Review of Abortion and Reproductive Rights (12th Edition, 2003), available at <http://www.naral.org/publications/whodecides2003.cfm>.

- district attorney or state's attorney (only for false and deceptive practices)
- health department divisions with responsibility for licensing, patient complaints, reviewing change in entity status; insurance department (e.g., for actions involving managed care entities)
- general consumer protection office or ombuds office
- legislators (to put pressure on government enforcement entities, to hold public hearings on the problems, to advocate for more protective legislation)
- Current or former patients, either individually or as a group
- Prospective patients or residents of the community the facility serves
- Donors to the facility
- Individual or group of health care practitioners whose practices have been limited by the restrictions
- Competing health care institutions
- Individuals with obligations to ensure that the hospital complies with applicable laws (corporate fiduciaries, i.e., the people on the hospital board of trustees)
- Press

5. Identify legal notice requirements.

After advocates have collected the above information, they need to determine which legal tools are available in a particular situation. They (and/or their attorneys) should consult the following: federal, state, and even sometimes local statutes, regulations, other documents (e.g., formal and informal opinions, letters, memos) from government sources (e.g., attor-

neys general, health department, consumer protection office, ombuds programs, insurance department), cases, secondary authorities (e.g., law review articles) and authorities from other states.

- Institutional refusal clause notice requirements
- Other notice requirements for health care entities
 - Medicare and Medicaid
 - State notice requirements
 - marketing, advertising
 - patients' rights
 - informed consent
 - counseling
 - certificate of need (CON) and other requirements about reducing services
 - conversion
 - community benefit
 - licensing
 - accreditation
- Unfair and deceptive acts and practices
 - state unfair and deceptive acts and practices law
 - federal law (FTC Act and Lanham Act)
- Other laws
 - common law fraud or misrepresentation
 - nonprofit corporation law
 - charitable trust law
 - antitrust law
 - tax law (and community benefits)

6. Identify potential legal remedies and those who can seek them.

The appropriate approach will depend on the particular law and the individuals or groups seeking the remedy (see numbers 4 and 5 above). For any of the following remedies, advocates should communicate with the health care entity, report to relevant governmental or accrediting offices, and/or initiate private lawsuits (if government offices are not enforcing law and/or if private individuals or groups have standing to sue):

- Entity must provide services at issue or provide appropriate notice
- Entity's ability to operate or receive government funding is restricted until appropriate notice is provided
- Entity must pay fines to the government
- Entity must pay individuals or groups for entity's failure to provide care or notice

7. Contact health care entity to ask about religious restrictions and insist on appropriate notice.

8. Consider formal action.

- Contact applicable federal, state, local government and accreditation entities to file a complaint for failure to provide appropriate notice. (See Appendix B for contact information and Appendix C for sample letter.)
- Initiate (or help initiate) private lawsuits

9. Monitor performance once agreement to provide appropriate notice has been reached.

APPENDIX B

Consumer Protection Governmental Agencies

Advocates can use this appendix to find contact information for agencies to report complaints concerning notice of religious restrictions and other related consumer complaints. The National Women's Law Center completed collection of this information in summer of 2003 by consulting governmental websites. There may be relevant contact information that exists but was not readily available, and therefore was not included. Advocates should be aware of the general political climate and position of the officials they consult, especially with respect to reproductive health. For a description of the positions of selected officials on reproductive health issues, see NARAL Pro-Choice America, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights* (12th Edition, 2003), available online at <http://www.naral.org/publications/whodecides2003.cfm>.

Contacts for Federal Agencies

Federal Trade Commission

Consumer Response Center
600 Pennsylvania Avenue, NW
Washington, DC 20580
Toll free Tel: 1-877-FTC-HELP (382-4357)
<http://www.ftc.gov/ftc/consumer.htm>
<http://www.ftc.gov/ftc/complaint.htm> (for filing a complaint against a competitor entity)

Centers for Medicare and Medicaid Services

<http://cms.hhs.gov/medicaid/mcontact.asp> (for federal Medicaid offices)
<http://cms.hhs.gov/about/regions/> (regional CMS offices to register a complaint about Medicare);
1-800-MEDICARE; medicare@custhelp.com

Contacts for Accrediting Organizations

Joint Committee on Accreditation of Healthcare Organizations (JCAHO)

One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Tel: 630-792-5000
<http://www.jcaho.org/contact+us/index.htm>
Complaint hotline: 800-994-6610; complaint@jcaho.org

National Committee for Quality Assurance (NCQA)

2000 L Street, NW, Suite 500
Washington, DC 20036
Tel: 202-955-3500
Fax: 202-955-3599
<http://www.ncqa.org>
consumersupport@ncqa.org

Contacts for State Agencies

Listed in the chart below are contacts for agencies for each state. The columns entitled “State Consumer Affairs Offices” and “Other Offices of Interest” sometimes include attorney general or health department information. In addition, there are websites that have updated information for the following state agencies:

State insurance departments: National Association of Insurance Commissioners at <http://www.naic.org/cis/fileComplaintMap.do> (for filing complaints directly with state insurance departments).

State Medicaid offices: Centers for Medicare and Medicaid Services at <http://cms.hhs.gov/medicaid/mcontact.asp>.

Consumer Health Assistance (Ombuds) Programs: Health Assistance Partnership at <http://www.healthassistancepartnership.org> (see the program locator section of the website to find the ombuds or health assistance program in the relevant state).

State Attorneys General: National Association of Attorneys General at http://www.naag.org/ag/full_ag_table.php.

State Attorney General Offices	State Health Departments	State Consumer Affairs Offices	Other Offices of Interest
Honorable Bill Pryor Attorney General of Alabama Alabama State House 11 South Union Street, Third Floor Montgomery, AL 36130-0152 Tel: 334-242-7300 Website: http://www.ago.state.al.us	Alabama Department of Public Health 201 Monroe Street, RSA Tower Montgomery, AL 36104 Tel: 334-206-5300 Website: http://www.adph.org	Consumer Affairs Section Office of the Attorney General of Alabama 11 South Union Street Montgomery, AL 36130-0152 Tel: 334-242-7335 Alabama Tel: 1-800-392-5658 Fax: 334-242-2433 Contact: Rhonda Barber	
Honorable Gregg Renkes Attorney General of Alaska P.O. Box 110300 Diamond Courthouse Juneau, AK 99811-0300 Tel: 907-465-3500 Website: http://www.law.state.ak.us	Alaska Department of Health and Social Services P.O. Box 110601 Juneau, AK 99811 Tel: 907-465-3030 Website: http://health.hss.state.ak.us/	Alaska Department of Law/Civil Division Fair Business Practices Section Consumer Protection Unit 1031 West 4th Avenue, Suite 200 Anchorage, AK 99501-1994 Tel: 907-269-5100 Fax: 907-276-8554	P.K. Wilson Provider and Beneficiary of Medical Services 4501 Business Park Blvd., Suite 24 Anchorage, AK 99503-7167 Tel: 907-561-2171 Recipient Hotline: 800-211-7470 Fax: 907-561-1684
Honorable Terry Goddard Attorney General of Arizona 1275 West Washington Street Phoenix, AZ 85007 Tel: 602-542-5025 Website: http://www.attorneygeneral.state.az.us	Arizona Department of Health Services 1740 West Adams Street Phoenix, AZ 85007-2670 Tel: 602-542-1001 Website: http://www.hs.state.az.us	Secretary of State of Arizona Customer Service Center 14 North 18th Avenue Phoenix, AZ 85007 Tel: 602-542-6187 Email: charities@sos.state.az.us	Arizona Department of Health Services Division of Assurance and Licensure Services 1647 East Morten Avenue Phoenix, AZ 85040 Tel: 602-674-4340 Website: http://www.hs.state.az.us/als/index.htm

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

Honorable Mike Beebe Attorney General of Arkansas 323 Center Street, Suite 200 Little Rock, AR 72201-2610 Tel: 800-482-8982 Website: http://www.ag.state.ar.us Email: oag@ag.state.ar.us	Arkansas Department of Health 4815 West Markham Little Rock, AR 72205 Tel: 501-661-2000 Website: http://www.healtharkansas.com	Office of the Attorney General of Arkansas Consumer Protection Division 323 Center Street, Suite 200 Little Rock, AR 72201-2610 Tel: 501-682-2341 Arkansas Tel: 800-482-8982 Fax: 501-682-8118 Email: consumer@ag.state.ar.us	Arkansas Department of Health Bureau of Health Resources Quality Assurance 4815 West Markham Little Rock, AR 72205 Tel: 501-661-2000 Website: http://www.healtharkansas.com
Honorable Bill Lockyer Attorney General of California 1300 I Street Suite 1740 Sacramento, CA 95814 Tel: 916-445-9555 Website: http://www.caag.state.ca.us	California Department of Health Services P.O. Box 942732 Sacramento, CA 94234-7320 Tel: 916-445-4171 Website: http://www.dhs.cahwnet.gov Health Rights Hotline 519 12th Street Sacramento, CA 95814 Tel: 916-551-2100 Website: http://www.hrh.org	California Department of Consumer Affairs 400 R Street Sacramento, CA 95814 Tel: 800-952-5210, 916-445-1254 Website: http://www.dca.ca.gov California Registry of Charitable Trusts P.O. Box 903447 Sacramento, CA 94203-4470 Tel: 916-445-2021 Website: http://caag.state.ca.us/charities	California Department of Justice Office of the Attorney General Public Inquiry Unit P.O. Box 944255 Sacramento, CA 94244-2550 Tel: 916-322-3360 Online Complaint Form: http://caag.state.ca.us/consumers/mailform.htm
Honorable Ken Salazar Attorney General of Colorado Department of Law 1525 Sherman Street, 7th Floor Denver, CO 80203 Tel: 303-866-4500 Fax: 303-866-5691 Website: http://www.ago.state.co.us	Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246-1530 Tel: 303-692-2035 Website: http://www.cdph.state.co.us/cdphehome.asp	Secretary of State of Colorado Licensing Division 1560 Broadway, Suite 200 Denver, CO 80202-5169 Tel: 303-894-2200, ext. 6407 Fax: 303-869-4861 Contact: Chris Cash - Charitable Solicitations	Health Facility Division Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246-1530 Tel: 303-692-2800 Email: health.facilities@state.co.us
		Colorado Consumer Line Department of Law 1525 Sherman Street, 7th Floor Denver, CO 80203 Tel: 800-222-4444	

Honorable Richard Blumenthal Attorney General of Connecticut P.O. Box 120 Hartford, CT 06141-0120 Tel: 860-808-5318 Fax: 860-808-5387 Website: http://www.cslb.org/attgen/	Connecticut Department of Public Health 410 Capitol Avenue P.O. Box 340308 Hartford, CT 06134-0308 Tel: 860-509-8000 Website: http://www.dph.state.ct.us	Connecticut Department of Consumer Protection 165 Capitol Avenue Hartford, CT 06106 Tel: 860-713-6300 Fax: 860-713-7239 Website: http://www.state.ct.us/dcp/complaints.htm	Complaint / Compliance Unit Division of Health Systems Regulation Connecticut Department of Public Health 410 Capitol Avenue Hartford, CT 06134-0308 Tel: 860-509-7407 Online Complaint Form: http://www.dph.state.ct.us/BHCS/Complaints/complaint_form.htm
Honorable M. Jane Brady Attorney General of Delaware Carvel State Office Building 820 North French Street Wilmington, DE 19801 Tel: 302-577-8400 Website: http://www.state.de.us/attgen	Delaware Health and Social Services 1901 North Du Pont Highway Main Building New Castle, DE 19720 Tel: 302-255-9040 Fax: 302-255-4429 Website: http://www.state.de.us/dhss	Delaware Department of Justice Consumer Protection Division Carvel State Office Bldg. 820 North French Street Wilmington, DE 19801 Tel: 302-577-8600	
Honorable Robert J. Spagnoletti District of Columbia Corporation Counsel 441 4th Street, NW Suite 1060N Washington, DC 20001 Tel: 202-727-3400 Website: http://occ.dc.gov	District of Columbia Department of Health 825 North Capitol Street, NE Washington, DC 20002 Tel: 202-442-5999 Website: http://dchealth.dc.gov	District of Columbia Department of Consumer and Regulatory Affairs 941 North Capitol Street, NE Washington, DC 20002-4259 Tel: 202-442-4400 Website: http://dcra.dc.gov	District of Columbia Department of Health 825 North Capitol Street, NE Washington, DC 20002 Complaint/Incidence Report Hotline: 202-442-5833 Online complaint form: http://dchealth.dc.gov/form/complaint_form.shtm
Honorable Charlie Crist Attorney General of Florida The Capitol, PL-01 Tallahassee, FL 32399-1050 Tel: 850-487-1963 Fax: 850-487-2564 Website: http://myfloridalegal.com/contact	Florida Department of Health 4052 Bald Cypress Way Bin# A00 Tallahassee, FL 32399-1701 Tel: 850-245-4321 Website: http://www.doh.state.fl.us	Florida Dept. of Agriculture and Consumer Services Division of Consumer Services 2005 Apalachee Parkway Rhodes Building Tallahassee, FL 32399-6500 Tel: 850-488-2221 Florida Tel: 800-435-7352 Website: http://www.doacs.state.fl.us/	Florida Medical Quality Assurance 4052 Bald Cypress Way Bin# C00 Tallahassee, FL 32399-3250 Tel: 850-245-4224

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

Honorable Thurbert E. Baker Attorney General of Georgia 40 Capitol Square, SW Atlanta, GA 30334-1300 Tel: 404-656-3300 Fax: 404-657-8733 Website: http://www.ganet.org/ago/	Georgia Department of Human Resources Division of Public Health Two Peachtree Street, NW Atlanta, GA 30303-3186 Tel: 404-657-2700 Website: http://www.ph.dhr.state.ga.us Email: (Public Health Questions) gdpinfo@dhr.state.ga.us	Securities and Business Regulation Division Secretary of State of Georgia 2 MLK Jr. Drive, SE Suite 802, West Tower Atlanta, GA 30334 Tel: 404-656-3920 Fax: 404-657-8410 Website: http://www.sos.state.ga.us/securities/	
Honorable Mark J. Bennett Attorney General of Hawaii 425 Queen Street Honolulu, HI 96813 Tel: 808-586-1500 Website: http://www.state.hi.us/ag/index.html	Hawaii Department of Health 1250 Punchbowl Street Honolulu, HI 96813 Tel: 808-586-4400, 586-4442 Website: http://hawaii.gov/doh	Hawaii Department of Commerce & Consumer Affairs Leiopapa A Kamehameha Building 235 South Beretania Street, Suite 801 Honolulu, HI 96813 Tel: 808-586-2630 Fax: 808-586-2640 Email: ocp@dccca.hawaii.gov	Hawaii Office of Health Care Assurance Medicare Section 601 Kamokila Boulevard, Room 395 Kapolei, HI 96707 Tel: 808-692-7420 Hawaii Office of Health Care Assurance State Licensing Section 601 Kamokila Boulevard, Room 361 Kapolei, HI 96707 Tel: 808-692-7400
Honorable Lawrence Wasden Attorney General of Idaho 700 West Jefferson Street P.O. Box 83720 Boise, ID 83720-1000 Tel: 208-334-2400 Fax: 208-334-2530 Website: http://www2.state.id.us/ag/	Idaho Department of Health and Welfare 450 West State Street, 10th Floor P.O. Box 83720 Boise, ID 83720-0036 Tel: 208-334-5546 Website: http://www2.state.id.us/dhw/	Consumer Protection Unit Civil Litigation Division Office of the Attorney General of Idaho 700 West Jefferson Street P.O. Box 83720 Boise, ID 83720-1000 Tel: 208-334-2424 Idaho Tel: 800-432-3545 Fax: 208-334-2830 Email: consumer_protection@ag.state.id.us	Bureau of Facility Standards Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0036 Tel: 208-334-6626

Honorable Lisa Madigan Attorney General of Illinois James R. Thompson Center 100 West Randolph Street Chicago, IL 60601 Tel: 312-814-3000 Website: http://www.ag.state.il.us	Illinois Department of Public Health 535 West Jefferson Street Springfield, IL 62761 Tel: 217-782-4977 Fax: 217-782-3987 Website: http://www.idph.state.il.us	Consumer Protection Bureau Office of the Attorney General of Illinois 500 South Second Street Springfield, IL 62706 Tel: 800-243-0618	Illinois Office of Healthcare Regulation 525 W. Jefferson Street, 5th Floor Springfield, IL 62761-0001 Hotline Tel: 800-252-4343 Illinois Healthcare Bureau 100 West Randolph Street Chicago, IL 60601 Healthcare Bureau Complaint Hotline Tel: 877-305-5145 Fax: 312-793-0802 Healthcare Bureau Complaint Form: http://www.ag.state.il.us/consumer/hcform.pdf
Honorable Steve Carter Attorney General of Indiana Indiana Government Center South Fifth Floor 302 West Washington Street Indianapolis, IN 46204 Tel: 317-232-6201 Fax: 317-232-7979 Website: http://www.in.gov/attorneygeneral/	Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Tel: 317-233-1325 Website: http://www.in.gov/isdh	Consumer Protection Division Office of the Attorney General of Indiana 302 West Washington Street 5th Floor Indianapolis, IN 46204 Tel: 800-382-5516, 317-232-6330	Home Health and Hospice Hotline 800-227-6334
Honorable Tom Miller Attorney General of Iowa Hoover State Office Building 1305 East Walnut Street Des Moines, IA 50319 Tel: 515-281-5164 Fax: 515-281-4209 Website: http://www.iowaAttorneyGeneral.org	Iowa Department of Public Health 321 East 12th Street Lucas State Office Building Des Moines, IA 50319-0075 Tel: 515-281-7689 Website: http://idph.state.ia.us/default.asp	Consumer Protection Division Office of the Attorney General of Iowa Hoover State Office Building 1300 East Walnut Des Moines, IA 50319 Tel: 515-281-5926 E-mail: consumer@ag.state.ia.us	Patient Safety Program Iowa Department of Public Health Lucas State Office Building 321 East 12th Street Des Moines, IA 50319-0075 Tel: 515-281-8936 Website: http://idph.state.ia.us/patient_safety/patientsafety.html

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

Honorable Phill Kline Attorney General of Kansas 120 SW 10th Avenue, 2nd Floor Topeka, KS 66612-1597 Tel: 785-296-2215 Fax: 785-296-6296 Website: http://www.ink.org/public/ksag	Kansas Department of Health and Environment Charles Curtis State Office Building 1000 SW Jackson Topeka, KS 66612 Tel: 785-296-1500 Fax: 785-368-6368 Website: http://www.kdhe.state.ks.us	Ron Thornburgh Secretary of State of Kansas Memorial Hall, 1st Floor 120 SW 10th Avenue Topeka, KS 66612-1594 Tel: 785-296-4564 Email: Ron_Thornburgh@kssos.org Consumer Protection/Antitrust Division Office of the Attorney General of Kansas 120 SW 10th Street, 2nd Floor Topeka, KS 66612-1597 Tel: 785-296-3751 Fax: 785-291-3699 Consumer Hotline Tel: 800-432-2310 Online Consumer Complaint Form http://www.ksag.org/contents/consumer/complaint.htm	Bureau of Health Facilities Kansas Department of Health and Environment Joseph Kroll, Director 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365 Tel: 785-296-1240 Fax: 785-296-1266 Email: healthfacilities@kdhe.state.ks.us
Honorable Albert Benjamin Chandler III Attorney General of Kentucky The Capitol, Suite 118 700 Capitol Avenue Frankfort, KY 40601-3449 Tel: 502-696-5300 Website: http://www.law.state.ky.us Email: attorneygeneral@law.state.ky.us	Kentucky Department for Public Health 275 East Main Street HISGWA Frankfort, KY 40621 Tel: 502-564-3970 Fax: 502-564-2556 Website: http://publichealth.state.ky.us/	Consumer Protection Division Office of the Attorney General of Kentucky The Capitol, Suite 118 700 Capitol Avenue Frankfort, KY 40601 Tel: 502-696-5389	Office of Inspector General of Kentucky Division of Community Health Services 275 East Main Street 5E-B Frankfort, KY 40621 Tel: 502-564-2888 Fax: 502-564-6546 Website: http://chs.state.ky.us/oig/community/complaintinfo.htm
Honorable Richard P. Ieyoub Attorney General of Louisiana Department of Justice P.O. Box 94095 Baton Rouge, LA 70804-4095 Tel: 225-342-7013 Fax: 225-342-5991 Website: http://www.ag.state.la.us	Louisiana Department of Health and Hospitals 1201 Capitol Access Road P.O. Box 629 Baton Rouge, LA 70821-0629 Tel: 225-342-9500 Fax: 225-342-5568 Website: http://www.dhh.state.la.us	Office of the Attorney General of Louisiana 301 Main Street, Suite 12th Floor Baton Rouge, LA 70801 Tel: 800-351-4889 Fax: 225-342-9637 Online Complaint Form: http://www.ag.state.la.us/forms/form100-complaint2.asp	Nursing Home Hotline: 888-810-1819

<p>Honorable G. Steven Rowe Attorney General of Maine 6 State House Station Augusta, ME 04333 Tel: 207-626-8800 Website: http://www.state.me.us/ag</p>	<p>Maine Bureau of Health 11 State House Station Key Plaza 286 Water Street Augusta, ME 04333 Tel: 207-287-8016 Fax: 207-287-9058 Website: http://www.state.me.us/dhs/boh/</p>	<p>Consumer Protection Division Office of the Attorney General of Maine Consumer Mediation Service 6 State House Station Augusta, ME 04333-0006 Tel: 207-626-8849 Fax: 207-626-8812</p>	<p>Maine Department of Professional and Financial Regulation Office of Licensing & Registration #35 State House Station Augusta, ME 04333-0035 Tel: 207-624-8603 Fax: 207-624-8637 Contact: Marlene M. McFadden Email: marlene.m.mcfadden@maine.gov Website: http://www.state.me.us/pfr/olr/</p>
<p>Honorable J. Joseph Curran, Jr. Attorney General of Maryland 200 St. Paul Place Baltimore, MD 21202-2202 Tel: 410-576-6300 Email: OAG@oag.state.md.us Website: http://www.oag.state.md.us</p>	<p>Maryland Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201 Tel: 410-767-6860 Maryland Tel: 877-463-3464 Website: http://www.dhmh.state.md.us</p>	<p>Office of the Secretary of State of Maryland Charitable Organizations Division State House Annapolis, MD 21401 Tel: 410-974-5534 Maryland Tel: 800-825-4510</p> <p>Consumer Protection Division Office of the Attorney General of Maryland 200 St. Paul Place Baltimore, MD 21202 Complaint hotline Tel: 410-528-8662</p>	<p>Online Healthcare Complaint Form http://www.oag.state.md.us/Forms/HEAUcompl.pdf</p>
<p>Honorable Tom Reilly Attorney General of Massachusetts One Ashburton Place Boston, MA 02108-1698 Tel: 617-727-2200 Website: http://www.ago.state.ma.us</p>	<p>Massachusetts Department of Public Health 250 Washington Street Boston, MA 02108-4619 Tel: 617-624-6000 Website: http://www.state.ma.us/dph/dph-home.htm</p>	<p>Division of Public Charities Office of the Attorney General of Massachusetts One Ashburton Place, Room 1413 Boston, MA 02108 Tel: 617-727-2200 Website: http://www.ago.state.ma.us/charity</p> <p>Office of the Attorney General of Massachusetts Consumer Complaint and Information Section 200 Portland Street Boston, MA 02114 Tel: 617-727-8400</p> <p>Online Complaint Form: http://www.ago.state.ma.us/con_pro/ccbot_h.pdf?searchStr=</p>	<p>Division of Health Care Quality Massachusetts Department of Public Health 10 West Street Boston, MA 02111-1212 Tel: 617-753-8104 Website: http://www.state.ma.us/dph/qualitytool/hcqfrm.htm</p> <p>Office of Patient Protection Massachusetts Department of Public Health Tel: 800-436-7757 Website: http://www.state.ma.us/dph/opp Email: opp.opp@dph.state.ma.us</p>

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

<p>Honorable Mike Cox Attorney General of Michigan P.O. Box 30212 525 West Ottawa Street Lansing, MI 48909-0212 Tel: 517-373-1110 Fax: 517-373-3042 Email: miag@ag.state.mi.us Website: http://www.ag.state.mi.us</p>	<p>Michigan Department of Community Health Sixth Floor, Lewis Cass Building 320 South Walnut Street Lansing, MI 48913 Tel: 517-373-3500 Website: http://www.michigan.gov/mdch</p>	<p>Charitable Trust Section Consumer Protection Division Department of Attorney General of Michigan P.O. Box 30214 Lansing, MI 48909-7714 Tel: 517-373-1152</p> <p>Consumer Protection Division Department of Attorney General of Michigan P.O. Box 30213-7713 Lansing, MI 48909 Tel: 517-373-1140 Fax: 517-241-3771</p> <p>Online Consumer Complaint/Inquiry Form: https://www.ag.state.mi.us/cp_division/w3cp_c01_new.asp</p>	<p>Office of Recipient Rights Michigan Department of Community Health 320 South Walnut Street Lewis Cass Building Lansing, MI 48913 Tel: 517-373-2319</p> <p>Online Complaint Form: http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_4901-14825--,00.html</p>
<p>Honorable Mike Hatch Attorney General of Minnesota 1400 NCL Tower 445 Minnesota Street St. Paul, MN 55101 Tel: 651-296-3353 Fax: 651-296-9663 Email: attorneygeneral@state.mn.us Website: http://www.ag.state.mn.us</p>	<p>Minnesota Department of Health P.O. Box 64975 St. Paul, MN, 55164-0975 Tel: 651-215-5800 Website: http://www.health.state.mn.us/</p>	<p>Charities Division Office of the Attorney General of Minnesota 1200 NCL Tower 445 Minnesota Street St. Paul, MN 55101 Tel: 651-296-8955</p> <p>Consumer Protection Office of the Attorney General of Minnesota 1400 NCL Tower 445 Minnesota Street St. Paul, MN 55101 Tel: 651-296-3353 Fax: 651-296-9663</p> <p>Online Consumer Complaint Form: http://www.ag.state.mn.us/pdf/complaintform_5.pdf</p>	<p>Office of Health Facility Complaints Minnesota Department of Health P.O. Box 64970 St. Paul, MN 55164-0970 Tel: 651-215-8702 Tel: 800-369-7994 Email: ohfc-complaints@health.state.mn.us</p>

<p>Honorable Mike Moore Attorney General of Mississippi P.O. Box 220 Jackson, MS 39205-0220 Tel: 601-359-3680 Website: http://www.ago.state.ms.us</p>	<p>Mississippi State Department of Health P.O. Box 1700 Jackson, MS 39215-1700 Tel: 601-576-7400 Website: http://www.msdh.state.ms.us</p>	<p>Secretary of State of Mississippi Charities Enforcement and Regulation P.O. Box 136 Jackson, MS 39205 Tel: 888-236-6167 Fax: 601-359-2663</p> <p>Consumer Protection Division Office of the Attorney General of Mississippi P.O. Box 22947 Jackson, MI 39225-2947 Tel: 601-359-4230</p> <p>Online Consumer Complaint Form: http://www.ago.state.ms.us/divisions/consumer/compform.pdf</p>
<p>Honorable Jeremiah W. Nixon Attorney General of Missouri Supreme Court Building 207 West High Street P.O. Box 899 Jefferson City, MO 65102 Tel: 573-751-3321 Fax: 573-751-0774 Website: http://www.ago.state.mo.us</p>	<p>Missouri Department of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102 Tel: 573-751-6400 Fax: 573-751-6041 Website: http://www.health.state.mo.us</p>	<p>Office of Attorney General of Missouri Consumer Protection Division Wainwright State Office Building 111 N. 7th St., Suite 204 St. Louis, MO 63101 Tel: 314-340-6816 Fax: 314-340-7957</p> <p>Online Consumer Complaint Form: http://www.ago.state.mo.us/complaint.htm</p> <p>Department of Health Consumer Protection Website: http://www.health.state.mo.us/ConsProt/ConsProt.html</p>

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

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111 North Sanders Street
P.O. Box 4210
Helena, MT 59604-4210
Tel: 406-444-5622
Fax: 406-444-1970
Website: <http://www.dphhs.state.mt.us>

Secretary of State of Montana
Room 260, Capitol
P.O. Box 202801
Helena, MT 59620-2801
Tel: 406-444-2034
Fax: 406-444-3976
E-mail: sos@state.mt.us

Montana Department of Administration
Consumer Protection Division
1219 8th Ave
P.O. Box 200501
Helena, MT 59620-0501
Tel: 406-444-4311

Online Consumer Complaint Form:
<http://discoveringmontana.com/doi/ConsumerProtectionComplaints/OnlineComplaintForm.asp>

Honorable Jon Bruning
Attorney General of Nebraska
2115 State Capitol
Lincoln, NE 68509-8920
Tel: 402-471-2682
Fax: 402-471-3297
Website: <http://www.nol.org/home/ago>

Nebraska Department of Health and
Human Services
P.O. Box 95044
Lincoln, NE 68509-5044
Tel: 402-471-2306
Website: <http://www.hhs.state.ne.us>

Secretary of State of Nebraska
Suite 2300
State Capitol
Lincoln, NE 68509
Tel: 402-471-2555
Fax: 402-471-3237
E-mail: sos08@nol.org

Consumer Protection Division
Secretary of State of Nebraska
2115 State Capitol
Lincoln, NE 68509
Tel: 800-727-6432

Nebraska Department of Health and
Human Services
Regulation and Licensure
Division of Investigations
301 Centennial Mall South
P.O. Box 95164
Lincoln, NE 68509-5164
Tel: 402-471-0175

Honorable Brian Sandoval
Attorney General of Nevada
100 North Carson Street
Carson City, NV 89701-4717
Tel: 775-684-1100
Website: <http://ag.state.nv.us>

Nevada State Health Division
505 East King Street, Room 201
Carson City, NV 89701
Tel: 775-684-4200
Fax: 775-684-4211
Website: <http://health2k.state.nv.us>

Secretary of State of Nevada
101 North Carson Street
Carson City, NV 89710
Tel: 775-684-5708
Website: <http://sos.state.nv.us/>

Bureau of Health Protection Services
Nevada State Health Division
1179 Fairview Drive
Carson City, NV 89701
Tel: 775-687-6353
Fax: 775-687-5197

<p>Honorable Peter W. Heed Attorney General of New Hampshire State House Annex 33 Capitol Street Concord, NH 03301-6397 Tel: 603-271-3658 Fax: 603-271-2110 Website: http://www.state.nh.us/nhdoj</p>	<p>New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857 Tel: 603-271-4958 Website: http://www.dhhs.state.nh.us</p>	<p>New Hampshire Department of Justice Charitable Trusts Unit 33 Capitol Street Concord, NH 03301 Tel: 603-271-3591 Fax: 603-271-2110</p> <p>New Hampshire Department of Justice Consumer Protection and Antitrust Bureau 33 Capitol Street Concord, NH 03301 Tel: 603-271-3641</p> <p>Online Consumer Complaint Form: http://www.state.nh.us/nhdoj/Consumer/conscmp.pdf</p>
<p>Honorable Peter C. Harvey Attorney General of New Jersey P.O. Box 080 Trenton, NJ 08625-0080 Tel: 609-292-4925 Fax: 609-292-3508 Website: http://www.state.nj.us/lps/oag/index.html</p>	<p>New Jersey Department of Health and Senior Services P. O. Box 360 Trenton, NJ 08625-0360 Tel: 609-292-7837 Fax: 609-292-0053 Website: http://www.state.nj.us/health</p>	<p>New Jersey Department of Law & Public Safety Division of Consumer Affairs Charities Unit P.O. Box 45027 Newark, NJ 07101 Tel: 973-504-6200</p> <p>New Jersey Department of Health and Senior Services Office of Managed Care P.O. Box 360 Trenton, NJ 08625-0360 Fax: 609-292-0807</p> <p>Managed Care Hotline: 888-393-1062 Facility Hotline: 800-792-9770</p>
<p>Honorable Patricia Madrid Attorney General of New Mexico P.O. Drawer 1508 Santa Fe, NM 87504-1508 Tel: 505-827-6000 Fax: 505-827-5826 Website: http://www.ago.state.nm.us</p>	<p>New Mexico Department of Health 1190 St. Francis Drive P.O. Box 26110 Santa Fe, NM 87502-6110 Tel: 505-827-2613 Website: http://www.health.state.nm.us</p>	<p>Division of Health Improvement New Mexico Department of Health Harold Runnels Bldg., Room N-3078 1190 St. Francis Drive P.O. Box 26110 Santa Fe, NM 87502-6110 Tel: 505-827-2651 Fax: 505-827-2695</p> <p>Registry of Charitable Organizations Attorney General of New Mexico 111 Lomas Blvd., NW, Suite 300 Albuquerque, NM 87102 Tel: 505-222-9090 Email: Charity.Registrar@ago.state.nm.us</p> <p>Consumer Protection Division Attorney General of New Mexico P.O. Drawer 1508 Santa Fe, NM 87504-1508 Tel: 800-678-1508</p> <p>Online Consumer Complaint Form: http://www.ago.state.nm.us/Protection/complaint/pdf/complaintform.pdf</p>

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

Honorable Eliot Spitzer Attorney General of New York Department of Law The Capitol 2nd Floor Albany, NY 12224 Tel: 518-474-7330 Website: http://www.oag.state.ny.us	New York Department of Health Coming Tower, Empire State Plaza Albany, NY 12237 Tel: 518-474-2011 Website: http://www.health.state.ny.us/home.html Consumer Healthcare Information Hotline: 800-206-8125 Website: http://www.health.state.ny.us/nysdoh/healthinfo/complaint.htm Area Offices Complaints Website: http://www.health.state.ny.us/nysdoh/consumer/director/hospicare.htm	Consumer Fraud and Protection Office of the Attorney General of New York 120 Broadway 3rd Floor New York, NY 10271 Tel: 212-416-8345 Consumer Helpline Tel: 800-771-7755	Healthcare Bureau Office of the Attorney General of New York 146 State Street 3rd Floor - Room 303 Albany, New York 12207 Tel: 518-474-8376 Fax: 518-402-2163 Healthcare Bureau Helpline 800-771-7755 Online Consumer Complaint Form: http://www.oag.state.ny.us/health/complaint_form.pdf
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Honorable Roy Cooper Attorney General of North Carolina Department of Justice P.O. Box 629 Raleigh, NC 27602-0629 Tel: 919-716-6400 Fax: 919-716-6750 Email: agjus@mail.jus.state.nc.us Website: http://www.jus.state.nc.us	North Carolina Department of Health and Human Services 2001 Mail Service Center Raleigh, NC 27699-2001 Tel: 919-733-4534 Fax: 919-715-4645 Website: http://www.dhhs.state.nc.us	Charitable Solicitation Licensing Section Department of the Secretary of State of North Carolina P.O. Box 29622 Raleigh, NC 27626-0622 Tel: 919-807-2214 Fax: 919-807-0220 Contact: Lionel Randolph, CSL Supervisor Tel: 919-807-2211 Consumer Protection Section Office of the Attorney General of North Carolina P.O. Box 629 Raleigh, NC 27602-0629 Tel: 919-716-6000 Fax: 919-716-6050 Online Complaint Form: http://www.jus.state.nc.us/cpframe.htm	
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<p>Honorable Wayne Stenehjem Attorney General of North Dakota State Capitol 600 East Boulevard Avenue, Dept. 125 Bismarck, ND 58505-0040 Tel: 701-328-2210 Fax: 701-328-2226 Website: http://www.ag.state.nd.us/ndag/default.htm</p>	<p>North Dakota Department of Health 600 E. Boulevard Avenue Bismarck ND 58505-0200 Tel: 701-328-2372 Fax: 701-328-4727 Website: http://www.health.state.nd.us/</p>	<p>Secretary of State of North Dakota Administration & Licensing 600 E Boulevard Ave., Dept. 108 Bismarck, ND 58505-0500 Tel: 701-328-3665 North Dakota Tel: 800-352-0867 ext. 8-3665 Fax: 701-328-1690 Email: sosadlic@state.nd.us</p> <p>Consumer Protection Division Office of the Attorney General of North Dakota 600 E. Boulevard Ave, Dept. 25 Bismarck, ND 58505-0040 Tel: 701-328-3404</p>	<p>North Dakota Department of Health Division of Health Facilities Critical Access Hospitals 600 E. Boulevard Avenue, Dept. 301 Bismarck, ND 58505-0200 Tel: 701-328-2352 Fax: 701-328-1890</p>
<p>Honorable Jim Petro Attorney General of Ohio State Office Tower 30 E. Broad Street, 17th Floor Columbus, OH 43215-3428 Tel: 614-466-4320 Website: http://www.ag.state.oh.us</p>	<p>Ohio Department of Health 246 North High Street Columbus, OH 43216-0118 Tel: 614-466-3543 Website: http://www.odh.state.oh.us</p>	<p>Charitable Law Section Office of the Attorney General of Ohio 101 East Town Street, 4th Floor Columbus, OH 43215 Tel: 614-466-3180 Ohio Tel: 800-282-0515</p> <p>Consumer Protection Office of the Attorney General of Ohio State Office Tower 30 E. Broad Street, 17th Floor Columbus, OH 43215-3428 Tel: 614-466-8831 Ohio Tel: 800-282-0515</p> <p>Online Complaint Form: http://www2.ag.state.oh.us/sections/consumer/ccapsplus/welcome.asp</p>	<p>Consumer Protection Division Office of the Secretary of State of Oklahoma Business Division 2300 North Lincoln Boulevard Suite 101 Oklahoma City, OK 73105-4897 Tel: 405-521-3912 Contact: Vickie Mitchell, Business Division Director Email: vickie.mitchell@sos.state.ok.us</p>
<p>Honorable W. A. Drew Edmondson Attorney General of Oklahoma 2300 North Lincoln Boulevard, Suite 112 Oklahoma City, OK 73105 Tel: 405-521-3921 Website: http://www.oag.state.ok.us</p>	<p>Oklahoma State Department of Health 1000 Northeast Tenth Street City, OK 73117 Tel: 405-271-5600 Website: http://www.health.state.ok.us</p>	<p>Consumer Protection Division Oklahoma State Department of Health 1000 Northeast Tenth Street Room 1214 Oklahoma City, OK 73117-1299 Tel: 405-271-5243 Fax: 405-271-3458 Website: http://www.health.state.ok.us/program/cpd/index.html</p>	

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

Honorable Hardy Myers
Attorney General of Oregon
Justice Building
1162 Court Street NE
Salem, OR 97310
Tel: 503-378-4400
Website: <http://www.doj.state.or.us>

Oregon Department of Human Services
Public Health
800 NE Oregon Street
Portland, OR 97232
Tel: 800-422-6012
Website: <http://www.ohd.hr.state.or.us>

Charitable Activities Section
Office of the Attorney General of Oregon
1515 SW 5th Avenue, #410
Portland, OR 97201
Tel: 503-229-5725
Fax: 503-229-5120
Email: charitable.activities@doj.state.or.us

Financial Fraud/Consumer Protection
Section

Office of the Attorney General of Oregon
1162 Court Street NE
Salem, OR 97301-4096
Consumer Hotline Tel: 877-877-9392

Online Consumer Complaint Form:
<http://www.doj.state.or.us/FinFraud/ConCompForm.htm>

<p>Honorable Mike Fisher Attorney General of Pennsylvania 16th Floor Strawberry Square Harrisburg, PA 17120 Tel: 717-787-3391 Email: info@attorneygeneral.gov Website: http://www.attorneygeneral.gov</p>	<p>Pennsylvania Department of Health P.O. Box 90 Health and Welfare Building Harrisburg, PA 17108 Tel: 1-877-PA-HEALTH Website: http://webserver.health.state.pa.us/health/site/</p>	<p>Bureau of Consumer Protection Office of the Attorney General of Pennsylvania Health Care Unit 14th Floor Strawberry Square Harrisburg, PA 17120 Tel: 717-787-9707 Fax: 717-787-1190</p> <p>Online Healthcare Complaint Form: http://www.attorneygeneral.gov/ppd/health/form.cfm</p> <p>Charitable Trusts and Organizations Office of the Attorney General of Pennsylvania 14th Floor Strawberry Square Harrisburg, PA 17120 Tel: 717-783-2853 Fax: 717-787-1190 Email: charities@attorneygeneral.gov</p> <p>OR</p> <p>Pennsylvania Department of State Bureau of Charitable Organizations 207 North Office Building Harrisburg, PA 17120 Tel: 717-783-1720 Pennsylvania Tel: 800-732-0999 Fax: 717-783-6014 Email: ST-CHARITY@state.pa.us Contact: Karl Emerson, Director</p>
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State Attorney General Offices	State Health Departments	State Consumer Affairs Offices	Other Offices of Interest
<p>Honorable Patrick Lynch Attorney General of Rhode Island 150 South Main Street Providence, RI 02903 Tel: 401-274-4400 Fax: 401-222-1331 Website: http://www.riag.state.ri.us</p>	<p>Rhode Island Department of Health 3 Capitol Hill Providence, RI 02908 Tel: 401-222-2231 Fax: 401-222-6548 Website: http://www.health.state.ri.us</p>	<p>Rhode Island Department of Business Regulation Charities Section 233 Richmond Street Providence, RI 02903 Tel: 401-222-3048 Website: http://www.dbr.ri.gov</p> <p>Consumer Protection Unit Office of the Attorney General of Rhode Island 150 South Main Street Providence, RI 02903 Tel: 401-274-4400</p> <p>Online Consumer Complaint Form: http://www.riag.state.ri.us/consumer/compform.html</p>	<p>Office of Managed Care Regulation Department of Health Room 410 3 Capitol Hill Providence, RI 02908 Tel: 401-222-6015 Fax: 401-222-3017</p>
<p>Honorable Henry McMaster Attorney General of South Carolina Rembert Dennis Building P.O. Box 11549 Columbia, SC 29211-1549 Tel: 803-734-4399 Fax: 803-734-4323 Email: info@scattorneygeneral.org Website: http://www.scattorneygeneral.org</p>	<p>South Carolina Department of Health and Environmental Control 2600 Bull Street Columbia, SC 29201 Tel: 803-898-3432 Website: http://www.scdhec.net</p>	<p>Office of the Secretary of State of South Carolina P.O. Box 11350 Columbia, SC 29211 Tel: 803-734-1790 Toll Free Tel: 1-888-chariti (1-888-242-7484) Fax: 803-734-1604 Contact: Carolyn Hatcher, Director Tel: 803-734-1796 Email: hatcher@scsos.com</p> <p>Department of Consumer Affairs 3600 Forest Drive, 3rd Floor P.O. Box 5757 Columbia, SC 29250 Tel: 803-734-4200</p> <p>Online Consumer Complaint Form: http://www.state.sc.us/consumer/</p>	<p>Bureau of Certification South Carolina Department of Health and Environmental Control 2600 Bull Street Columbia, SC 29201-1708 Tel: 803-545-4200 Website: http://www.scdhec.net/Health_Reg/cert/hrcomp.htm</p> <p>Consumer Health Resources Website: http://www.scdhec.net/co/ELSA/elsacons.htm</p>

<p>Honorable Larry Long Attorney General of South Dakota 500 East Capitol Avenue Pierre, SD 57501-5070 Tel: 605-773-3215 Fax: 605-773-4106 Email: atghelp@state.sd.us Website: http://www.state.sd.us/attorney/default.asp</p>	<p>South Dakota Department of Health 600 East Capitol Avenue Pierre, SD 57501-2536 Tel: 605-773-3361 Website: http://www.state.sd.us/doh/index.htm</p>	<p>Division of Consumer Protection Office of the Attorney General of South Dakota 500 East Capitol Avenue Pierre, SD 57501-5070 Tel: 605-773-4400 South Dakota Tel: 800-300-1986 Fax: 605-773-7163 E-Mail: consumerhelp@state.sd.us Website: http://www.state.sd.us/attorney/office/divisions/consumer/default.asp</p>
<p>Honorable Paul D. Summers Attorney General of Tennessee P. O. Box 20207, Nashville, TN 37243 Tel: 615-741-5860 Website: http://www.attorneygeneral.state.tn.us</p>	<p>Tennessee Department of Health Cordell Hull Building 425 5th Avenue N Nashville, TN 37247 Tel: 615-741-3111 Fax: 615-724-2491 Website: http://www.state.tn.us/health/index.htm Health Related Boards Hotline Tel: 800-852-2187</p>	<p>Division of Consumer Affairs Tennessee Department of Commerce and Insurance 500 James Robertson Parkway, Fifth Floor Nashville, TN 37243-0600 TN Consumer Hotline: 800-342-8385 Consumer Hotline: 615-741-4737 Fax: 615-532-4994 Email: ConsumerAffairs@state.tn.us Online Complaint Form: http://www.state.tn.us/consumer/online-form.html Secretary of State of Tennessee Division of Charitable Solicitations 312 8th Avenue North 8th Floor, William R. Snodgrass Tower Nashville, TN 37243 Tel: 615-741-2555 Contact: Graham Sugg, Assistant Director Email: graham.sugg@state.tn.us</p>

State Attorney General Offices State Health Departments State Consumer Affairs Offices Other Offices of Interest

<p>Honorable Greg Abbott Attorney General of Texas Capitol Station P.O. Box 12548 Austin, TX 78711-2548 Tel: 512-463-2100 Email: cac@oag.state.tx.us Website: http://www.oag.state.tx.us</p>	<p>Texas Department of Health 1100 West 49th Street Austin, TX 78756-3199 Toll Free Tel: 888-963-7111 Tel: 512-458-7111 Website: http://www.tdh.texas.gov</p>	<p>Charitable Trust Section Office of the Attorney General of Texas P.O. Box 12548 Austin, TX 78711 Tel: 512-463-2070 Texas Tel: 800-621-0508 Consumer Protection Division Office of the Attorney General of Texas PO Box 12548 Austin, TX 78711-2548 Consumer Protection Hotline Tel: 800-621-0508</p>	<p>Health Facility Licensing and Compliance Division Texas Department of Health 1100 West 49th Street Austin, TX 78756 Complaint Hotline Tel: 888-973-0022 Fax: 512-834-6653</p>
<p>Honorable Mike Shurtleff Attorney General of Utah State Capitol, Room 236 Salt Lake City, UT 84114-0810 Tel: 801-538-9600 Fax: 801-538-1121 Email: uag@utah.gov Website: http://attorneygeneral.utah.gov/</p>	<p>Utah Department of Health P.O. Box 1010 Salt Lake City, UT 84114-1010 Tel: 801-538-6101 Website: http://health.utah.gov/</p>	<p>Utah Department of Commerce Division of Consumer Protection Heber Wells Building, Second Floor 160 East 300 South SM Box 146704 Salt Lake City, UT 84114-6704 Tel: 801-530-6601 Utah Tel: 800-721-7233 Fax: 801-530-6001</p>	<p>Division of Health Systems Improvement Utah Department of Health 288 North 1460 West P. O. Box 142002 Salt Lake City, UT 84116 Tel: 801-538-7024 Fax: 801-538-7053 Health Resource Hotline Tel: 1-888-222-2542</p>
<p>Honorable William H. Sorrell Attorney General of Vermont 109 State Street Montpelier, VT 05609-1001 Tel: 802-828-3171 Fax: 802-828-2154, 802-828-3187 Email: aginfo@atg.state.vt.us Website: http://www.state.vt.us/atg</p>	<p>Vermont Department of Health 108 Cherry Street, P.O. Box 70 Burlington, VT 05402-0070 Tel: 802-863-7200 Fax: 802-865-7754 Website: http://www.healthvermonters.info</p>	<p>Consumer Assistance Program 104 Morrill Hall The University of Vermont Burlington, VT 05405 Tel: 802-665-3183 Vermont Tel: 800-649-2424 Email: Consumer@uvm.edu Online Consumer Claim Form: http://www.state.vt.us/atg/complaint%20fo rm.htm</p>	

<p>Honorable Jerry Kilgore Attorney General of Virginia 900 East Main Street Richmond, VA 23219 Tel: 804-786-2071 Email: mail@oag.state.va.us Website: http://www.oag.state.va.us</p>	<p>Virginia Department of Health P.O. Box 2448 Richmond, VA 23218-2448 1500 East Main Street Richmond, VA 23211 Tel: 804-786-3561 Website: http://www.vdh.state.va.us/</p>	<p>Virginia Department of Agriculture and Consumer Services Office of Consumer Affairs 1100 Bank Street Richmond, VA 23219 Tel: 804-786-2042 Virginia Tel: 800-552-9963 Email: Consumer@oag.state.va.us</p>	<p>Center for Quality Health Care and Consumer Services Virginia Department of Health 3600 West Broad Street, Suite 216 Richmond, VA 23230 Tel: 800-955-1819 Fax: 804-367-2149</p>
<p>Honorable Christine O. Gregoire Attorney General of Washington P.O. Box 40100 1125 Washington Street, SE Olympia, WA 98504-0100 Tel: 360-753-6200 Fax: 360-664-0988 Website: http://www.atg.wa.gov Email: ago@atg.wa.gov</p>	<p>Washington State Department of Health 1112 SE Quince Street P.O. Box 47890 Olympia, WA 98504-7890 Tel: 360-236-4030 Website: http://www.doh.wa.gov/</p>	<p>Secretary of State of Washington Charitable Solicitations Program P.O. Box 40234 Olympia, WA 98504-0234 Tel: 360-753-0863 Washington Tel: 800-332-GIVE Email: charities@secstate.wa.gov Attorney General of Washington Consumer Protection P.O. Box 40100 1125 Washington Street, SE Olympia, WA 98504-0100 Tel: 800-551-4636</p>	<p>Washington State Department of Health Consumer Hotline Tel: 800-525-0127 Health Facilities and Services Complaint Hotline Tel: 800-633-6828</p>
		<p>Online Consumer Complaint Form: https://www2.wa.gov/ago/formhandler/regularca3.html</p>	

State Attorney General Offices	State Health Departments	State Consumer Affairs Offices	Other Offices of Interest
Honorable Darrell V. McGraw Jr. Attorney General of West Virginia State Capitol, Room 26E 1900 Kanawha Boulevard, East Room 26E Charleston, WV 25305-9924 Tel: 304-558-2021 Website: http://www.state.wv.us/wwag	West Virginia Department of Health and Human Resources State Capitol Complex Building 3 Room 206 Charleston, WV 25305 Tel: 304-558-0684 Fax: 304-558-1130 Website: http://www.wvdhhr.org	Charitable Organizations Division Secretary of State of West Virginia Bldg. I, Suite 157-K 1900 Kanawha Blvd. East Charleston, WV 25305-0770 Tel: 304-558-6000 Email: charities@wvsos.com Contact: Jennifer Twyman, Charitable Organizations Assistant Email: jtwyman@wvsos.com Consumer Protection Division Office of the Attorney General of West Virginia 812 Quarrier Street, 6th Floor P. O. Box 1789 Charleston, WV 25326-1789 Tel: 800-368-8808 Online Consumer Complaint Form: http://www.state.wv.us/wwag/consumer/fo rms/gencomp.htm	Complaint Committee of the West Virginia Board of Medicine 101 Dee Drive Charleston, WV 25311 Tel: 304-558-2921 Online Consumer Complaint Form: http://www.wvdhhr.org/wvbom/complaint form - html.html
Honorable Peg Lautenschlager Attorney General of Wisconsin State Capitol, Suite 114 E P.O. Box 7857 Madison, WI 53707-7857 Tel: 608-266-1221 Website: http://www.doj.state.wi.us	Wisconsin Department of Health and Family Services 1 West Wilson Street Madison, WI 53702 Tel: 608-266-1865 Website: http://www.dhfs.state.wi.us/	Wisconsin Department of Regulation and Licensing Charitable Organizations P.O. Box 8935 Madison, WI 53708-8935 Tel: 608-266-5511, ext. 441 Email: dorl@dhrl.state.wi.us Office of Consumer Protection Wisconsin Department of Justice 17 W. Main Street P.O. Box 7857 Madison, WI 53707-7857 Tel: 608-224-4960 Online Consumer Complaint Form: http://www.doj.state.wi.us/columns/ complaint.asp	Bureau of Health Information Division of Health Care Financing Wisconsin Department of Health and Family Services P.O. Box 309 Madison, WI 53701-0309 Tel: 608-267-9055 Consumer Guide to Healthcare Website: http://www.dhfs.state.wi.us/ guide/index.htm

<p>Honorable Pat Crank Attorney General of Wyoming 123 Capitol Building 200 West 24th Street Cheyenne, WY 82002 Tel: 307-777-7841 Fax: 307-777-6869 Website: http://attorneygeneral.state.wy.us</p>	<p>Wyoming Department of Health 135 Hathaway Building Cheyenne, WY 82002 Tel: 307-777-7656 Fax: 307-777-7439 rdoman@state.wy.us Website: http://wdhfs.state.wy.us/wdh/</p>	<p>Secretary of State of Wyoming Capitol Building 200 West 24th Street Cheyenne, WY 82002 Tel: 307-777-7378</p> <p>Consumer Protection Unit Office of the Attorney General of Wyoming 123 Capitol Building Cheyenne, WY 82002 Tel: 307-777-7874 Fax: 307-777-7956</p> <p>Online Consumer Complaint Form: http://attorneygeneral.state.wy.us/con-com.pdf</p>
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APPENDIX C

Sample Letter to the Consumer Protection Enforcement or Accrediting Agencies

[Advocates should replace the bracketed information with the facts as they apply to the specific situation. The same letter can be tailored to different enforcement and accrediting agencies, depending on which laws are at issue.]

[Applicable consumer protection enforcement agencies in your state: see Appendix B for contact information]

Dear _____:

We are [describe your organization or who you are and whom else you represent]. Since your office is responsible for ensuring that the [type of law] is being followed, we are writing to bring to your attention a possible violation of that law.

We have learned that [religious entity with restriction, e.g., religious hospital or religious managed care company] refuses [or is planning to refuse] to [provide, counsel about, pay for, or make referrals about] health care services to which they claim to object for religious or moral reasons. These services include [list services].

Nevertheless, [entity] appears not to have provided the legally required notice of these limitations. Specifically, [cite law] mandates that [include type of entity, type of service, and type of notice requirement, for example: hospitals must post in a conspicuous place and in their admissions material that they do not provide sterilizations]. However, [name of entity] has not done so. [repeat this for each type of law discussed in the report that is relevant and that this agency has the authority to address].

[If the situation involves a transaction that is being proposed instead of already in place, also include the following three paragraphs].

We understand that [name of entity] is planning to merge with [(modify as appropriate to reflect whatever is known about the nature of the anticipated transaction) with the entity without restriction (e.g., secular hospital)] in [city, state]]. We are particularly concerned about the impact that this [transaction] will have on the availability of reproductive health and other health services in our community. [Restricted entity] is affiliated with the Catholic church and is governed by the *Ethical and Religious Directives for Catholic Health Care Services*, which generally prohibit abortion, contraceptive services and counseling, sterilization procedures, infertility treatments, and emergency contraceptives (the “morning-after pill”). [Modify as appropriate if other religious restrictions are at issue.] We understand that after the transaction, if it is allowed to go forward, [secular provider] would also be governed by these prohibitions. [Cite and enclose documentation of this intention.]

[secular provider] currently provides the following services that would be banned under the *Directives*: [list the affected services]. The elimination of these services will have serious repercussions in our community. [Quantify the loss of services to the extent possible, e.g., number of tubal ligations the unrestricted entity performed in the past year] [unrestricted entity] has historically provided these services; our community has come to depend on them and their established reputation for a full range of care.

We are also concerned that [entities] have not disclosed this planned reduction during the governmental review phase. Such disclosures, however, are required under [name of law and cites to relevant provisions].

[All letters should continue from here.]

As it is your role to ensure that [entity] complies with [laws or types of laws], we urge you to investigate this situation. Further, we respectfully request the opportunity to meet with you or the relevant investigatory staff to discuss the matter: [if situation involves a proposed restriction, add the following: – and to do so before your office reaches a conclusion about the likely impact of the transaction and makes a recommendation on whether to challenge it.]

We will call you shortly to follow up, if we do not hear from you. Thank you for your consideration.

Sincerely,

[signature and title]

[List enclosures]

cc: [allies, including the National Women's Law Center]

APPENDIX D

Helpful Consumer Protection Nongovernmental Organizations

The following nongovernmental organizations may be especially useful allies in challenging notice practices of entities with religious restrictions (listed alphabetically by agency name).

Key: W: women's and reproductive rights groups; **H:** health care consumer groups; **GC:** general consumer groups; **R:** religious groups; **C:** civil liberties groups.

(W) ACLU Reproductive Freedom Project

125 Broad Street, 18th Floor
New York, NY 10004
(212) 549-2633
<http://aclu.org/reproductiverights>

(W) Alan Guttmacher Institute (AGI)

1120 Connecticut Avenue, NW, Suite 460
Washington, DC 20036
(202) 296-4012
<http://www.agi-usa.org>
info@guttmacher.org

(R) Americans United for Separation of Church and State

518 C Street, NE
Washington, DC 20002
(202) 466-3234
<http://www.au.org>
americansunited@au.org

(GC) Better Business Bureau

Use the following sites to find the address of your local Better Business Bureau:
<http://lookup.bbb.org>
<http://complaints.bbb.org/Welcome.asp>

(R) Catholics for a Free Choice (CFFC)

1436 U Street NW, Suite 301
Washington, DC 20009
(202) 986-6093
<http://www.catholicsforchoice.org>
cffc@catholicsforchoice.org

(H) Center for Medical Consumers

130 Macdougall Street
New York, NY 10012-5030
(212) 674-7105
<http://www.medicalconsumers.org>
medconsumers@earthlink.net

(H) Center for Medicare Advocacy

P.O. Box 350
Willimantic, CT 06226
(860) 456-7790
<http://www.medicareadvocacy.org>

(H) Center for Patient Advocacy

1350 Beverly Road, Suite 207
McLean, VA 22101
(800) 846-7444 or (703) 748-0400
<http://www.patientadvocacy.org>
advocate@patientadvocacy.org

(W) Center for Reproductive Rights (formerly CRLP, Center for Reproductive Law & Policy)

120 Wall Street
New York, NY 10005
(212) 637-3600
<http://www.reprorights.org>
info@reprorights.org

(H) Citizen Advocacy Center

1400 16th Street, NW, Suite 330
Washington, DC 20036
(202) 462-1174
<http://www.cacenter.org>
cac@cacenter.org

(H) Community Catalyst

30 Winter Street, 10th Floor
Boston, MA 02108
(617) 338-6035
<http://www.communitycat.org>

(H) Consumer Coalition for Quality Health Care

1101 Vermont Avenue, NW, Suite 1001
Washington, DC 20005
(202) 789-3606
<http://www.consumers.org>
bwlind@erols.com

(GC) Consumer Federation of America (CFA)

1424 16th Street, NW
Washington, DC 20036
(202) 387-6121
<http://www.consumerfed.org>

(H) FamiliesUSA

1334 G Street, NW
Washington, DC 20005
(202) 628-3030
<http://www.familiesusa.org>
info@familiesusa.org

(H) Foundation for Consumer & Taxpayer Rights

1750 Ocean Park Blvd., Suite 200
Santa Monica, CA 90405
(310) 392-0522
<http://www.consumerwatchdog.org>
ftcr@consumerwatchdog.org

(H) Health Assistance Partnership

1334 G Street, NW
Washington, DC 20005
(202) 737-6340
<http://www.healthassistancepartnership.org>
infohap@healthassistancepartnership.org

(R) Law Students for Choice

43 Norfolk Street
San Francisco, CA 94103
(650) 281-3661
<http://www.lawstudentsforchoice.org>
info@lawstudentsforchoice.org

(W) Medical Students for Choice

P.O. Box 70190
Oakland, CA 94612
(510) 238-5210
<http://www.ms4c.org>
msfc@ms4c.org

(H) Medicare Rights Center

1460 Broadway, 17th Floor
New York, NY 10036
(212) 869-3850
<http://www.medicarerights.org>
info@medicarerights.org

(W) MergerWatch Project, Education Fund of Family Planning Advocates of NYS

17 Elk Street
Albany, NY 12207
(518) 436-8408
<http://www.mergerwatch.org>
info@mergerwatch.org

(W) NARAL Pro-Choice America

1156 15th Street, NW, Suite 700
Washington, DC 20005
(202) 973-3000
<http://www.naral.org>

(GC) National Consumer Law Center (NCLC)

77 Summer Street, 10th Floor
Boston, MA 02110-1006
(617) 542-8010
<http://www.consumerlaw.org>
nclc@consumerlaw.org

(GC) National Consumers League

1701 K Street, NW, Suite 1200
Washington, DC 20006
(202) 835-3323
<http://www.natlconsumersleague.org>
info@nclnet.org

**(H) National Health Law Program
(NHLP)**

2639 South La Cienega Blvd.
Los Angeles, CA 90034-2675
(310) 204-6010
<http://healthlaw.org>
nhelp@healthlaw.org

**(W) National Partnership for Women
& Families**

1875 Connecticut Avenue, NW, Suite 650
Washington, DC 20009
(202) 986-2600
<http://www.nationalpartnership.org>
info@nationalpartnership.org

**(W) National Women's Law Center
(NWLC)**

11 Dupont Circle, NW, Suite 800
Washington, DC, 20036
(202) 588-5180
<http://www.nwlc.org>
info@nwlc.org

(H) Partnership for Caring (PFC)

1620 Eye Street NW, Suite 202
Washington, DC 20006
(202) 296-8071 or (800) 989-9455
<http://www.partnershipforcaring.org/HomePage/>
pfc@partnershipforcaring.org

(H) People's Medical Society

P.O. Box 868
Allentown, PA 18105-0868
(610) 770-1670
<http://www.peoplesmed.org>
info@peoplesmed.org

**(W) Physicians for Reproductive Choice
and Health® (PRCH)**

55 West 39th Street, 10th Floor
New York, NY 10018
(646) 366-1890
<http://www.prch.org>
info@prch.org

**(W) Planned Parenthood Federation of
America (PPFA)**

434 West 33rd Street
New York, NY 10001
(212) 541-7800
<http://www.ppfa.org>
communications@ppfa.org

**(R) Religious Coalition for Reproductive
Choice (RCRC)**

1025 Vermont Ave, NW, Suite 1130
Washington, DC 20005
(202) 628-7700
<http://www.rcrc.org>
info@rcrc.org

APPENDIX E

Glossary

Note: This glossary defines terms and abbreviations as they are used in this report. It is always important, however, to check a jurisdiction's statutes, case law and other authority to determine whether that jurisdiction has its own definition for a particular term in a particular context. Unless otherwise indicated (e.g., "as used in this report" or a source is cited), the definitions are paraphrases from Black's law dictionary, available at <http://www.westlaw.com>; Centers for Medicare & Medicaid Services, Glossary, available at <http://cms.hhs.gov/glossary>, or general usage. Terms in bold in the definitions are also defined in the glossary. Terms in bold and italics are used interchangeably with defined terms, but there is not a separate definition for them in the glossary.

accreditation: a process in which an organization that is separate from a health care entity examines the health care entity's policies, procedures, and performance to ensure that the health care entity meets certain quality standards. Sometimes, the government uses the findings of private accrediting organizations as a substitute for its oversight of some quality related standards (referred to as **deemed compliance** with the standard). Public or private payment programs often require accreditation as a condition of payment for covered services. Compare with **certification**.

acts (used in this report interchangeably with **practices**): "acts" usually implies individual transactions, while "practices" implies a pattern or scheme. For convenience, however, this report uses the two interchangeably when referring to unfair and deceptive conduct that is governed by **unfair and deceptive acts and practices laws**.

advance directives (not to be confused with the **Directives**): a written instruction, such as a **living will** or **health care proxy**, recognized under state law (whether statutory or as recognized by state courts), relating to the provision of health care when the individual is unable to make health care decisions.¹

affiliation: as used in this report, affiliation is a general term describing any formal relationship or integration among health care entities.

antitrust laws: federal and state statutes that protect trade and commerce from unlawful restraints, price discriminations, price fixing, and monopolies.

beneficiary (in this report, used interchangeably with **enrollee**): a person who has health insurance through **Medicare, Medicaid**, or some other public or private financing program.

by-laws, corporate: rules that corporations adopt for their internal governance. Corporate by-laws define the powers and obligations of various officers, persons, or groups within the corporate structure and provide rules for how corporate decisions are made and how business must be conducted. Most state statutes require that every corporation adopt by-laws. Compare with **by-laws, medical staff**.

by-laws, medical staff: written by-laws approved by the governing authority of a hospital, which are generally required by state statutes, federal regulations, and the national organization that accredits hospitals. The medical staff by-laws generally must define the organizational structure of the hospital's medical staff and its relationship to the governing body; give criteria for admission, reappointment, and advancement of the medical staff; and generally provide rules governing the rights and responsibilities of the medical staff.² Compare with **by-laws, corporate**.

¹ 42 C.F.R. § 489.100.

² MATTHEW BENDER TREATISE ON HEALTH CARE LAW § 6.01[3] (Michael G. MacDonald et al. eds. 2000).

Centers for Medicare & Medicaid Services (CMS): the federal agency (formerly Health Care Financing Administration, HCFA), that runs **Medicare** and works with states to run **Medicaid**. CMS is a part of **HHS**.

certificate of need (CON): a requirement in many states for health care facilities proposing construction, changes in ownership, or significant changes in services. CON rules are designed to promote cost containment, prevent unnecessary duplication of health care facilities and services, and ensure that services best serve public needs.

certified, certification: the process by which a state government (or its representative) inspects health care entities and grants certification to those that pass inspection. **Medicare** or **Medicaid** only covers care by certified providers. Being certified is not the same as receiving **accreditation** or receiving a **certificate of need**.

charitable assets laws: as used in this report, state statutes, cases, or other legal authority requiring that charitable institutions use their assets to fulfill their charitable missions.

charitable trust: as traditionally defined, a trust is a legal entity in which one person or entity (the “trustee”) manages property for the benefit of another person or entity (the “beneficiary”). In the case of a charitable trust, the trustee has a “fiduciary duty” (i.e., a legal responsibility) to use the corpus of the trust, e.g., the assets of the charity, to help the beneficiaries and carry out the charitable mission. In the case of a charitable trust, the intended beneficiaries are the community at large or some specified portion of the community, but not specifically named persons. Because of the similarities between charitable trusts and nonprofit organizations generally, there is support for the argument that nonprofit charitable organizations, as holders of assets for public good, function and should be treated legally as charitable trusts, even if they do not fulfill all of the technical requirements of a charitable trust (e.g., are organized as a corporation and not a trust, and are not created with a trust instrument).

common law: used to describe legal principles developed from custom, usage, and case law, as opposed to those found in statutes.

community benefits (sometimes referred to as **community need, indigent care, charity care, or free care** requirements): health care services provided to the community, often for free or at a discounted rate, as a condition of state approval to provide care or **conversion**, or to become a **tax-exempt organization**.

community hospital: community hospitals are defined by the American Hospital Association as: “all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.”³

conditions of participation: as used in this report, federal requirements for entities to participate in and receive payments from **Medicare** and **Medicaid**.

consumer protection: as used in this report and unless otherwise indicated, refers to legal protections to ensure that consumers receive appropriate notice or disclosures about services.

contraceptive coverage or contraceptive equity laws: state laws that require insurers that cover prescription drugs and devices to also cover prescription contraceptives.

conversion: as used in this report, refers to a transaction in which a nonprofit hospital is purchased by, or otherwise transfers some or all of its assets or control to, either a different type of nonprofit entity (a nonprofit-to-nonprofit conversion) or a for-profit one (a nonprofit to for-profit conversion).

³ American Hospital Association, Fast Facts on U.S. Hospitals from *Hospital Statistics*, at http://www.hospitalconnect.com/aha/resource_center/fastfacts/fast_facts_US_hospitals.html (last modified Dec. 10, 2002).

corporate articles of incorporation, articles of incorporation (used interchangeably in this report with **certificates of incorporation, articles of organization, articles of association,** and **corporate charter**): the basic set of documents filed with the appropriate government agency, usually the secretary of state, regarding the incorporation of a business or organization. The content of these documents varies according to state law, but they usually include the corporation's name, the period of existence, the purpose and powers of the corporation, and other conditions of operation. In most jurisdictions, corporate existence begins with the filing of the articles of incorporation with the secretary of state.

corporate fiduciaries (used interchangeably with **governing body, board of directors,** or **board of trustees**): individuals or entities who govern an entity, manage its assets, and who must exercise a standard of care and loyalty in such management activity imposed by law.

crisis pregnancy center (CPC): center that counsels women faced with unintended pregnancies that are designed to prevent women from obtaining abortions.

damages (used interchangeably with **money damages or monetary damages**): financial compensation that courts order the party being sued to pay to the successful plaintiff who has suffered a loss. There are several different kinds of damages. "Nominal damages" are a small amount of damages for the vindication of a right where no real loss or injury can be proved. "Compensatory damages" is payment that will compensate the party for injury sustained and nothing more. "Punitive damages" are damages beyond compensatory damages where the wrong that was done was aggravated by certain circumstances (e.g., malice or fraud) and are intended to punish the party being sued to make an example of the consequences of the party's conduct. "Treble damages" are damages that a statute awards that triples the amount of damages found at trial.

deeming authority, deemed compliance: authority granted by the federal or state government to accrediting organizations to determine, on

the government's behalf, whether the entity being evaluated by the organization complies with applicable federal or state requirements.

Directives (used interchangeably in this report with the **Ethical and Religious Directives for Catholic Health Care Services**, not to be confused with **advance directives**): as used in this report, the *Directives* are rules created by the U.S. Conference of Catholic Bishops that govern Catholic health care institutions and professionals. The *Directives* forbid Catholic health care institutions and professionals from providing treatment at odds with Catholic doctrine and give a detailed delineation of what health care is prohibited.

emergency contraception (sometimes referred to as **EC** or the **morning-after pill**): a back-up method of birth control that, when used within days of unprotected sex, can prevent pregnancy. Emergency contraception is available as a prepackaged regimen of high-dose birth control pills or as an intrauterine device. Emergency contraception will not interrupt an established pregnancy and is not the same as the **medical abortion** drug mifepristone or RU-486.

enjoin: use a court order called a writ of **injunction** to require a person or entity to perform, or to prevent or stop from performing, some act.

False Claims Act (FCA): a federal law that allows, among other things, a person to bring an action on behalf of the federal government against an individual or entity that has made a false claim to the federal government. The FCA has been used in the **Medicare** and **Medicaid** context.

family planning services: generally, the use of birth control measures designed to regulate the number and spacing of children a woman has. Federal statutes do not define family planning, but the U.S. Department of Health and Human Services has determined that abortion, while covered by Medicaid under limited circumstances, may not be defined as family planning. According to **CMS** guidelines, to receive the 90 percent federal match for **Medicaid** family planning services, a service must be "expected to achieve a family planning purpose." Thus, for example, a treatment that

results in sterility (such as a hysterectomy to treat endometriosis), but does not have family planning as its primary purpose is not covered as a family planning service. Beyond these federal guidelines, states adopt their own definitions of family planning for their **Medicaid managed care organizations**, and these definitions vary from state to state. Gynecological exams, Pap smears, STD and HIV testing, all FDA-approved forms of contraception (and related services) and sterilization are generally considered family planning. Preconception counseling and emergency contraception are considered family planning in about half of the states, while infertility tests and treatment are rarely defined as family planning.⁴

Federal Trade Commission (FTC): federal agency that enforces and has administrative responsibility for federal laws, including the **Federal Trade Commission Act**, designed to protect consumers from fraud, deception and unfair business practices, as well as anticompetitive mergers and other business practices that restrict competition in the marketplace.

Federal Trade Commission Act (FTC Act): federal law that prohibits unfair methods of competition, and unfair or deceptive acts or practices in or affecting commerce.

HHS (Health and Human Services, the U.S. Department of): the federal department with oversight responsibility for **Medicaid**, **Medicare**, and other health-related programs. **CMS** is a part of HHS.

health care entity (used interchangeably with **facility** or **institution**): as used in this report, unless otherwise indicated, refers to a hospital, clinic, **managed care organization**, nursing home or other entity providing or paying for health care services.

health care proxy (also referred to as **durable power of attorney for health care**): an **advance directive** document in which a person (the principal) appoints an agent to make decisions

on the principal's behalf, rather than describing the patient's preferences. Compare with **living will**.

health maintenance organization (HMO): a type of **managed care organization** in which a group of doctors, hospitals and other health care providers agree to give health care for a set amount of money over a certain time period. In an HMO, the **beneficiaries** must get all their care from providers that are part of the plan. Compare with **preferred provider organization (PPO)**.

health plan: an entity that assumes the risk of paying for medical treatments (e.g., self insured employer, payer, or **health maintenance organization**).

hospital: for convenience, "hospital" in this report may sometimes include other types of **health care entities**, e.g., **managed care organizations**.

informed consent: legal principle that patients must be informed about the nature and consequences of a proposed treatment, as well as the risks, benefits and alternatives to such treatment before they can consent to medical care.

injunction: granted by a court, a document ordering someone to perform some act or stop performing some act.

institutional refusal clauses: federal and state laws that allow institutions to refuse to **provide** care based on a religious or moral objection.

interveners (or intervenors): a person or entity who is not originally a party to a legal proceeding or suit who voluntarily comes into the case with the permission of the court.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): a private nonprofit organization that provides **accreditation** to hospitals and other health care entities.

⁴ NAT'L WOMEN'S LAW CTR. & KAISER FAMILY FOUND., WOMEN'S ACCESS TO CARE: A STATE-LEVEL ANALYSIS OF KEY HEALTH POLICIES 52 (2003), available at <http://www.nwlc.org/pdf/KaiserFinal.pdf>.

Lanham Act: federal law that prohibits, among other things, any person from using in commerce any false or misleading description of fact which in commercial advertising or promotion misrepresents the nature, characteristics or quality of his or her or another person's goods, services, or commercial activities.

legally authorized representative: as used in this report, a person authorized by law to act on the patient's behalf concerning medical care (e.g., a guardian or someone appointed in **health care proxy**).

licensure: the process by which a state authorizes the establishment or operation of a **health care entity**, either upon its initial licensure or as the license is periodically renewed, as well as the day-to-day oversight of the facility by the licensing entity. Usually state health departments license hospitals and nursing homes, and state insurance departments license insurers.

living will: an **advance directive** that describes patient preferences in certain medical situations if the patient becomes unable to express his or her wishes when the decision must be made. Compare with **health care proxy**.

managed care organization (MCO): a **health plan** that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with a network of providers who deliver services and frequently share financial risk, typically relying on a **primary care** physician to act as gatekeeper. The term includes, but is not limited to **health maintenance organizations**, and **preferred provider organizations**.

Medicaid: the nation's major publicly financed program for providing health and long-term care coverage to low-income people and people with disabilities. It is financed by the state and federal government and administered by the states. Although there are broad federal requirements for Medicaid, states also have flexibility for how to design their Medicaid program.

medical abortion: induced abortion (termination of a pregnancy) through medical means (i.e., chemically, using a prescribed drug regimen, currently RU-486—called mifepristone in the U.S.—and misoprostol) that causes an abortion in early pregnancy. It is different than **emergency contraception** or traditional surgical abortion.

Medicare: the federal health insurance program that covers people age 65 and over and also younger adults with permanent disability. Medicare serves all eligible **beneficiaries** without regard to income or medical history.

merger: a transaction in which one corporation is absorbed into the other. The absorbed corporation loses its legal identity and ceases to exist, while the surviving corporation retains its name and identity and acquires the assets, powers, liabilities, and franchises of the absorbed corporation.

NCQA (National Committee for Quality Assurance): a private nonprofit organization that provides **accreditation** primarily to **managed care organizations**.

nonprofit corporation (synonymous with **not-for-profit corporation**): a corporation organized for a purpose besides making profits that does not distribute any of its income to its members, directors, or officers. In the context of **hospitals**, most nonprofit charitable corporations are also tax exempt under Section 501(c)(3) of the Internal Revenue Code. See also **tax-exempt organization**.

nursing home (used interchangeably in this report with **long-term care facility, skilled nursing facility**): a residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.

ombuds: an individual who is supposed to help people resolve problems they may have with the people or entities that provide or pay for their care. Sometimes ombuds programs are governmental offices and sometimes they are privately funded.

patient: as used in this report, the term also can include a **legally authorized representative** to speak on the patient's behalf when making health care decisions.

Patient Self-Determination Act (PSDA):

a federal law requiring most entities receiving **Medicare** or **Medicaid** payments to notify patients about state law regarding the rights of patients to accept or reject treatment and to formulate **advance directives**.

potential enrollee (used interchangeably with **potential member** or **beneficiary, subscriber**): in the **Medicaid** managed care context, a Medicaid recipient who is subject to mandatory enrollment or may voluntarily enroll in the future.⁵ Generally, it refers to someone who is eligible to be enrolled in a health plan but has not yet enrolled.

preferred provider organization (PPO): managed care organization in which people use doctors, **hospitals** and providers that belong to the network, but people can use providers outside of the network for an additional cost. Compare to **health maintenance organization**.

prevailing party (used interchangeably with **prevailing plaintiff** or **prevailing defendant**): the party to a suit who successfully prosecutes the action or successfully defends against it, winning on the main issue, although not necessarily all issues.

primary care: basic level of care usually given by doctor who works with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians).

provide: unless otherwise indicated, as used in this report for convenience, "providing" includes not only rendering the care, but also includes paying for, counseling about, and making referrals for services.

refusal clauses (also referred to as **conscience, noncompliance, or denial clauses**): federal or state laws that allow health care providers to refuse to **provide** health care services to which they have a moral or religious objection.

religious corporation: a **nonprofit corporation** formed for the purpose of maintaining or propagating religion or of supporting religious services in a particular religious tradition, and owning and administering real and personal property for religious uses. In many jurisdictions, there are special rules for religious corporations.⁶

religious or restricted entities: for convenience, unless otherwise indicated, this report refers to entities with religious limits as **restricted** or **religiously affiliated** providers, and those without bans as **unrestricted, nonsectarian** or **secular** providers.

restitution: restoring the people suing to the position they would be in if the impermissible conduct had not occurred.

sanctions (used interchangeably with **penalties** or **finest**): unless otherwise indicated, these terms refer to payments to the government as well as payment to private individuals or groups.

secular: for convenience, the term is used in this report to refer to the health care entity that does not impose religious restrictions, even though some of these entities may have a religious affiliation.

sponsor: entities that have the authority to approve the sale, **merger**, or dissolution of the sponsored corporation; to select and remove the board of directors; to adopt an institutional philosophy and mission; to approve the sale, mortgage, or encumbrance of property; and to control amendments of the articles of incorporation and **corporate by-laws**.⁷ The sponsor of a Catholic entity is

⁵ 42 C.F.R. § 438.10.

⁶ See e.g., N.Y. Relig. Corp. Law; N.Y. Not-for-Profit Corp. Law § 910; N.Y. Exec. Law § 172-a; GEORGE G. BOGERT & GEORGE T. BOGERT, THE LAW OF TRUSTS AND TRUSTEES, Chapter 17 § 322 n.54 (2d ed. rev. 1991 & supps.) (citing state statutes).

⁷ See Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market*, 72 TUL. L. REV. 159, 181 (1997).

a religious community, diocese, or religious lay body that has a canonical, legal, ethical and moral relationship with a Catholic ministry.⁸

standing: a concept used to determine whether or not people or entities are sufficiently affected by a controversy that is properly resolved by a court; if these people or entities are sufficiently affected, they are said to have “standing.”

tax-exempt organization: an organization exempt from federal income tax under Section 501 of the Internal Revenue Code. A corporation may be exempt from tax under Section 501(c)(3) if it is organized and operated exclusively for one or more of the following purposes: religious, charitable, scientific, testing for public safety, literary, educational, prevention of cruelty to children or animals, or to foster national or international sports. If a **hospital** is formed as a formal **charitable trust** (as opposed to a **nonprofit corporation**), it could also be exempt under 501(c). See also **nonprofit corporation**.

unfair and deceptive acts and practices (UDAP) laws (sometimes referred to as **consumer protection acts, consumer sales acts, unfair trade practices acts, deceptive trade practices acts**, and **consumer fraud acts**): state statutes that broadly apply to most consumer transactions, aimed at preventing consumer deception and abuse in the marketplace.

⁸ Lawrence E. Singer & Elizabeth Johnson Lantz, *The Coming Millennium: Enduring Issues Confronting Catholic Health Care*, 8 ANNALS HEALTH L. 299, 330 n.19 (1999).

NOTES

Section I: The Problem: Little-known Religious Restrictions Severely Reduce Access to Reproductive and Other Health Care Services

¹ U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (4th ed. 2001), available at <http://www.nccbuscc.org/bishops/directives.htm> (June 15, 2001) [hereinafter *DIRECTIVES*]. For further discussion on the impact of the *Directives* on care, see LOIS UTTLEY & RONNIE PAWELKO, MERGERWATCH, NO STRINGS ATTACHED: PUBLIC FUNDING OF RELIGIOUSLY-SPONSORED HOSPITALS IN THE UNITED STATES 22-24, 26-33 (2002) [HEREINAFTER NO STRINGS ATTACHED].

² See, e.g., NO STRINGS ATTACHED, *supra* note 1, at 24-25 (discussing policies of Baptists, the Church of Jesus Christ of Latter Day Saints and Seventh-Day Adventists); Diane Levick, *HealthSouth Centers Resume Abortions: Controversy Blamed on Confusion*, HARTFORD COURANT, Dec. 24, 1998, at A1 (a for-profit corporation with no religious affiliation had banned abortions; the corporation reversed its policy after the state attorney general threatened action); Tom Strode, *Resolutions Repudiate Earlier Abortion Stance, Affirm Family, Religious Liberty*, BAPTIST PRESS, June 19, 2003, at <http://www.bpnews.net/bpnews.asp?Id=16131> (reporting that the 2003 Southern Baptist Convention repudiated its 1971 and 1974 resolutions permitting abortion in certain instances and reaffirmed its belief that abortion is an “act of injustice against unborn children”); Elena N. Cohen, *Refusing and Forgoing Treatment*, in TREATISE ON HEALTH CARE LAW (Alexander M. Capron & Irwin M. Birnbaum eds., 2003), § 18.05[2](c) n.43 (citing authorities stating that Orthodox Jewish principles may prohibit discontinuing life-sustaining treatment, even though they authorize not beginning the treatment) [hereinafter Cohen, *Refusing Treatment*].

Not all religiously affiliated hospitals restrict services. See St. John’s Hospital transaction, described in Section III.C.3 of this report; United Methodist Church General Conference, *Resolution #102: United Methodist Response to Hospital Mergers*, in THE BOOK OF RESOLUTIONS OF THE UNITED METHODIST CHURCH (2000) (resolution to alert constituents to the problem of restrictions on reproductive and end-of-life care especially in the context of hospital mergers, by expanding its public policy program to include the issue and to work with community groups to make resource material available to local churches), available at <http://www.umc-gbcs.org/issues/resolutions.php?resolutionid=54> (last visited May 30, 2003); *Methodists Reject Resolution to Change Statement on Abortion*, ASSOCIATED PRESS NEWSWIREs, June 5, 2003; Cohen, *Refusing Treatment*, *supra*, at § 18.05[2](c) n.43 (citing other Jewish authorities that do not restrict health care services).

³ *DIRECTIVES*, *supra* note 1, at Directive 5. Each Catholic hospital is within a particular diocese, a geographic jurisdiction supervised by a bishop. The bishop oversees the functioning of, and compliance with, the *Directives* of the hospitals within his diocese, and interprets the *Directives*. *DIRECTIVES*, *supra* note 1, at General Introduction (“As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese.”).

⁴ *DIRECTIVES*, *supra* note 1, at Directive 45 (abortion is defined as “the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus;” Catholic institutions “are not to provide abortion services, even based upon the principle of material cooperation”).

⁵ *DIRECTIVES*, *supra* note 1, at Directive 48 (“In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion”); NO STRINGS ATTACHED, *supra* note 1, at 29-30 (reporting that some Catholic hospitals do not allow using methotrexate to treat ectopic pregnancies because termination of the fetus is the intended result of administering the drug).

⁶ See ALAN GUTTMACHER INSTITUTE, FACTS IN BRIEF: CONTRACEPTIVE USE (1999), available at http://www.guttmacher.org/pubs/fb_contr_use.html (last visited June 3, 2003) (more than ten million women, or almost 28 percent of women aged 15 to 44 currently using birth control reported using sterilization, making it the most commonly used form of birth control in the United States). Tubal ligations (surgical “sterilization”) are often provided in hospitals. NAT’L CTR. FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL & PREVENTION, SURGICAL STERILIZATION IN THE UNITED STATES: PREVALENCE & CHARACTERISTICS, 1965-95, 2 (1998). Indeed, many women choose postpartum tubal ligation because it is safer and less costly to have the sterilization procedure while in the hospital for childbirth than to undergo two separate hospitalizations. Andrea P. MacKay et al., *Tubal Sterilizations in the United States, 1994-1996*, 33 FAMILY PLANNING PERSPECTIVES 161, 163 (2001) (reporting that nearly 50 percent of the two million tubal sterilizations performed from 1994 to 1996 were done postpartum and that the sterilization rate for women of reproductive age increased from 4.7 per 100,000 women in 1970 to 11.5 per 100,000 in 1994-1996), available at <http://www.guttmacher.org/pubs/journals/3316101.pdf>; Kathleen Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, n.304 and accompanying text (1995) (citing authorities that, in 1970, one out of every 25 women who gave birth in a hospital had postpartum sterilization; in 1985, 1 out of every 10 did) [hereinafter Boozang].

⁷ *DIRECTIVES*, *supra* note 1, at Directive 53 (“Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution.”). Procedures that result in sterility but are intended to cure a serious illness are permitted, presuming no other cure is available. *Id.* The *Directives* always prohibited Catholic entities from “immediate material cooperation in actions that are intrinsically immoral,” but the U.S. Conference of Catholic Bishops revised the *Directives* in June 2001 to include not only abortion, euthanasia, and assisted suicide, but also “direct sterilization” as “intrinsically immoral” actions, thus limiting the ability of non-Catholic merger partners to preserve the provision of sterilization services, and particularly tubal ligation, while respecting the *Directives*. *DIRECTIVES*, *supra* note 1, at Directive 70 (prohibits Catholic entities from engaging in “immediate material cooperation in actions that are intrinsically immoral, such as abortion,

euthanasia, assisted suicide, and direct sterilization"). The revised *Directives* require that the Catholic partner shield itself from the "governance, management, and financial benefit" of such services, but provide little guidance as to what kind of participation in these services violates the *Directives*. DIRECTIVES, *supra* note 1, at Part Six, Forming New Partnerships with Health Care Organizations and Providers. See Directive 69 ("If a Catholic health care organization is considering entering into an arrangement with another organization that may be involved in activities judged morally wrong by the Church, participation in such activities must be limited to what is in accord with the moral principles governing cooperation"); Directive 71 (instructs Catholic entities to avoid "scandal" in their affiliations, which is defined as "an attitude or behavior which leads another to do evil"); Directive 72 (instructs the Catholic partner in an arrangement to "periodically assess whether the binding agreement is being observed and implemented in a way that is consistent with Catholic teaching"). See generally DIRECTIVES, *supra* note 1, at Appendix, The Principles Governing Cooperation.

For a discussion of the 2001 changes in the *Directives*, see Press Release, Catholic Health Association, CHA Sets the Record Straight Regarding Changes to the Ethical and Religious Directives for Catholic Health Care Services (June 15, 2001), available at <http://www.chausa.org/NEWSREL/R010615B.ASP> (last visited June 10, 2003); *Special Section: The ERDs and Health Care Partnerships*, HEALTH PROGRESS, Nov.-Dec. 2002, especially Thomas Kopfensteiner, *Responsibility and Cooperation*; Kevin O'Rourke, *Catholic Health Care and Sterilization*; Ron Hamel, *Part Six of The Directives* (noting that footnote 44 of the *Directives* still acknowledges differences in moral gravity among intrinsically evil actions: "Direct sterilization, for example, while judged to be intrinsically evil, is not as morally grave as abortion or euthanasia"), available at <http://www.chausa.org/PUBS/PUBSCONT.ASP?ISSUE=HP0211> (last visited June 10, 2003).

⁸ DIRECTIVES, *supra* note 1, at Directive 52 ("Catholic health institutions may not promote or condone contraceptive practices" other than counseling in methods of natural family planning for married couples). By extension, women also could not participate in research or clinical trials requiring subjects to take contraceptive precautions to avoid unknown harm to fetuses caused by the treatment under investigation, thus hindering women's access to new treatments and the advancement of medical research. Although there are not many studies about the extent to which contraceptive services are available at Catholic hospitals or clinics, at least one study has shown that contraceptives are not widely available at Catholic university health services. CATHOLICS FOR A FREE CHOICE, STUDENT BODIES: REPRODUCTIVE HEALTH CARE AT CATHOLIC UNIVERSITIES 13, 17, 19, 28, 67 (2002), available at <http://www.cath4choice.org/pdf/studentbodies.pdf> [hereinafter STUDENT BODIES] (in fall of 2000, CFFC researcher contacted all 191 four-year Catholic universities nationwide; of 133 that responded and said that they had health centers on campus, only 16 (12 percent) responded that they made contraceptives available to students for birth control purposes, and only three said they would provide emergency contraception; the report also noted that, although there is not a comprehensive study of reproductive health services at universities generally, at least one survey of 39 northern and midwestern secular universities conducted by Choice USA in 1998 found that 59 percent provided emergency contraception and 69 percent provided oral contraception) (citation omitted).

⁹ DIRECTIVES, *supra* note 1, at Directive 52 ("Catholic health institutions may not promote or condone contraceptive practices"); see also NATIONAL CONFERENCE OF CATHOLIC BISHOPS, CALLED TO COMPASSION AND RESPONSIBILITY: A RESPONSE TO THE HIV/AIDS CRISIS 20 (3d prtg. 1997) (stating that encouraging condom use to prevent HIV is "in effect, promoting behavior that is morally unacceptable"), available at <http://www.dioceseofcleveland.org/prolife/Articles/CALLEDTO.pdf>; Boozang, *supra* note 6, at nn.219, 220 and accompanying text.

¹⁰ DIRECTIVES, *supra* note 1, at Directives 38-41 (prohibiting assisted conception that "substitutes for the marital act," including methods of "artificial fertilization," which would include both in vitro fertilization and artificial insemination); see also Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights*, 51 STAN. L. REV. 1703, nn.103-109 and accompanying text (1999) [hereinafter White].

¹¹ DIRECTIVES, *supra* note 1, at Directive 51 (prohibiting "nontherapeutic experiments on a living embryo"); see also Vincent Branick & M. Therese Lysaught, Catholic Health Association, *Stem Cell Research: Licit or Complicit?*, 80 HEALTH PROGRESS, Sept.-Oct. 1999 (doctrine of "complicity" would forbid research using fetal tissue or embryos derived from abortion or in vitro fertilization), available at <http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9909&ARTICLE=B> (last visited June 2, 2003); CATHOLIC HEALTH ASSOCIATION, GENETICS, SCIENCE, AND THE CHURCH: A SYNOPSIS OF CATHOLIC CHURCH TEACHINGS ON SCIENCE AND GENETICS 21 (2003) ("The church maintains that obtaining stem cells from human embryos resulting in the demise of those embryos is morally illicit," it is "equally illicit to use embryonic stem cells, and the differentiated cells obtained from them, which are supplied by other researchers or are commercially obtainable"), available at <http://www.chausa.org/transform/genescience.pdf>.

¹² The *Directives* consider emergency contraception to the extent it prevents embryo implantation in the uterus to be abortion. Directive 45 states that abortion includes termination of pregnancy in the "interval between conception and implantation of the embryo." Although Directive 36 states that a woman who has been raped should be able to "defend herself against a potential conception from the sexual assault," it conditions such a "defense" on whether conception has already occurred. If conception has occurred, "it is not permissible to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum." For more information about the Catholic perspective on emergency contraception, see Michael D. Place, *A Venue for Theological/Ethical Issues*, HEALTH PROGRESS (July-Aug. 2003), available at <http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0307&ARTICLE=B>; Ronald P. Hamel & Michael R. Panicola, *Emergency Contraception and Sexual Assault*, HEALTH PROGRESS, Sept.-Oct. 2002, available at <http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP0209&ARTICLE=I> (last visited June 2, 2003).

Several studies on emergency contraception policies and practice show a lack of consensus among emergency contraception (EC) policies at Catholic hospitals and differences between Catholic and non-Catholic hospitals in providing emergency contraception. See Steven S. Smugar et al., *Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims*, 90 AM. J. PUB. HEALTH 1372, 1375 (2000).

(reporting a lack of consensus in emergency contraception policies in Catholic hospitals) [hereinafter Smugar]; CATHOLICS FOR A FREE CHOICE, CAUTION: CATHOLIC HEALTH RESTRICTIONS MAY BE HAZARDOUS TO YOUR HEALTH 7, 10 (1999) [hereinafter CFFC, HAZARDOUS] (in nationwide telephone survey of 589 Catholic hospital emergency rooms, 82 percent said that they would not provide emergency contraception, with no exceptions made in cases of rape; a third of those refusing also refused to provide rape survivors with referrals). A more recent national survey of all 597 Catholic hospital emergency rooms found that only five percent provided EC upon request, an additional 23 percent provided EC only to rape survivors, and 55 percent did not provide EC to women under any circumstances. CATHOLICS FOR A FREE CHOICE, SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS 5-6 (2002), available at <http://www.catholicsforchoice.org/PDF/EC%20Study.pdf> (survey of all Catholic hospital emergency rooms in the U.S. conducted by Ibis Reproductive Health). See also FAMILY PLANNING ADVOCATES OF N.Y. STATE, STATEWIDE SURVEY: PROVISION OF EMERGENCY CONTRACEPTION TO RAPE SURVIVORS AT HOSPITAL EMERGENCY DEPARTMENTS IN NYS, available at <http://www.fpaofnys.org/education/summaryoffindings.html> (last modified Apr. 24, 2003) (reporting results of 2002 survey in which 210 hospital emergency departments in New York state were contacted; of the 201 respondents, 171 (85 percent) said their standard policy is to dispense EC to all rape survivors who choose it after having been counseled. Among the 36 of 38 Catholic hospitals that responded, 27 (75 percent) said their standard policy is to dispense EC to all rape survivors, but some said they required a pregnancy test before medication is dispensed). Family Planning Advocates of New York State also has on its website information about the emergency contraception policies of specific emergency departments in the state, available at <http://www.fpaofnys.org/map/index.html> (interactive map) (last visited June 2, 2003); see also Annette L. Amey & David Bishai, *Measuring the Quality of Medical Care for Women Who Experience Sexual Assault with Data from the National Hospital Ambulatory Medical Care Survey*, 39 ANNALS OF EMERGENCY MED. 631, 636 (2002) (nationwide survey found fewer than half of all rape survivors eligible for EC actually received the treatment during a hospital emergency room visit); Boozang, *supra* note 6, at 1449-51 (citing authorities that Catholic hospitals in Illinois refuse to offer emergency contraception). See also study in note 8 *supra* about availability of emergency contraception at university health services. Increased access to emergency contraception prevented an estimated 51,000 pregnancies that would have ended in abortion in 2000. Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 PERSP. ON SEXUAL AND REPROD. HEALTH 294, 300 (2002), available at <http://www.guttmacher.org/pubs/journals/3429402.pdf>; ACLU REPRODUCTIVE FREEDOM PROJECT AND THE CLARA BELL DUVAL REPRODUCTIVE FREEDOM PROJECT OF THE ACLU OF PENNSYLVANIA, E.C. IN THE E.R.: A MANUAL FOR IMPROVING SERVICES FOR WOMEN WHO HAVE BEEN SEXUALLY ASSAULTED (July 2003).

¹³ The Directives state that Catholic health care providers “will not honor an advance directive that is contrary to Catholic teaching.” DIRECTIVES, *supra* note 1, at Directive 24; Directive 59 (“the free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching”). The Directives allow a person to reject “life-prolonging procedures that are insufficiently beneficial or excessively burdensome.” DIRECTIVES, at Part Five, Introduction. The Directives define euthanasia as “an action or omission that of itself or by intention causes death in order to alleviate suffering.” DIRECTIVES, at Directive 60. There may be situations where it is legally permissible to honor patient end-of-life preferences, but impermissible according to Catholic doctrine, for example, forgoing artificial nutrition and hydration for some patients (e.g., those who are permanently unconscious or Alzheimer’s patients), or forgoing life-sustaining treatment for a pregnant woman in her first trimester, thus also terminating her pregnancy. For a discussion of the Catholic perspective on artificial nutrition and hydration, see National Conference of Catholic Bishops Committee for Pro-Life Activities, *Nutrition and Hydration: Moral and Pastoral Reflections*, 15 J. CONTEMP. HEALTH L. & POL’Y 455 (1999). Although physician-assisted suicide is legally permissible under certain circumstances in Oregon, OR. REV. STAT. § 127.005 *et seq.*, Directive 60 prohibits honoring legally permissible patient preferences for physician-assisted suicide.

Although there is not much literature about the extent to which institutions have religious or moral restrictions for end-of-life care, two older surveys in New York found that several institutions did indeed have religious or moral restrictions; the surveys, however, did not identify the basis for the restriction (e.g., what religion was at issue). See Anna Maria Cugliari & Tracy E. Miller, *Moral and Religious Objections by Hospitals to Withholding and Withdrawing Life-Sustaining Treatment*, 19 J. COMMUNITY HEALTH 87 (1994) (29 percent of hospitals in New York State would object on grounds of conscience either to withholding or withdrawing life-sustaining treatment in some circumstances, but only ten percent of those that would object to decisions to forgo treatment had stated their objections in the form of a written policy); FRIENDS AND RELATIVES OF INSTITUTIONALIZED AGED (FRIA), RESPECTING END-OF-LIFE TREATMENT WISHES: ISSUES RAISED BECAUSE OF RELIGIOUS OR MORALLY BASED POLICIES AFFECTING END-OF-LIFE TREATMENT IN NEW YORK CITY NURSING HOMES 9, 14 (2001) (nearly 40 percent of nursing homes in New York City have “conscience” policies, usually founded on religious conviction, that would prevent them from carrying out some end-of-life treatment decisions of patients or their legally authorized representatives; nearly 90 percent of those with restrictions report communicating their policies both orally and in writing to patients, patients’ legally authorized representatives and their families).

¹⁴ Catholic teachings on the immorality of homosexuality could also affect access to health care and patients’ rights for gay and lesbian patients. While the Directives do not expressly forbid decision-making or visitation by homosexual partners in Catholic health care institutions, church leaders have been vocal opponents of state legislation (e.g., VT. STAT. ANN. tit. 15, § 1204(e)(10)-(11)) allowing homosexual partners these rights. Matt Kantz, *Bishop Calls for Stand Against Same Sex Marriages*, NAT’L CATH. REP., Feb. 4, 2000, at 13.

¹⁵ See note 87 *infra* and accompanying text.

¹⁶ Vince Galloro & Patrick Reilly, *Trickling Down*, MOD. HEALTHCARE, June 2, 2003, at 27 (Table: 10 Largest Healthcare Systems, based on patient revenue). See also Patrick Reilly, *Mergers Minus the Mania*, MOD. HEALTHCARE, Jan. 20, 2003, at 36 (current market still allows cautious systems opportunities to expand market share); Deanna Bellandi, *Catholic Systems Gain Market Share*, MOD. HEALTHCARE, Mar. 29, 1999, at 22.

¹⁷ Arthur Jones, *Catholic Aim: Aid Poor, Survive*, NAT'L CATHOLIC REP., June 6, 2003, available at http://natcath.org/NCR_Online/archives2/2003b/060603/060603d.php.

¹⁸ NO STRINGS ATTACHED, *supra* note 1, at 4, 31 (48 of 585 religious hospitals in the study's database are the sole providers of hospital care for more than 75 percent of the population in their service area or are located more than 35 miles away from a comparable institution); 42 C.F.R. § 412.92 (The Centers for Medicare & Medicaid Services classify a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or if it is located in a rural area and meets one of the following conditions: (1) it is located 25 to 35 miles from another hospital and meets other statutory requirements, such as severe weather or terrain conditions during parts of the year that make other hospitals inaccessible; (2) it is located 15 to 25 miles from other like hospitals but those hospitals are inaccessible for at least 30 days in each two out of three years; or (3) regardless of actual distance, the travel time between the hospital and the closest comparable hospital is at least 45 minutes).

¹⁹ More than half of all Medicaid recipients are enrolled in a managed care plan. NARAL/NY, *RESHAPING REPRODUCTIVE HEALTH: A STATE-BY-STATE EXAMINATION OF FAMILY PLANNING UNDER MEDICAID MANAGED CARE I* (2000). For more discussion of Fidelis, a Catholic-sponsored managed care company in New York, see *infra* note 46.

²⁰ See, e.g., Complaint, *Amelia E. v. Public Health Council*, Index No. 7062-94 (N.Y. Supreme Ct., Albany Cty., 1994), discussed in Section III.C.1 of this report.

²¹ See DIRECTIVES, *supra* note 1, at Directives 69-72 and Appendix, The Principles Governing Cooperation.

²² One survey revealed that reproductive health services were discontinued in 48 percent of the mergers and affiliations involving Catholic entities that were completed in 1998 and on which the surveyors were able to obtain information. CFFC, *HAZARDOUS*, *supra* note 12, at 5. See MERGERWATCH, *RELIGIOUS HOSPITAL MERGERS & HMOs: THE HIDDEN CRISIS FOR REPRODUCTIVE HEALTH CARE 19-21* (1997-1998 ed.). The restrictions persist even after the affiliation ends. See Karen Brandon, *Ex-Catholic Hospitals Retain Restrictions*, CHI. TRIB., Sept. 17, 2002, at 1 (many secular hospitals with former Catholic affiliations retain religious restrictions on reproductive health services and end-of-life care). Some non-Catholic hospitals in these affiliations, however, have interpreted the Directives as allowing them to retain services, often due to community resistance to restrictions and hospitals' recognition of the importance of these services to community health.

Religious restrictions can be particularly troublesome for certain groups of patients. For example, in Vermont, a proposal to move the Fletcher Allen Health Care psychiatric facility from its local location on a nonsectarian campus to the Catholic-owned Fanny Allen campus raised concerns about the effect it would have on the ability of female psychiatric patients—who are uniquely vulnerable to abusive relationships and ill-prepared to handle unwanted pregnancies—to receive the reproductive health care and counseling that they need. See *Hearing Before the Public Oversight Commission, Banking Insurance, Securities and Health Care Administration of Vermont*, 2001-2002 Leg. (Vt. 2002) (May 1, 2002 statement of Lois Uttley, Director, MergerWatch, Family Planning Advocates of NYS)(on file with NWLC and MergerWatch).

²³ See, e.g., Letter from Mark J. Urban, Deputy Attorney General of California, to James R. Schwartz, Attorney, Manatt, Phelps & Phillips, Concerning the Sale of Daniel Freeman Hospitals, Inc. to Tenet Health Systems (Dec. 7, 2001) (on file with NWLC). In effect, these sale agreements mandate observance of the Directives for an unlimited duration, establishing the Directives as a “covenant” that runs with the land and itself. However, at least one attorney general has expressed reservations about the enforceability of such provisions. See *id.* For more information on Tenet's relationship with Catholic entities, see Press Release, Tenet Healthcare Corp., Tenet Announces Initiatives to Sharpen Strategic Focus, Reduce Operating Expenses, Accelerate and Share Repurchasers (Mar. 18, 2003) available at <http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases/Initiatives+to+Sharpen+Strategic+Focus+-+Oper+Exp+-+Accel+Share+Repurch.htm>.

²⁴ See, e.g., Susan Berke Fogel, *Commentary, Perspective on Health: When Hospitals and Doctors Play God*, L.A. TIMES, Apr. 8, 1998, at B7 (noting lease restrictions requiring compliance with the Directives in doctors' private practices); Paul Clegg, *Health Care Ties that Bind: Religious Control Often Ends Reproductive Services*, SACRAMENTO BEE, July 18, 1998, at A1 (reporting that a doctor who tried to rent office space from a Catholic hospital in California was told that she would have to sign a lease agreement that required her to follow the Directives' prohibitions on reproductive health care).

²⁵ Some recent trends, however, may create opportunities to reclaim some of the lost services. The hospital sale and closure wave has limited health care access. Mary Chris Jaklevic, *Trouble in the City: Mergers, Medicare and Managed Care Combine to Force Closing of 38 Urban Hospitals*, MOD. HEALTHCARE, Jan. 8, 2001, at 52. Nevertheless, this trend has created the possibility that non-Catholic entities that adopted the Directives as part of Catholic affiliations could once again provide comprehensive health care if they are later sold to entities that do not impose religious restrictions. See Jaklevic, *Trouble in the City*; Deanna Bellandi, *Spinoffs, Big Deals Dominate in '99*, MOD. HEALTHCARE, Jan. 10, 2000, at 36; Preventing the Proposed Service Consolidation at Good Samaritan Hospital and St. Mary's Hospital (West Palm Beach, FL), in ELENA N. COHEN & JILL C. MORRISON, NAT'L WOMEN'S LAW CTR., *HOSPITAL MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES: USING CHARITABLE ASSETS LAWS TO FIGHT BACK 30-32* (2001) [hereinafter NWLC CHARITABLE ASSETS]. The federal government is also examining whether consummated mergers have actually harmed competition and patient care. Timothy J. Muris, Chairman, Federal Trade Commission, *Everything Old is New Again: Health Care and Competition in the 21st Century 19* (Nov. 7, 2002) (prepared remarks before the 7th Annual Competition in Health Care Forum stating that consumer protection role in health care is renewed area of FTC focus), available at <http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf>; Federal Trade Commission and Department of Justice, *Hearings on Health Care and Competition Law and Policy*, available at <http://www.ftc.gov/ogc/healthcarehearings/index.htm> (last visited May 29, 2003)[hereinafter

Muris]; Mark Taylor, *Getting Back in the Game: FTC, Justice Department Step Up Scrutiny of Antitrust Issues in Healthcare, Including a Look at Mergers Past and Present*, MOD. HEALTHCARE, Feb. 17, 2003, at 26. This renewed attention could also result in dismantling some religious and secular partnerships.

²⁶ CATHOLICS FOR A FREE CHOICE, RELIGION, REPRODUCTIVE HEALTH AND ACCESS TO SERVICES: A NATIONAL SURVEY OF WOMEN I, 9, 14 [hereinafter CFFC, NATIONAL SURVEY] (reporting results of survey conducted by Belden, Russonello & Stewart in April 2000). See also ACLU REPRODUCTIVE FREEDOM PROJECT, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS (2002) at 20 [hereinafter ACLU, RELIGIOUS REFUSALS] (2001 focus group study revealed that none of the focus group participants initially knew what refusal clauses or “conscience clauses” were, though 76 percent of those polled then said they opposed “giving hospitals an exemption from the law allowing them to refuse to provide medical services they object to on religious grounds”).

²⁷ CFFC, NATIONAL SURVEY, *supra* note 26, at 1, 9, 14.

²⁸ For a discussion of women and HIV, see, e.g., NAT’L WOMEN’S LAW CTR & KAISER FAMILY FOUND., WOMEN’S ACCESS TO CARE: A STATE-LEVEL ANALYSIS OF KEY HEALTH POLICIES 96-97 (2003) [hereinafter NWLC KAISER REPORT], available at <http://www.nwlc.org/pdf/KaiserFinal.pdf>.

²⁹ Seton Health System in Troy, New York refuses to provide some reproductive health services, but its brochures and advertisements indicate that it offers comprehensive ob/gyn care. Dr. Josefina Vega Marin stated in an advertisement published in the *Times Union* that she provides “comprehensive obstetric and gynecologic care” at Seton Health. See *TIMES UNION* (Albany, NY), Feb. 7, 1999, at D4. As of 2003, Seton is still circulating a brochure entitled “What Every Woman Should Know About OB/GYN” that claims Seton’s women’s health program provides “comprehensive health care services to women of all ages,” but says nothing about its restrictions on reproductive health services. See Seton Health for Women, What Every Woman Should Know About OB/GYN, available at <http://www.setonhealth.org/pdf/OBGYN.pdf> (last visited August 8, 2003). For a further discussion of the Seton case, see Section III.C.1 of this report.

In a New York State Public Health Council Committee hearing regarding a pending merger, Chairperson Susan Regan stated, “I think when people come to a hospital that offers maternity services as a general hospital, they have the right to expect that everything listed in the ... [New York regulations] as part of the maternity services will be provided at the standard of care of the community... if there is to be any deviation of that, for any reason, that needs to be said.” Letter to Russell W. Besette, Chair, New York State Public Health Council from Family Planning Advocates of New York State 6 (Mar. 16, 1999) (internal citations omitted) (on file with NWLC). The regulations do, in fact, include family planning as a maternity service. See N.Y. COMP. CODES R. & REGS. tit. 10 §§ 405.21 (f)(3)(iv) (each maternity patient shall be offered a program of instruction and counseling in family planning and arrangements for family planning services shall be made if desired by the patient”); 405.21 (f)(5)(iii) (prior to discharge, the hospital shall determine that “the mother has been instructed regarding family planning”); 405.21 (b)(13) (family planning is defined as “planning and spacing of children by medically acceptable methods to achieve pregnancy, or prevent unwanted pregnancy”). Cf. § 405.21 (c)(1) (hospital providing maternity and newborn services shall provide services in accordance with current standards of professional practice).

³⁰ CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, ADVOCACY AGENDA: 2003 & 2004 (undated), available at <http://www.chausa.org/PUBLICPO/ADVOCACY2003.pdf> (last visited August 8, 2003).

³¹ See Michael Place, *The Sunshine Covenant: Part of Hospitals’ Mission is to Share Information with Patients, Public*, MOD. HEALTHCARE, Apr. 7, 2003, at 24 (“The Catholic Health Association has a continuing commitment to promoting transparency and community accountability.... As we serve, we engage with people in their most vulnerable moments and they rely on us to put their interests first. The relationship is, in essence, a covenant based on trust that requires honesty, openness and reciprocity by both parties.... Every participant in the healthcare system should be accountable to their communities, but accountability depends on the availability of accurate information presented fairly and intelligently.... We as leaders in the [health care system] encourage the development of responsible and reliable programs and methods for demonstrating accountability to the communities we serve so that we can strengthen the bonds of trusts that are essential to the well-being of our nation’s healthcare system”).

³² ACLU, RELIGIOUS REFUSALS, *supra* note 26, at 20-22, 24 (telephone survey conducted in July of 2001 of 1,001 people 18 and over).

³³ ACLU, RELIGIOUS REFUSALS, *supra* note 26, at 20-22, 24.

³⁴ ACLU, RELIGIOUS REFUSALS, *supra* note 26, at 20-22, 24.

³⁵ ACLU, RELIGIOUS REFUSALS, *supra* note 26, at 20-22, 24.

³⁶ Three out of four women responding in the 2000 survey mentioned above said that they would oppose the merger of a Catholic and a non-Catholic hospital if it would mean that women were denied reproductive health services. CFFC, NATIONAL SURVEY, *supra* note 26, at 9. In another national survey in 2001, 87 percent of those surveyed supported women’s access to birth control (survey conducted by the NARAL Foundation; 60 percent of the people also opposed refusal clauses in laws that require insurers to cover prescription contraceptives if they cover other prescriptions). NARAL PRO-CHOICE AMERICA, THE CONTRACEPTION REPORT: A STATE-BY-STATE REVIEW OF ACCESS TO CONTRACEPTION i, ii (2001) [hereinafter NARAL, CONTRACEPTION REPORT], available at http://www.naral.org/publications/contraceptive_report_2001.cfm.

Section II: Federal and State Notice Requirements Can Help Challenge Improper Warnings about Institutional Religious Restrictions

³⁷ For a discussion of using charitable assets laws, see NWLC CHARITABLE ASSETS, *supra* note 25; Deanna Bellandi, *Separation of Church and State: Catholic, Secular Hospital Mergers Face New Hurdles as Sides Diverge Further*, MOD. HEALTHCARE, July 9, 2001, at 18; Alison Manolovici Cody, *Success in New Jersey: Using the Charitable Trust Doctrine to Preserve Women's Reproductive Services When Hospitals Become Catholic*, 57 N.Y.U. ANN. SURV. AM. LAW 323 (2000). For a discussion of antitrust laws, see JUDITH C. APPELBAUM, NAT'L WOMEN'S LAW CTR., HOSPITAL MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES: USING ANTITRUST LAWS TO FIGHT BACK (1998) [hereinafter NWLC ANTITRUST REPORT]; NAT'L WOMEN'S LAW CTR., HEALTH CARE PROVIDER MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES: 2003 PROVIDES NEW CHALLENGES AND OPPORTUNITIES TO USE ANTITRUST LAWS TO FIGHT BACK (2003), available at <http://www.nwlc.org/pdf/AntitrustUpdateApril2003.pdf>; Judith C. Appelbaum & Jill C. Morrison, *Hospital Mergers and the Threat to Women's Reproductive Health Services: Applying the Antitrust Laws*, 26 N.Y.U. REV. L. & SOC. CHANGE 1, 28-31 (2000-2001) (discussing Clayton Act § 16, 15 U.S.C. § 26 and other legal authorities related to antitrust). For more recent activity at the federal level, see Mark Taylor, *Getting Back in the Game: FTC, Justice Department Step Up Scrutiny of Antitrust Issues in Healthcare, Including a Look at Mergers Past and Present*, MOD. HEALTHCARE, Feb. 17, 2003, at 26; Federal Trade Commission website, at <http://www.ftc.gov>. For tax issues, see Internal Revenue Service, Field Service Advisory, IRS FSA 200110030 (Mar. 9, 2001) (regarding charity care and tax-exempt status)(exempting hospitals' compliance with U.S. Treasury Regulation § 1.501(c)(3)-1(c)); see also *IHC Health Plans v. Comm'r of Internal Revenue*, 325 F.3d 1188, 1199-1201 (10th Cir. 2003) (denying tax-exempt status to three HMOs because they did not operate primarily to promote health for the benefit of the community; they did not furnish direct health care services or offer free or below-cost health care services, nor did they conduct research or offer free educational programs to the public and two of the three HMOs did not offer their plans to the general public). For a general discussion of legal tools, see Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087 (1996); Cyril Tokar, *Hospital Mergers That Strangle Reproductive Services: Can the Patient Find Any Remedy Within the Legal System?*, 2 FLA. COASTAL L.J. 291 (2001) [hereinafter Tokar]; White, *supra* note 10; Jane Hochberg, Comment, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 OR. L. REV. 945 (1996); Monica Sloboda, Recent Development, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140 (2001).

³⁸ See, e.g., Michael Romano, *Not Just a Web Site*, MOD. HEALTHCARE, May 26, 2003, at 22 (experts note that hospital websites are now expected by consumers for information they can trust; 82 percent of hospitals in 2002-2003 use the Internet in their marketing efforts); Charles S. Lauer, *Getting Back to Basics: Treating Customers Right is the Key to Success in the Long Run*, MOD. HEALTHCARE, Apr. 14, 2003, at 24; see also Appendices B and D of this report (listing government and nongovernmental groups that focus on health care consumer needs).

³⁹ See, e.g., Vince Galloro & Mark Taylor, *In Charge of Change: CMS' No. 2 Executive Concentrates on Reducing the Uninsured, Modernizing Medicare*, MOD. HEALTHCARE, Apr. 7, 2003, at 34, 36-38 (official from U.S. Health and Human Services Centers for Medicare & Medicaid Services (CMS) notes that CMS's objective is to provide information to health care consumers about hospitals and physicians that is "useful" and "credible" and that "leads but doesn't mislead"). In 2002, the federal government began carefully examining the effect of consummated health care mergers to determine whether they actually increased costs to the consumers, rather than saving them money and improving health care access. See Timothy J. Muris, Chairman, Federal Trade Commission, *Everything Old is New Again: Health Care and Competition in the 21st Century* 20 (Nov. 7, 2002) (prepared remarks before the 7th Annual Competition in Health Care Forum discussing a retrospective study of consummated mergers to determine effect of mergers on consumers), available at <http://www.ftc.gov/speeches/muris/murishealthcare-speech0211.pdf>. The government began holding hearings to study "the state of the health care marketplace and the roles of competition, antitrust enforcement, and consumer protection in satisfying consumer preferences for high-quality, cost-effective health care." For an overview of the hearings and to obtain transcripts, see Federal Trade Commission and Department of Justice, *Hearings on Health Care and Competition Law and Policy*, available at <http://www.ftc.gov/ogc/healthcarehearings/index.htm> (last visited May 29, 2003). See also David Balto, *Revitalizing Hospital Merger Antitrust Enforcement*, ANTITRUST HEALTH CARE CHRONICLE, Summer 2002, at 2 (reporting that one recent study showed that a nonprofit merger resulted in increased costs); Barbara Martinez, *After an Era of Dominant HMOs, Hospitals Are Turning the Tables*, WALL STREET J., Apr. 12, 2002, at A1 (noting that mergers have allowed hospitals to demand higher reimbursement rates from HMOs); Lindy Washburn, *Hospital Sues to Escape Joint Venture With Two Others*, THE RECORD (Bergen County, N.J.), Mar. 21, 2002, at A16; Jennifer Steinhauer, *Hospital Mergers Stumbling as Marriages of Convenience*, N.Y. TIMES, Mar. 14, 2001, at A1. See also Mary Chris Jaklevic, *Christus Seeks Buyer for Two Texas Hospitals*, MOD. HEALTHCARE'S DAILY DOSE (May 29, 2003) (reporting that one two-hospital Catholic health care system sought a buyer two years after it established a monopoly in the market because it was losing between \$500,000 and \$1 million a month), available at http://www.modernhealthcare.com/dailydose/2003-05-29_dailydose.html#ts2. This renewed examination creates opportunities for dismantling economically inefficient mergers or other affiliations that impose religious restrictions on the nonsectarian partners.

⁴⁰ Some refusal clauses specify the acceptable reasons for the objection (e.g., religious and/or moral reasons for objection), while others do not. See NWLC KAISER REPORT, *supra* note 28, at 82-87 (of the 45 states allowing institutional health care providers to refuse to provide abortions, 22 limit to refusals for religious or moral reasons; of the 25 states allowing individual or institutional health care providers to refuse to provide family planning or contraception, 23 limit to refusals for religious or moral reasons; five states allow employers or insurers affiliated with religious entities to refuse to provide insurance coverage for infertility treatment for religious or moral reasons).

⁴¹ For convenience, "providing" service is used in this report (unless otherwise indicated) to include: rendering, paying for, counseling about, and making referrals for service.

⁴² For more information about refusal clauses generally and challenges and limitations, see ACLU, RELIGIOUS REFUSALS, *supra* note 26; ACLU REPRODUCTIVE FREEDOM PROJECT, CONFLICTS BETWEEN RELIGIOUS REFUSALS AND WOMEN'S HEALTH: HOW THE COURTS RESPOND (2002)

[hereinafter ACLU, COURTS]; NWLC KAISER REPORT, *supra* note 28, at 82-87; NARAL PRO-CHOICE AMERICA FOUNDATION, REFUSAL CLAUSES: DANGEROUS FOR WOMEN'S HEALTH (Jan. 14, 2003), available at <http://www.naral.org/facts/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=1571>; NARAL PRO-CHOICE AMERICA, WHO DECIDES? A STATE-BY-STATE REVIEW OF ABORTION AND REPRODUCTIVE RIGHTS xxiii, 222-24 (12th ed. 2003) [hereinafter NARAL, WHO DECIDES?] (grading states on their refusal clauses; see also individual state pages for court challenges), available at <http://www.naral.org/publications/whodecides2003.cfm> (last visited June 6, 2003); NARAL, CONTRACEPTION REPORT, *supra* note 36, at 72-75 (grading states on their refusal clauses; see also individual state pages for court challenges); NO STRINGS ATTACHED, *supra* note 1, at 34-40, 45-54. See also Op. Att'y Gen. 5 (Wash. 2002), available at http://www.wa.gov/ago/opinions/opinion_2002_5.html (Washington Attorney General and Insurance Commissioner concluded that health insurers and employers include coverage for prescription drugs but do not include coverage for prescription contraception because of their religious objections are engaged in impermissible unfair and deceptive acts or practices under the insurance law because this practice unfairly discriminates against women, notwithstanding the existence of a refusal clause for contraceptive coverage, relying on WASH. REV. CODE §§ 48.30.010, 48.43.065, WASH. ADMIN. CODE § 284-43-822). Some states that require insurers to cover prescription contraceptives if they cover other prescriptions (contraceptive equity laws) exempt religious organizations from coverage. However, a few states have included narrow refusal clauses that exempt religious organizations only if they meet certain criteria (e.g., inculcation of religious values is the purpose of the entity, entity primarily employs persons who share its religious tenets, entity serves primarily persons who share its religious tenets). Catholic Charities, a social service organization that is not exempt from contraceptive equity laws in California or New York, has challenged these narrow refusal clauses. See Catholic Charities of Sacramento, Inc. v. Superior Court, 109 Cal. Rptr. 2d 176 (2001), appeal filed, 31 P.3d 1271 (2001); Complaint of Catholic Charities of Albany et al., Catholic Charities of Albany v. Serio, No. 8229-02 (N.Y. Sup. Ct. filed Dec. 30, 2002).

⁴³ For a discussion of the issue of institutional ethical and religious restrictions especially in context of end-of-life care, see Cohen, *Refusing Treatment*, *supra* note 2, at § 18.05; Boozang, *supra* note 6, at nn. 106-109 and accompanying text; Steven H. Miles et al., *Conflicts Between Patients' Wishes to Forgo Treatment and the Policies of Health Care Facilities*, 321 NEW ENG. J. MED. 48, 50 (1989) (noting that "[a] facility that did not inform a patient in advance that its mission was incompatible with possible future requests for treatment might lose the option of restricting its treatment later"); White, *supra* note 10, at 1723.

⁴⁴ There are very few institutional refusal clauses that apply to health services generally. The most prominent one concerns federal Medicaid managed care rules. Federal law also allows managed care plans that serve Medicaid patients to refuse "to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects to the provision of such service on moral or religious grounds." 42 U.S.C. § 1396u-2(b)(3); see also 42 C.F.R. §§ 438.10(e)(2)(E), 438.102, as discussed in 67 Fed. Reg. 40,988, 41,101, 41,104 (June 14, 2002). If the program does not provide counseling or referrals for a service because of "moral or religious" objections, the state or its contracted representative must provide information about where and how to obtain the service to all potential enrollees before and during enrollment; current enrollees must be notified of their right to request information about the scope of benefits as well as the "extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers." 42 U.S.C. §§ 1396a(a)(23)(B) (referring to services generally); 1396n(b)(4) (referencing family planning services provisions; sometimes referred to as "freedom of choice" or "free access provisions"); 42 C.F.R. §§ 438.10(e)(2)(ii)(E), 438.10(f)(2), 438.10(f)(6)(v), 438.10(f)(6)(vii), 438.10(f)(6)(xii). The federal law does not require the objecting program itself to provide information about "how and where to obtain [a] service;" instead, it is the state's responsibility to provide a Medicaid enrollee with this information. *Id.* at § 438.10(f)(xii).

Outside the Medicaid managed care context, on the state level, at least one state allows institutions to refuse to provide any type of health care service contrary to the institution's "conscience," as long as this policy is reflected in official documents. See, e.g., 745 Ill. Comp. Stat. 70/10 (prohibiting discrimination against a health care facility for its refusal to perform health care services that it opposes on the basis of conscience). Although the law does not expressly require that disclosures be made directly to patients, it does require that the refusal be included in several documents to which patients could have access. 745 Ill. COMP. STAT. 70/9 ("No person, association, or corporation, which owns, supervises, or manages a health care facility shall be civilly or criminally liable to any person, estate, or public or private entity by reason of refusal of the health care facility to permit or provide any particular form of health care service which violates the facility's conscience as documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents.").

⁴⁵ See, e.g., CAL. HEALTH & SAFETY CODE § 123420 ("Any [religiously affiliated] facility or clinic that does not permit the performance of abortions on its premises shall post notice of that proscription in an area of the facility or clinic that is open to patients and prospective admittees."); 2000 Cal. Legis. Serv. Ch. 347, A.B. 525, codified at CAL. HEALTH & SAFETY CODE §§ 1339.80, 1363.02; CAL. INS. CODE § 10604.1; CAL. WELF. & INST. CODE § 14016.8 and discussed in more detail in note 63 *infra* and accompanying text [hereinafter A.B. 525]; 720 ILL. COMP. STAT. ANN. 510/13, 745 ILL. COMP. STAT. 70/1-14, 30/1 (No hospital, surgical center, or employee thereof may be required to perform or participate in any abortion objectionable on the grounds of conscience; patient must be promptly notified if a request for abortion is denied); NEB. REV. STAT. §§ 28-337 to 28-341 (hospital, institution or facility must inform women of its policy not to participate in abortion related services; refusal to perform or allow abortion cannot be basis for cause of action); Or. Rev. Stat. § 435.475 (refusal of private hospital to participate in abortion may not be basis for civil liability where the hospital notifies the woman seeking admission of its policy; "[A]ll hospitals that have not adopted a policy not to admit patients seeking termination of a pregnancy shall admit patients seeking such termination in the same manner and subject to the same conditions as imposed on any other patient seeking admission to the hospital."); 18 PA. CONST. STAT. § 3213, 43 PA. CONS. STAT. § 955.2 (except where the practice endangers the health or safety of patient and other reasons, no private hospital or health care facility may be required to or held liable for refusing to perform or permit abortion contrary to a written ethical policy adopted after Jan. 22, 1973 and posted conspicuously for public inspection; expressed willingness or refusal to perform or permit abortion cannot be basis for dis-

crimination, denial of public funds or other penalty); WYO. STAT. ANN. § 35-6-105 (private hospital, institution or facility must inform any woman seeking an abortion of its policy not to permit or admit). Some of these laws require that an institution that wants to object must formally express the objection, although it is not always clear that patients will have access to these formal statements. See, e.g., IDAHO CODE § 18-612 (hospital governing board needs to object, then can refuse to provide abortion); S.C. CODE ANN. §§ 44-41-40, 44-41-50 (refusal of private or nongovernmental hospital or clinic to provide abortion services in accordance with an adopted policy may not be a basis for civil liability); S.D. CODIFIED LAWS §§ 34-23A-11 to 34-23A-14 (refusal of hospital to participate in abortion in accordance with adopted policy may not be a basis for liability).

⁴⁶ For more information about family planning religious restrictions generally, see NARAL CONTRACEPTION REPORT, *supra* note 36, at iii, xiii-xiv and individual state pages; NWLC KAISER REPORT, *supra* note 28, at 84-85. Medicaid patients are legally entitled to family planning services. 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20. However, the aforementioned federal Medicaid managed care refusal clause for general health care services also allows institutions to restrict their provision of family planning services.

Some states have family planning service notice requirements in their Medicaid managed care programs that exceed those in the federal requirements. These additional notice requirements address concerns that the federal rules do not mandate clear and timely notice that allows potential enrollees to decide whether they want to select a plan that does not cover the desired services or whether they want to select another plan. NWLC KAISER REPORT, *supra* note 28, at 54-56 (state-by-state analysis of how states inform Medicaid enrollees about obtaining family planning services). For a discussion of New York's approach, see N.Y. SOC. SERV. LAW § 364-j(4)(a)(iii)(C) and other provisions, as discussed in Miriam Hess & Robert Jaffe, WHEN RELIGION COMPROMISES WOMEN'S HEALTH CARE: A CASE STUDY OF A CATHOLIC MANAGED CARE ORGANIZATION 7-9 (New York: NARAL/NY Foundation, 2001) [hereinafter Hess & Jaffe] (Fidelis case study); CATHOLICS FOR A FREE CHOICE, CATHOLIC HMOs AND REPRODUCTIVE HEALTH CARE 27, 31 (2000) [hereinafter CFFC HMOs] (survey also found that 48 Catholic managed care plans nationwide enroll nearly 2.5 million people nationwide, including privately insured individuals); Rachel Gold, *States Key to Women's Family Planning Access Under New Medicaid Managed Care Rules*, 5 GUTTMACHER REP. ON PUB. POL'Y 12 (2002); Letter from National Health Law Program (NHeLP) and other organizations (including NWLC), to CMS (Oct. 19, 2001), available at <http://www.healthlaw.org/pubs/200110.reprocomments.html> (last visited June 4, 2003) (discussing CMS-2104-P proposed Medicaid Managed care rule); SARA R. SILLS ET AL., NARAL/NY FOUNDATION & NATIONAL HEALTH LAW PROGRAM, PROTECTING REPRODUCTIVE HEALTH CARE FOR LOW-INCOME WOMEN: AN ORGANIZING GUIDE FOR REPRODUCTIVE HEALTH CARE ADVOCATES AND LEGAL SERVICE ORGANIZATIONS (2002); ROBERT JAFFE ET AL., NARAL/NY FOUNDATION, RESHAPING REPRODUCTIVE HEALTH: A STATE-BY-STATE EXAMINATION OF FAMILY PLANNING UNDER MEDICAID MANAGED CARE, 2-4, 24-26 (2000) (finding barriers to beneficiaries' exercise of their freedom of choice to include lack of information and referrals and lack of appropriate and timely reimbursement of out-of-network providers who do provide services); ACLU, RELIGIOUS REFUSALS, *supra* note 26, at 2-3; White, *supra* note 10, at 1743-48.

Notice is especially important in states with mandatory Medicaid managed care enrollment, a large Catholic-sponsored managed care company, and automatic enrollment. Automatic enrollment is also referred to as "auto enrollment" or "auto assignment." In New York, a person can be assigned to a managed care organization if he or she has not selected one within 60 days of receiving the notice of mandatory enrollment. See New York Contract 6.4, in Ctr. for Health Servs. Research & Policy, Negotiating the New Health System (Online database, 4th ed. 2000), available at http://www.gwu.edu/~chsrf/Fourth_Edition/GSA/States/NY.html (auto assignment executed pursuant to N.Y. Soc. Servs. Law § 364-j). In Colorado, the enrollee can be automatically assigned 65 days after Medicaid eligibility is determined. See Colorado Contract II.B.1.a., in Ctr. for Health Servs. Research & Policy, Negotiating the New Health System (Online database, 4th ed. 2000), available at http://www.gwu.edu/~chsrf/Fourth_Edition/GSA/States/CO.html (auto assignment executed pursuant to 10 COLO. CODE REGS. 2050-10, § 8.209.29). Some states give preference to nonprofit plans (including Catholic-run plans) over other plans. Fidelis, along with other nonprofit plans in the area, is given preference over commercial plans in the auto-enrollment process. See CFFC HMOs, *supra*, at 32-33. In these states, lack of notice is especially problematic, because potential enrollees, unaware of restrictions, may be assigned to a plan that contains them. For information about notice problems with Fidelis, which has religious restrictions, refusing to provide any family planning services (including contraceptives, family planning counseling, tubal ligations) and abortions, see CFFC HMOs, *supra*, at 21-23, 29-33; Hess & Jaffe, *supra*, at 4, 8-9, 13, 17-19, 25; White, *supra* note 10, at 1740-41. For updated information about Fidelis' enrollment figures, see <http://www.health.state.ny.us/nys-doh/mancare/medicaid/main.htm> (last visited July 31, 2003).

There are also state family planning refusal clauses that apply beyond the Medicaid managed care context. Some of these laws require that institutions that want to object must formally express the objection, although it is not always clear that patients will have access to these formal statements. See, e.g., MASS. GEN. LAWS ch. 272, § 21B ("No privately controlled hospital or other privately controlled health facility shall be required . . . to furnish any family planning services within or through said hospital or other health facility or to make referrals to any other hospital or health facility for such services when . . . contrary to the religious or moral principles of said hospital or said health facility as expressed in its charter, by-laws or code of ethics, or vote of its governing body.").

⁴⁷ See, e.g., CAL. HEALTH & SAFETY CODE § 1367.25, CAL. INS. CODE § 10123.196; Memorandum from Barbara H. Yonemura, Acting Assistant Commissioner, Health Plan Division, Department of Corporations, California to all Licensed Health Care Service Plans (Apr. 5, 2000) (HMOs that provide religious employers with coverage for contraceptives must file contracts with the Department of Corporations to show that religious employers provide the legally required written notice); CONN. GEN. STAT. §§ 38a-503e, 38a-530e (any health insurance policy that excludes coverage for prescription contraceptive methods must provide the insured with written notice of the exclusion); DEL. CODE ANN. tit. 18, § 3559 (religious employers can request exclusion of coverage for contraceptive drug and devices if employers gives reasonable

and timely notice of the exclusion to employees); HAW. REV. STAT. §§ 431:10A-116.6, 431:10A-116.7, 432:1-604.5 (religious employers must provide: (1) written notice of the exclusion upon enrollment in the health insurance plans, and (2) prompt written information on how to access contraceptive services and supplies); MO. ANN. STAT. § 376.1199 (health benefit plans must provide clear and conspicuous written notice indicating (1) whether plan covers contraception, (2) that enrollees can get a policy excluding contraceptive coverage if such coverage conflicts with their own religious or moral beliefs, and (3) that enrollees in a plan that excludes contraceptive coverage have a right to purchase coverage for contraceptives); NEV. REV. STAT. Ann. §§ 689A.0145, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 689B.1918, 695C.1715, 695C.1717 (insurers and HMOs affiliated with religious organizations that object to coverage for contraceptives and related services on religious grounds must provide written notice of their objection to the prospective insured before the issuance of a policy of health insurance and before the renewal of such a policy); N.C. GEN. STAT. §§ 58-3-178, 58-50-155 (insurers providing health benefit plans to religious employers must provide written notice of exclusion to the insured); N.Y. INS. LAW § 3221(l)(16) (religious employers invoking a religious exemption must provide written notice to prospective enrollees and must list all refused contraceptive services); TEX. INS. CODE ANN. Art. 21.52L (insurer exercising religious exemption must provide written notice of exclusion in all health plan materials). See also NWLC KAISER REPORT, *supra* note 28, at 24-25, 84-85 (state-by-state listing of states with contraceptive equity laws and whether they have refusal clauses; state-by-state listing of states with religious or moral refusal clauses concerning family planning services); NARAL, CONTRACEPTIVE REPORT, *supra* note 36.

⁴⁸ Some of these laws require that institutions that want to object must formally express the objection, although it is not always clear that patients will have access to these formal statements. See, e.g., CAL. HEALTH & SAFETY CODE §§ 1339.80, 1339.81, 1363.02; MASS. GEN. LAWS ch. 272, § 21B (privately controlled hospital or other privately controlled health facility that wants exemption under refusal clause must express it through by-laws, code of ethics, or vote of its governing body); MONT. CODE ANN. §§ 50-5-501 to 50-5-505 (private hospital must state its refusal concerning sterilization through its governing body or board); 43 PA. CONS. STAT. § 955.2 (hospital or other health facility must have “stated ethical policy”).

⁴⁹ These refusal clauses are usually found in the context of state laws requiring private insurers to cover infertility treatment in some form. See NWLC KAISER REPORT, *supra* note 28, at 86-87 (state-by-state chart of religious or moral refusal clauses concerning infertility treatment coverage). Five of the 15 states with such insurance mandates allow religious health care providers and organizations to be exempted from the requirement. *Id.* Three of these states require that employers or insurers claiming a religious exemption provide written notice to consumers that coverage is not available. CAL. HEALTH & SAFETY CODE § 1374.55 (requiring every plan to communicate the availability of the coverage to all group contract holders and all prospective group contract holders); N.J. STAT. ANN. § 17:48-6x (requiring insurance carriers to provide written notice to current or prospective subscribers in the contract, application or sales brochure when religious employers refuse to offer coverage for infertility treatment); TEX. INS. CODE ANN. art. 3.51-6 (requires entities with religious objections to in vitro fertilization to provide written notice to “group policyholder, contract holder, employer, multiple-employer, union, association, or trustee” that they are claiming the exemption).

⁵⁰ See, e.g., CAL. PROB. CODE § 4734 (health care institutions may decline to comply with individual instruction for reasons of conscience if the policy was “timely communicated” to the patient or patient’s proxy); MASS. GEN. LAWS ch. 201D, § 15 (private facilities may refuse to honor health care decision if facility has informed the patient or patient’s health care proxy of such policy prior to or upon admission); N.Y. COMP. CODES R. & REGS. tit. 10 §§ 400.21, 505.14(f)(2)(ii), 505.14(g)(3)(xxv), 700.5; N.Y. COMP. CODES R. & REGS. tit. 14 §§ 527.6, 527.7 (New York state licensing regulations adopted in response to the Medicare and Medicaid advance directives requirements, discussed *infra* notes 55, 69-71 and accompanying text, apply to various types of facilities with state licenses, not merely those participating in Medicare and Medicaid; they require, among other things, that information about advance directives be provided to hospital inpatients and outpatients and posted in emergency rooms). For information about state advance directives refusal clauses, see P’ship for Caring, Noncompliance Provisions in Living Will Statutes (map) (Mar. 2002); Noncompliance Provisions in Statutes Authorizing Health Care Agents (map) (Mar. 2002); Noncompliance Provisions in Advance Directive Statutes (Mar. 2002) (providing legal citations for all relevant provisions), available at www.partnershipforcaring.org. (requires subscription). For a general discussion of health care provider objections in the context of refusing treatment, see Cohen, *Refusing Treatment*, *supra* note 2, at § 18.05.

⁵¹ Some, for example, apply to any private hospital or any private health facility. See, e.g., MASS. GEN. LAWS ch. 272, § 21B (privately controlled hospital or other privately controlled health facility that wants exemption for provision of abortion, sterilization, contraceptive devices or contraceptive counseling under refusal clause must express it through by-laws, code of ethics, or vote of its governing body); NEB. REV. STAT. §§ 28-337 to 28-341 (hospital, institution or facility must inform women of its policy not to participate in abortion related services; refusal to perform or allow abortion cannot be basis for cause of action). Some apply to health plans. See, e.g., note 47 *supra* (notice requirements in contraceptive equity laws).

⁵² For requirements concerning Medicaid managed care, see, e.g., 42 C.F.R. §§ 438.10(e)(2)(ii) (the state or its contracted representative must provide potential enrollees with information about the benefits covered by each managed care organization and other programs operating within the service area. If the program does not provide counseling or referrals for a service because of “moral or religious” objections, the state must provide information about where and how to obtain the service to all potential enrollees); 438.10(f)(2), 438.10(f)(6)(v), 438.10(f)(6)(vii), 438.10(f)(6)(xii). For Medicare and Medicaid requirements for notice requirements about advance directives, see notes 55, 69-71 and accompanying text *infra*. The contraceptive equity laws discussed above apply to private insurers.

⁵³ See, e.g., CAL. HEALTH & SAFETY CODE § 123420 (“facility or clinic that does not permit the performance of abortions on its premises shall post notice of that proscription in an area of the facility or clinic that is open to patients and prospective admittees”); 18 PA. CONS. STAT. §

3213, 43 PA. CONS. STAT. § 955.2 (hospital or health care facility must post “conspicuously for public inspection” religious restriction about abortion). New York City law permits pharmacies to refuse to provide emergency contraception, but a notice that they do not sell emergency contraception must be “conspicuously” posted “at or adjacent to each counter over which prescription drugs are sold, indicating in large type that emergency contraception is not sold at such pharmacy.” Int. No. 278-A (N.Y.C. 2003) (to be codified at N.Y.C. ADMIN. CODE, tit. 20 §§ 20-712, 20-713.1).

⁵⁴ See, e.g., N.J. STAT. ANN. § 17:48-6x (insurance carriers must provide written notice to current or prospective subscribers in the contract, application or sales brochure when religious employers refuse to offer coverage for infertility treatment); TEX. INS. CODE ANN. Art. 21.52L (insurer affiliated with religious organization or health care provider affiliated with insurer may refuse to offer, recommend, advise on, pay for, provide, assist in, perform, arrange, or participate in medical or health care services that violate religious rules unless necessary to save a person’s life or health; the insurer exercising religious exemption must, however, provide written notice of exclusion in all health plan materials).

⁵⁵ See, e.g., P.L. No. 101-508, §§ 4206(a)(2), 4751(a)(2), *codified in several places, including* 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395cc(f), 1396a(a)(57), and 1396a(w); 42 C.F.R. §§ 482.13(b)(3), 489.100 to 489.104, *as discussed in* 60 Fed. Reg. 33280-83 (June 27, 1995) (under the Patient Self-Determination Act (PSDA), the facility must: (1) furnish at the time specified by law written information to each such adult concerning: (a) that person’s rights under state law to decide about his or her medical care, including the right to accept or refuse treatment and the right to formulate “advance directives” and (b) the provider’s policies concerning implementation of these rights; (2) ensure compliance with state law concerning advance directives, and (3) educate facility staff and the community on issues concerning advance directives); CONN. GEN. STAT. §§ 38a-503e, 38a-530e (any health insurance policy that excludes coverage for prescription contraceptive methods must provide the insured with written notice of the exclusion); HAW. REV. STAT. §§ 431:10A-116.6, 431:10A-116.7, 432:1-604.5 (religious employers must provide: (1) written notice of the exclusion upon enrollment in the health insurance plans, (2) prompt written information on how to access contraceptive services and supplies); N.C. GEN. STAT. §§ 58-3-178, 58-50-155 (insurers providing health benefit plans to religious employers must provide written notice of exclusion to the insured); TEX. INS. CODE ANN. art. 3.51-6 (entities with religious objection to in vitro fertilization must provide written notice to “group policyholder, contract holder, employer, multiple-employer, union, association, or trustee” that they are claiming the exemption).

⁵⁶ See, e.g., WYO. STAT. ANN. § 35-6-105 (private hospital, institution or facility must inform any woman seeking an abortion of its policy not to permit or admit).

⁵⁷ Disclosure rules require that written statements about the policy must be formally adopted, for example in a hospital charter, by-laws, code of ethics, or vote by its governing body. See, e.g., CAL. HEALTH & SAFETY CODE §§ 1339.80, 1339.81, 1363.02; MASS. GEN. LAWS ANN. ch. 112, § 12I, ch. 272, § 21B (for private hospitals concerning family planning services or referrals; must be stated in by-laws, charter, code of ethics, or vote of its governing body); MONT. CODE ANN. §§ 50-5-501 to 50-5-505 (private hospital must state its refusal concerning sterilization through its governing body or board); 43 PA. CONS. STAT. § 955.2 (hospital or other health facility must have “stated ethical policy” refusing to provide abortion and sterilization services). Some contraceptive equity provisions require the entity seeking the exemption to file contracts with the state that show they have provided written notice of exclusion of coverage. CAL. HEALTH & SAFETY CODE § 1367.25, CAL. INS. CODE § 10123.196; Memorandum from Barbara H. Yonemura, Acting Assistant Commissioner, Health Plan Division, Department of Corporations, California to all Licensed Health Care Service Plans 7 (Apr. 5, 2000) (HMOs that provide religious employers with coverage for contraceptives must file contracts with Department of Corporations to show that religious employers provide legally required written notice).

⁵⁸ See, e.g., CAL. HEALTH & SAFETY CODE § 123420 (“Any [religiously affiliated] facility or clinic that does not permit the performance of abortions on its premises shall post notice of that proscription in an area of the facility or clinic that is open to patients and prospective admittees.”); NEV. REV. STAT. ANN. §§ 689A.0145, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 689B.1918, 695C.1715, 695C.1717 (insurers and HMOs affiliated with religious organizations that object to coverage for contraceptives and related services on religious grounds must provide written notice of their objection to the prospective insured before the issuance of a policy of health insurance and before the renewal of such a policy).

⁵⁹ See, e.g., DEL. CODE ANN. tit. 18, § 3559(d) (religious employer can request exclusion of coverage for contraceptive drug and devices provided that employer gives reasonable and timely notice of the exclusion to employees); HAW. REV. STAT. §§ 431:10A-116.6, 431:10A-116.7, 432:1-604.5 (religious employers shall provide: (1) written notice of the exclusion upon enrollment in the health insurance plans, (2) prompt written information on how to obtain contraceptive services and supplies); 42 C.F.R. § 438.10(e)(2)(ii)(A) (enrollees in Medicaid managed care organizations must receive information about covered benefits, either from the state or the managed care organization, prior to enrollment); 42 C.F.R. § 489.102(b) (notice about restrictions on advance directives must be provided (1) at the time of a patient’s admission to a hospital; (2) at the time of an inpatient’s admission to a nursing facility; and (3) prior to an individual’s care with a home health agency).

⁶⁰ See, e.g., PSDA requirements, *infra* notes 69 to 71 and accompanying text.

⁶¹ See, e.g., federal PSDA requirements, *infra* notes 69 to 71 and accompanying text regarding advance directives for notice content; California’s notice requirements under A.B. 525, note 63 *infra*; MO. ANN. STAT. § 376.1199 (health benefit plans shall provide clear and conspicuous written notice indicating (1) whether plan covers contraception, (2) that enrollee can get policy excluding contraceptive coverage if conflicts with own religious or moral beliefs and (3) an enrollee in a plan that excludes contraceptive coverage has a right to purchase coverage for contraceptives).

⁶² CAL. HEALTH & SAFETY CODE § 1363.02 (requires notice at the beginning of provider directory to be in at least 12-point boldface type.).

⁶³ In California, under A.B. 525, *supra* note 45, all managed care plans that contract with the state to provide Medicaid services, as well as private sector health plans and disability insurers, must notify their members in writing that some hospitals participating in their networks may not, for religious reasons, perform all covered reproductive health services, specifically mentioning abortion, infertility treatment, tubal ligation, or contraception and emergency contraception for rape survivors. CAL. HEALTH & SAFETY CODE §§ 1339.80 (hospitals and other providers do not have to post statement), 1339.81 (“provider” in this context means any “professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services”); *Id.* at § 1363.02 (health care service plan that covers hospital, medical, and surgical benefits, shall do both of the following:

- (1) Include the following statement, in at least 12-point boldface type, at the beginning of each provider directory: “Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at (insert the health plan’s membership services number or other appropriate number that individuals can call for assistance) to ensure that you can obtain the health care services that you need).”
- (2) Place the statement [above] in a prominent location on any provider directory posted on the health plan’s website, if any, and include this statement in a conspicuous place in the plan’s evidence of coverage and disclosure forms.)

Similar language is in CAL. INS. CODE § 10604.1 (relating to disability insurance) and CAL. WELF. & INST. CODE § 14016.8 (requiring that all state Medicaid beneficiaries receive similar information as above).

⁶⁴ 42 U.S.C. § 1396u-2(a)(5)(D) (state, directly or through managed care entities, shall, on or before an individual enrolls “inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under [Medicaid] but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.”); 42 C.F.R. §§ 438.10(e) (state or its contracted representatives must provide information about “[b]enefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service the [managed care organization or other entity] does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service”; this information must be provided to potential enrollees when they first become eligible to enroll in a voluntary program or are first required to enroll in a mandatory program, and within a timeframe that enables potential enrollees to use the information in choosing among coverage); 438.10(f)(6)(vii) (state, its contracted representatives, or the managed care organization and other entities must notify all enrollees of their right to request and obtain certain information at least once a year including information on any restriction on the enrollee’s freedom of choice among network providers and “[t]he extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers”).

⁶⁵ See NWLC KAISER REPORT, *supra* note 28, at 52-55 (providing a state-by-state analysis of how states inform Medicaid enrollees about obtaining family planning services).

⁶⁶ For example, one unusual California law requires that all managed care plans, rather than hospitals, provide notice that hospitals at which managed care enrollees receive health care might restrict reproductive health services. See A.B. 525, discussed in more detail in note 63 *supra* and accompanying text.

⁶⁷ See NO STRINGS ATTACHED, *supra* note 1, at 4, 9 (reporting results of data collected on non-federal acute care hospitals for 1998 and 1999).

⁶⁸ See, e.g., 42 C.F.R. Part 482 (hospitals); 42 C.F.R. Part 483 (nursing homes; also called long-term care facilities, skilled nursing facilities); 42 C.F.R. Part 438 (managed care). For more discussion on conditions of participation, see Susan C. Waltman, *Facility Licensure and Accreditation and Health Planning*, in TREATISE ON HEALTH CARE LAW § 4.04[4] (Alexander M. Capron & Irwin M. Birnbaum eds., 2003) [hereinafter Waltman]. Medicare conditions of participation also apply to Medicaid. 42 C.F.R. § 482.1(a)(5). See also the Nursing Home Reform Act, 42 U.S.C. § 1396r, as discussed in Lawrence A. Frolik, RESIDENCE OPTIONS FOR OLDER OR DISABLED CLIENTS § 12.08[2] (rev. 2002).

⁶⁹ The Patient Self Determination Act’s most relevant sections can be found at 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395cc(f), 1396a(a)(57), and 1396a(w); 42 C.F.R. § 482.13(b)(3) and §§ 489.100 through 489.104, as discussed in 60 Fed. Reg. 33,262 (June 27, 1995). For more information on the PSDA, see Cohen, *Refusing Treatment*, *supra* note 2, at § 18.05.

⁷⁰ 42 C.F.R. §§ 417.436(d)(i)(B), as discussed in HCFA Comments on Federal Regulation Addressing Advance Directives “Conscience” Objections, 60 Fed. Reg. at 33,280-83 (June 27, 1995) [hereinafter HCFA Advance Directive comments]. The U.S. Department of Health and Human Services responses to public comments that were published in the *Federal Register* when these regulations implementing the law were promulgated provide additional guidance about notice concerning an institution’s religious restrictions. In response to a concern that it is impossible for Catholic providers to give a precise description of their limits regarding advance directives, the agency advised that a statement of limitations can be drafted to accommodate a case-by-case approach, writing:

Although we cannot readily envision a situation in which the required information, if properly provided, would not adequately inform the patient, we agree that such a situation would permit an individualized notice [F]acilities may comply with the law by providing patients

with written materials indicating the basis upon which decisions will be made, that each decision would be unique, and how the patient may predict the decision in his or her own case. It is not necessary that the written material distributed to patients contain enough information to permit the patients to make a definitive determination about what action the provider will take in every situation. It is only necessary for the provider to state its policy with respect to complying with the provisions of State law regarding an adult individual's right to accept or refuse medical or surgical treatment or formulate an advance directive, even if that policy is to make individual decisions based on religious rules. "

Id. at 33,281-82.

A notice, however, that merely states that advance directives will be honored if they comply with Catholic tenets may not by itself fulfill this requirement. For example, the general public may not be aware that Catholic principles could prohibit compliance with a request to forgo artificial feeding, but could honor a request to forgo a respirator; such principles may prohibit compliance with a prior request to forgo artificial feeding by an Alzheimer's patient who is currently decisionally incapable, but may permit a dying cancer patient to forgo artificial feeding. See note 13 *supra* and accompanying text.

Some of the statements in the Catholic *Directives* misstate the scope of the PSDA requirements. For example, federal law requires that the notice about refusal clauses must be provided to all patients upon admission and that the hospital engage in public education about advance directives. See, e.g., 42 C.F.R. § 489.102(a)(6) (requiring hospitals to provide community education for issues concerning advance directives). Directive 24, however, indicates that hospitals would comply with federal law if they merely "made available" information about advance directives. *DIRECTIVES*, *supra* note 1. Furthermore, the *Directives* misstate the law when they assert that the institution is not obliged to honor any advance directive that is contrary to Catholic teaching, with an explanation to the patient." The federal law does *not* create a federally sanctioned refusal clause—it merely says that if the state law recognizes one, the institution must comply with federal notice requirements about it. Accordingly, if a Catholic hospital is in one of the several states *without* such institutional refusal clauses, Catholic hospitals would not be legally authorized to refuse to comply with the terms of the advance directives, even if the terms were contrary to Catholic teaching. Indeed, 16 states and the District of Columbia do not have institutional refusal clauses in their living will statutes; 12 states and the District of Columbia do not have these clauses in their health care proxy statutes. See P'ship for Caring, Noncompliance Provisions in Living Will Statutes (map) (Mar. 2002); Noncompliance Provisions in Statutes Authorizing Health Care Agents (map) (Mar. 2002); Noncompliance Provisions in Advance Directive Statutes (Mar. 2002) (providing legal citations for all relevant provisions), available at <http://www.partnershipforcaring.org> (requires subscription).

⁷¹ See, e.g., 42 C.F.R. § 489.102(6). The regulations do not exempt religious entities from the community education requirement based on their religious beliefs; HCFA Advance Directive Comments, *supra* note 70, 60 Fed. Reg. at 33281 ("[T]he provider must meet the requirements relating to community education; that is, the provider must furnish information to the community concerning State law regarding the right to accept or refuse medical or surgical treatment and to formulate an advance directive, even if the provider simultaneously informs the community that it is exercising a conscience objection that would permit it to refuse to honor an advance directive.").

⁷² See, e.g., 42 C.F.R. §§ 417.428(b)(5) (prohibiting HMOs and other entities from distributing misleading marketing materials), 422.80(e)(1) (prohibiting an Medicare + Choice organizations from engaging in misleading marketing), 438.104(b)(2) (requiring HMOs and other entities to specify methods by which it assures that marketing materials are accurate), 438.700(c) (providing for sanctions of HMOs and others that engage in misleading advertising); cf. 42 C.F.R. § 1003.102(b)(4) (providing for sanctions of any person that knowingly gives false or misleading information that influences decisions to discharge patients from hospitals).

⁷³ See, e.g., 42 U.S.C. §§ 1395i-3(c)(1)(A)(i), 1396r(c)(1)(A)(i) (nursing homes); 42 C.F.R. §§ 482.13 (hospitals), 483.10(b)(3) (managed care); see also Appendix A, Hospitals Interpretive Guidelines and Survey Procedures, available at <http://www.cpmc.org/professionals/hslibrary/resource/AP-A.pdf> (last visited July 14, 2003) (dealing with patient rights section of 42 C.F.R. § 482).

⁷⁴ See White, *supra* note 10, at 1745 n.281 (citing federal Medicaid laws and regulations, located at 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 42 C.F.R. §§ 441.61, 441.62).

⁷⁵ 42 C.F.R. § 482.13(a) (hospital notice requirements).

⁷⁶ 42 U.S.C. §§ 1395aa(a); 1396a(9), 1396a(33); 42 C.F.R. §§ 431.610, 488.10. As a general rule, the U.S. Department of Health and Human Services (HHS), through its Centers for Medicare & Medicaid Services (CMS), determines whether facilities meet the requisite conditions of participation or coverage based on recommendations made by state survey agencies (usually state health agency or departments) with whom the federal government contracts, and sometimes by private accrediting entities. See Waltman, *supra* note 68 at § 4.04[3].

⁷⁷ 42 C.F.R. § 482.11.

⁷⁸ Most of these prohibitions apply in the managed care context. See, e.g., ALASKA STAT. § 21.86.150(b) (HMO or HMO representative "may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or a form of evidence of coverage that is deceptive"; terms are defined in the statute); N.Y. SOC. SERV. LAW §§ 364-j(5)(e), 364-j(6) (New York's Medicaid managed care plans may not use "deceptive or coercive marketing methods to encourage participants to enroll" or "distribute marketing materials to recipients of medical assistance, unless such materials are approved" by state health or mental health departments; information must be "reasonably understandable and culturally and linguistically appropriate form, to assure that such recipients can make an informed choice of managed care and primary care providers").

⁷⁹ See, e.g., 410 ILL. COMP. STAT. 50/1 to 50/5 (each patient must receive a written statement of rights specified by statute or by accrediting organization upon entry to the hospital or as soon as possible thereafter); MASS. GEN. LAWS. ch. 111, § 70E (applies to hospitals, clinics, nursing homes, etc.; requires written notice upon admission and rights “conspicuously posted” in the facility); N.Y. PUB. HEALTH LAW § 2803-c; N.Y. COMP. CODES R. & REGS. tit. 10 § 405.7. For more information about patients’ rights generally, see Waltman, *supra* note 68, at § 4.03[4][vi]; ERIC M. CARLSON, LONG-TERM CARE ADVOCACY, § 2.23 (2002) [hereinafter ERIC CARLSON]; Robin Cheryl Miller, *Construction and Application of State Patient Bill of Rights Statutes*, 87 A.L.R. 5th 277 (2001); Elena Cohen, *Patients’ Rights Laws and the Right to Refuse Life-Sustaining Treatment in Nursing Home: A Hidden Weapon for Patient Advocacy*, 29 BioLAW 5:231 (1989) [hereinafter Cohen, *Nursing Home Patients’ Rights*].

⁸⁰ Some also have “continuity of care” provisions, requiring entities to ensure that services are provided in a timely manner or that prompt referrals and follow-up occur to ensure that patients receive requested services. See, e.g., N.Y. PUB. HEALTH LAW § 4404, N.Y. COMP. CODES R. & REGS. tit. 10, § 98-1.8 (making HMO certificates of authority contingent on providing continuity of care among other standards); see also White, *supra* note 10, at 1745 n. 281; NWLC KAISER REPORT, *supra* note 28, at 34-35 (35 states require managed care plans to continue services after an individual provider’s status changes, usually in the context of pregnancy or other medical condition that necessitates ongoing care; this coverage is usually required for 30 to 120 days after the provider’s status changes).

⁸¹ N.Y. COMP. CODES R. & REGS. tit. 10 § 405.7.

⁸² See, e.g., N.Y. COMP. CODES R. & REGS. tit. 10 § 400.21.

⁸³ Jurisdictions vary about whether they evaluate informed consent by a “physician-based” or “patient-based” analysis. The physician-based approach focuses on what doctors commonly tell patients; the allegation of professional negligence requires an inquiry into what a “reasonably prudent health care professional” would offer under similar circumstances, based on expert witness testimony. The “patient-based” approach focuses on what patients consider material to the decision. See Arnold J. Rosoff, *Consent to Medical Treatment*, in TREATISE ON HEALTH CARE LAW § 17.03 (Alexander M. Capron & Irwin M. Bimbaum eds., 2003) [hereinafter Rosoff]. The “informed consent” doctrine is also grounded in the tort of battery, an unpermitted touching. Battery, however, is an intentional tort and may not be appropriate where physicians act in good faith and for patient’s benefit; battery may apply where there was “fraudulent concealment, misrepresentation or other deliberate wrongdoing on physician’s part” (citation omitted). *Id.* at § 17.03[1][b][1]. For more information on these informed consent rules generally, see ACLU, COURTS, *supra* note 42, at 8; Boozang, *supra* note 6, at 1515 (“Sectarian health care facilities should in every instance be required to adhere to the doctrine of informed consent by requiring disclosure of all available treatment options.”); NARAL, WHO DECIDES?, *supra* note 42, at xiii, xiv, xxi; Rosoff, at § 17.01; John H. Derrick, Annotation, *Medical Malpractice: Liability for Failure of Physician to Inform Patient of Alternative Modes of Diagnosis or Treatment*, 38 A.L.R.4th 900 (1985 & Supp. 2001)[hereinafter Derrick].

⁸⁴ See, e.g., Current Opinions of the AMA Council on Ethical and Judicial Affairs, available at <http://www.ama-assn.org/ama/pub/category/2503.html> (last visited July 30, 2003), including E-8.08 (“The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination on treatment. The physician’s obligation is to present the medical facts accurately to the patient... and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.”); E-10.01 (“The patient has the right to receive information and to discuss the benefits, risks, and costs of appropriate treatment alternatives.... Patients are also entitled... to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.... The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care”); E-5.02 (addressing the need to protect the public from deceptive practices, and stating that the issue is whether advertising, regardless of format or content, is true and not materially misleading); E-8.053 (addressing restrictions on disclosure in health care plan contracts, and stating that the right of patients to be informed of all pertinent medical information must be reaffirmed by the medical profession, and individual physicians must continue to uphold their ethical obligation to disclose such information); E-8.12 (“It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients”); E-8.13 (in managed care, “[t]he duty of patient advocacy is a functional element of the patient-physician relationship that should not be altered by the system of health care delivery. Physicians must continue to place the interests of their patients first.... Full disclosure includes informing patients of all their treatment options, even those that may not be covered under the terms of the health care plan”). See also Center for Prevent and Treatment of Infections, Commitment to My Patients (stating member physicians’ ethical commitment to “[t]o tell you about appropriate treatment options, answer your questions about medical risks and to give you the current and accurate and medical facts you need to make an informed decision about your treatment” and “[t]o respect your wishes in decisions about your health care”), available at www.infectioncenter.com/about/ourpatients.htm (last visited July 30, 2003).

⁸⁵ See, e.g., FLA. STAT. ANN. § 766.103; GA. CODE ANN. § 31-20-2; MASS. GEN. LAWS. ch. 111, § 70E; N.Y. PUB. HEALTH LAW § 2805-d; TENN. CODE ANN. § 29-26-118. Informed consent protections exist even when there is not an explicit statute (e.g., recognized in court cases); see sources cited in note 88-91 *infra*. There are also some federal statutory requirements concerning informed consent, especially concerning sterilization and concerning human experimentation. See 42 C.F.R. §§ 50.201 to 50.210 (and appendix) (federally assisted family planning project); 42 C.F.R. §§ 441.253 to 441.258 (Medicaid funding for sterilization), as discussed in Rosoff, *supra* note 83, at § 17.08[4] n.45.5; Lori B. Andrews, *Reproduction and Genetics*, in TREATISE ON HEALTH CARE LAW § 22.04 (Alexander M. Capron & Irwin M. Bimbaum eds., 2003). *Cf.* 42 C.F.R. § 59.5 (Title X requires “full options” counseling for pregnant patients).

⁸⁶ For more information about the “alternatives” element of informed consent, see Rosoff, *supra* note 83, at § 17.01[2][d] (emphasis is shifting from lawsuits involving nondisclosure of risks to those involving nondisclosure of treatment alternatives); Derrick, *supra* note 83. There

are some exceptions to informed consent requirements. See Rosoff, *supra* note 83, at § 17.05[1]. However, they generally do not eliminate the need to counsel about reasonable medical alternatives to treatment.

The Catholic *Directives* misstate the law on the scope of information about alternatives to be provided. Although Directive 28 recognizes that each person “should have access to medical and moral information and counseling so as to be able to form his or her conscience,” Directive 26 states that “Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature or the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable *and morally legitimate* [emphasis added] alternatives, including no treatment at all.” DIRECTIVES, *supra* note 1. As noted above, however, the law of informed consent generally does not limit the alternatives to those that are considered “morally legitimate,” but to any reasonable medical alternatives.

⁸⁷ Physicians whose privileges have been terminated or denied because they perform or counsel in contravention of the *Directives* may have some remedies under: (1) the refusal clauses that protect practitioners who either object to or support the practice on both the federal and state level (see, e.g., 42 U.S.C. § 300a-7, the so-called “Church Amendment”; Peter Leibold & Charles S. Gilham, *When Physicians Perform Abortions Outside the Catholic Hospital*, HEALTH PROGRESS (Mar.-Apr. 1998), available at <http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9803&ARTICLE=O> (stating that under the Church Amendment “Catholic healthcare providers may not discriminate against physicians who perform abortion outside the Catholic healthcare facility”); CAL. HEALTH & SAFETY CODE § 123420 (willingness or refusal to participate in abortion cannot be basis for liability)); (2) state laws against improper or discriminatory practices in hospital staff appointments; see, e.g., CAL. BUS. & PROF. CODE § 2056(c), N.Y. PUB. HEALTH LAW §§ 206-a, 2801-b; (3) physician advocacy provisions in managed care laws (see, e.g., Linda C. Fentiman, *Patient Advocacy and Termination from Managed Care Organizations: Do State Laws Protecting Health Care Professional Advocacy Make Any Difference?*, (forthcoming, Nebraska Law Review)); or (4) federal or state antitrust laws (see, e.g., NWLC ANTITRUST REPORT, *supra* note 37, at 22-23 (privilege denial may constitute an unlawful restraint on trade)).

Although individual practitioners, not hospitals, generally have the legal responsibility to obtain informed consent, courts have also found that hospitals have informed consent obligations in some situations. See *Fritter v. Iolab Corp.*, 607 A.2d 1111 (Pa. Super. Ct. 1992) (hospital had assumed duty to obtain informed consent in context of human research); *Magana v. Elie*, 439 N.E.2d 1319 (Ill. Ct. App. 1982) (it is a question of fact whether the standard of care provides that hospital take affirmative steps to require physician to advise patients of risks of the medical procedure to be carried out in the hospital); see also JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., 2003 HOSPITAL ACCREDITATION STANDARDS 78-79 (RI.1.2.1) (2003); Joint Comm’n on Accreditation of Healthcare Orgs., at <http://www.jcaho.org>. JCAHO has different standards for 2004 [hereinafter JCAHO 2003 Standards] (requiring hospital staff to obtain informed consent for any treatment or procedures); Rosoff, *supra* note 83, at § 17.07[2][d] (institutional responsibility for obtaining consent); Note, *Hospital Corporate Negligence Based upon a Lack of Informed Consent*, 19 Suffolk U. L. Rev. 835 (1985).

⁸⁸ *Hummel v. Reiss*, 589 A.2d 1041, 1045 (N.J. Super. Ct. App. Div. 1991), *aff’d*, 608 A.2d 1341 (N.J. 1992), as discussed in ACLU, COURTS, *supra* note 83, at 10 and *Boozang*, *supra* note 6, at 1485-86 nn.27-28 (woman sued a Catholic hospital on behalf of her severely disabled daughter; although the case was dismissed because the pregnancy occurred before *Roe v. Wade* recognized the constitutional right to abortion, and therefore a patient could not reasonably expect a hospital to offer the service or referral, the trial court speculated that if the case had arisen after *Roe*, there might have had a cause of action if the woman could have proven that she had been wrongly deprived of advice on and the choice of terminating the pregnancy); *Harbeson v. Parke-Davis*, 656 P.2d 483, 487, 491, 497 (Wash. 1983) (physician had a duty to provide genetic counseling to Mrs. Harbeson, including the option of abortion, notwithstanding a refusal clause creating a statutory right to refuse to participate in abortions). For a discussion of wrongful birth/wrongful life cases, see Lori Andrews in TREATISE ON HEALTH CARE LAW, § 22.07[5] (including statutes addressing wrongful birth and wrongful life); Derrick, Annotation, *supra* note 83 at §§ 3, 4.

⁸⁹ For a further discussion of emergency contraception and informed consent, see note 90 *infra* and accompanying text; Smugar, *supra* note 12, at 1372 (policies that prohibit discussion about EC “undermine a victim’s right to information about her treatment options and jeopardize physicians’ fiduciary responsibility to act in their patient’s best interests”; refusal to disclose all treatment options is “tantamount to abandonment of patient”). The American Medical Association advises that rape victims be counseled on emergency contraception. American Medical Association, *Access to Emergency Contraception*, H-75.985 (2000, rev. 2002) (acknowledging that “information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims”). See also CAL. PENAL CODE § 13823.11; 410 ILL. COMP. STAT. 70/2-2.2; ILL. ADMIN. CODE tit. 77 §§ 545.60(a)(3), 545.95, 545.App. C (requires that all hospitals provide accurate information about emergency contraception to alleged sexual assault survivors; hospitals have the option to implement a protocol of providing emergency contraception to all patients who want it, or a protocol that limits it to patients whose tests confirm they are not ovulating (a policy endorsed by the Catholic Health Association); OHIO REV. CODE § 2907.29; OHIO PROTOCOL FOR SEXUAL ASSAULT FORENSIC AND MEDICAL EXAMINATION at 16 (2002); 2003 N.M. H.B. 119, 46th Legis., 1st Reg. Sess. (Enacted Mar. 28, 2003); S.C. CODE ANN. § 16-3-1350; WASH. REV. CODE § 70.41.350.

Some of the language in the *Directives* about emergency contraception could be misleading or confusing. For example, Directive 36 recommends that “a sexually assaulted woman be advised of the ethical restrictions which prevent Catholic hospitals from using *abortifacient procedures*” (emphasis added). This advice can be confusing to patients, because the *Directives*’ position that emergency contraception is abortion—not contraception—conflicts with the position of medical and ethical authorities that emergency contraception is not abortion, as it does not affect a fertilized egg already implanted in the uterus. See, e.g., *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 244-45 (Ct. App. 1989).

Legal and medical authorities have also concluded that provision of emergency contraception upon request of sexual assault survivors is the standard of care, so it is actually medical malpractice not to provide the care. See American Medical Association, *Strategies for the Treatment and Prevention of Sexual Assault*, 15 (1995) (recognizing that some physicians may have a moral objection to providing “pregnancy prophylaxis,” but notes that the physician is obligated to find someone else who can provide this treatment); *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 244-45 (Ct. App. 1989), discussed *infra*; White, *supra* note 10, at 1714. For more on emergency contraception, see note 12 *supra* and NWLC KAISER REPORT, *supra* note 28, at 78-80.

⁹⁰ *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 244-45 (Ct. App. 1989), as discussed in ACLU, COURTS, *supra* note 83, at 9 (damages are more readily apparent in a situation where the viability of an option is lost if not exercised within a finite timeframe). Although the court dismissed the patient’s claim against the hospital because she failed to allege that she had suffered harm resulting from the hospital’s refusal to provide emergency contraception (she apparently did not become pregnant as a result of the rape), the case offers strong support for liability when a rape survivor does indeed get pregnant as a result of the rape and alleges in her complaint that the pregnancy is harm she suffered resulting from the hospital’s refusal to provide her with emergency contraception. The court wrote: “The duty to disclose information such as the morning-after pill [emergency contraception] treatment option arises from the fact that an adult of sound mind has the right in the exercise of control over her own body, to determine whether or not to submit to lawful medical treatment. Meaningful exercise of this right is possible only to the extent that patients are provided with adequate information upon which to base an intelligent decision with regard to the options available....Appellant’s right to control her treatment must prevail over respondent’s moral and religious conviction.” *Brownfield*, 256 Cal. Rptr. at 244.

⁹¹ See *In re Jobes*, 529 A.2d 434, 450 (N.J. 1987) (requiring nursing home to fulfill family’s request to withdraw patient’s feeding tube in part because it had failed to advise the family of its policy against removal of artificial feeding devices upon patient’s admission); *In re Requena*, 517 A.2d 886, 890-91 (N.J. Super. Ct. Ch. Div.), *aff’d*, 517 A.2d 869 (N.J. Super. Ct. App. Div. 1986) (hospital had to honor wishes of dying patient who refused artificial feeding tubes because hospital had failed to notify patient of its policy mandating artificially feeding when she was originally admitted; policy adopted after nonsectarian hospital and Catholic hospital merged; although the hospital where she was being treated offered to transport her to another facility that was willing to honor her request, she did not wish to face the trauma of losing the care and companionship of doctors and nurses on whom she had grown to depend; in ordering the hospital to honor her preferences, the New Jersey trial court concluded that the hospital’s refusal to discontinue artificial feeding was unreasonable and overly burdensome to the patient); *Gray v. Romeo*, 697 F. Supp. 580, 590-91 (D.R.I. 1988) (requiring the hospital to honor the husband’s wish to remove a vegetative patient’s feeding tube, despite an institutional policy against discontinuation of nutrition and hydration, in part because hospital failed to advise Gray family of policy at time of Gray’s admission). See also note 43 *supra* concerning issue of institutional religious restrictions in end-of-life context.

⁹² N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(13).

⁹³ See, e.g., COLO. REV. STAT. ANN. § 25-4-1405(5) (every physician has a duty to inform a patient infected with HIV “of the interpretation of laboratory results and counsel the patient on measures for preventing the infection to others, prophylaxis and treatment of opportunistic infections”); N.Y. PUB. HEALTH LAW § 2781(5) (requiring that “a person ordering the performance of an HIV related test shall provide the subject . . . with counseling or referrals for counseling . . . for behavior change to prevent transmission or contraction of HIV infection”). There is little information on the extent to which religious health care entities are prohibiting their doctors from complying with the laws, although there is some anecdotal evidence that Catholic nursing homes specifically designed to care for AIDS patients in New York refused to provide AIDS prevention counseling or to refer patients to other facilities that might provide this service. See White, *supra* note 10, at 1718.

⁹⁴ Although the federal planning requirements were largely repealed in 1986, as discussed in Waltman, *supra* note 68, at § 4.06, many states have their own planning analog health planning. For more information about health planning, see Waltman, *supra* note 68, at §§ 4.06, 4.06[4], 4.06[5]; NATIONAL CONFERENCE OF STATE LEGISLATURES (Health Policy Tracking Service), CERTIFICATE OF NEED (2002); Lauretta Higgins Wolfson, *State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261 (2001); Michael Romano, *Pros and Cons of Certificates: American Health Planning Association Directory Suggests that Certificate-of-Need Process is Regulatory in Theory, Not in Practice*, MOD. HEALTHCARE, Apr. 21, 2003, at 4; American Health Planning Association, <http://www.ahpanet.org>; NATIONAL WOMEN’S LAW CENTER, HEALTH CARE PROVIDER MERGERS AND THE THREAT TO WOMEN’S HEALTH SERVICES: USING CERTIFICATE OF NEED LAWS TO FIGHT BACK (2002), available at <http://www.nwlc.org/pdf/CertificateOfNeedJune02.pdf>; NATALIE SETO ET AL., COMMUNITY CATALYST, PROTECTING HEALTH, PRESERVING ASSETS: A COMPREHENSIVE STUDY OF LAWS GOVERNING CONVERSIONS, MERGERS AND ACQUISITIONS AMONG HEALTH CARE ENTITIES (1997) (charts updated 2002), available at <http://www.communitycat.org/acrobat/protectingassets.pdf> [hereinafter COMMUNITY CATALYST, PROTECTING HEALTH].

⁹⁵ See NATIONAL WOMEN’S LAW CENTER, HEALTH CARE PROVIDER MERGERS AND THE THREAT TO WOMEN’S HEALTH SERVICES: USING CERTIFICATE OF NEED LAWS TO FIGHT BACK (June 2002), available at <http://www.nwlc.org/pdf/CertificateOfNeedJune02.pdf>; Tenn. Code Ann. § 68-11-1607(a)(7) (requiring health care facilities to obtain a Certificate of Need from the state before they discontinue any obstetrical or maternity service).

⁹⁶ Under these rules, hospitals must provide to the public and the health department notice of proposed closure of any essential service, which must include, among other things, current utilization rates for services(s) being discontinued; a description of the anticipated impact of discontinuance on individuals in the hospital’s service area; and the names and addresses of any organization, health care coalition or community group that is known to have expressed concerns about the services to the hospital. Furthermore, the hospital must submit a copy of the notice provided to each of the organizations listed. See MASS. REGS. CODE tit. 105, § 130.020 (“essential health services” includes, among other services, “outpatient reproductive health services”), authorized by MASS. GEN. LAWS ch. 111, §§ 3, 51 to 56, as explained in Memorandum from

Paul Dreyer, Director, Division of Health Care Quality, to Commissioner Howard K. Koh and Members of Public Health Counsel 1-2 (Apr. 24, 2001) [hereinafter Dreyer Memo] (explaining that “hospitals that contemplate closing an ‘essential service’ must provide 90 days advance notice of closure to the Department, which in turn must hold a public hearing on the proposal, and must determine whether the proposed closure will ‘significantly reduce access to necessary services.’”); MASS. REGS. CODE tit. 105, § 130.122(H), as explained in Dreyer Memo, *supra*, at 3 (Department must assess extent to which health care services have been maintained prior to closure); see also MASS. REGS. CODE tit. 105, § 130.122(C).

⁹⁷ See, e.g., TEX. HEALTH & SAFETY CODE ANN. §§ 311.044(c), 311.0455(c), 311.046(d) (community benefit plan must contain a method of soliciting community views; state department of health must issue press release stating that the report is available to the public; written notice about charity care must be in appropriate languages and “conspicuously posted”); CAL. HEALTH & SAFETY CODE § 127350(d); IND. CODE §§ 16-21-9-5, 16-21-9-7(c), 16-21-9-7(d) (hospitals must post annual report in prominent places throughout hospital, including emergency room waiting area and admissions waiting areas; hospital must provide written notice about its charity care and how to apply); N.H. REV. STAT. ANN. §§ 7:32-e VI, 7:32-gl, 7:32-h II (community members can provide input into development of plan or there is a public hearing requirement; hospital must provide notice annually and must file in public place; should post on website where practicable).

⁹⁸ Some CON statutes exempt or accommodate religiously affiliated institutions from some CON requirements. KY. REV. STAT. ANN. § 311.800(5)(a) (abortion refusals); PA. STAT. ANN. tit. 43, § 955.2(b)(1) (abortion, sterilization refusals), as discussed in Boozang, *supra* note 6, at 1514; Kathleen M. Boozang, *Developing Public Policy for Sectarian Providers: Accommodating Religious Beliefs and Obtaining Access to Care*, J. LAW, MED. & ETHICS, 91, 92 n.32 (1996) [hereinafter Boozang 1996]. Ohio, for example, states that CON review shall consider “special needs and circumstances resulting from moral and ethical values and the free exercise of religious rights of health care facilities administered by religious organizations.” OHIO REV. CODE ANN. § 3702.52(l). In at least one case, a religious entity tried to use the CON process to authorize obstetric units to refuse to provide care to which Catholics object rather than to provide services, but the court rejected the arguments. *Providence Hosp. of Everett v. Dep’t of Soc. and Health Servs.*, 770 P.2d 1040, 1045 (Wash. 1989) (rejecting argument that CON approval should have been granted for a new obstetrics unit at a Catholic hospital because Catholic hospital would meet “need” for obstetric unit free of religiously objectionable services, such as abortion and sterilization; the court wrote that it would be contrary to the goal of the laws “to hold that the subjective religious or ethical beliefs of some people are mandatory elements of the determination of health care needs of all the people”).

⁹⁹ For information about conversion laws generally, see NWLC CHARITABLE ASSETS, *supra* note 25, at 20-22; COMMUNITY CATALYST, PROTECTING HEALTH, *supra* note 94.

¹⁰⁰ As noted earlier, this report only focuses on nonprofit-to-nonprofit conversions, since most of the religious restrictions are imposed by nonprofit entities, although clearly the issue of nonprofit to for-profit conversions is the topic for its own report. The most recent development in this area is passage of a new California law that precludes the seller of a nonprofit hospital from placing restrictions on the types of medical services that the new owners (either nonprofit or for-profit) will be permitted to offer. S.B. 932, 2003-2004 Sess. (Cal. 2003) (to be codified at CAL. CORP. CODE § 5917.5).

¹⁰¹ See NWLC CHARITABLE ASSETS, *supra* note 25 and accompanying text for citations to nonprofit-to-nonprofit conversion citations.

¹⁰² For a discussion of community needs/benefits in conversion laws, see COMMUNITY CATALYST, SUMMARY OF COMMUNITY BENEFITS LAWS (1999), available at <http://www.communitycat.org/acrobat/compedium.pdf> [hereinafter COMMUNITY CATALYST, COMMUNITY BENEFITS].

¹⁰³ See, e.g., R.I. GEN. LAWS § 23-17.14-8(b)(3).

¹⁰⁴ See VOLUNTEER TRUSTEES FOUNDATION, THE SALE AND CONVERSION OF NOT-FOR-PROFIT HOSPITALS: A STATE-BY-STATE ANALYSIS OF NEW LEGISLATION 3-4 (1998), available at http://www.volunteertrustees.org/hospitals/hospitals_toc.html (last visited July 11, 2003); COMMUNITY CATALYST, PROTECTING HEALTH, *supra* note 94 at Chart, All Conversion Laws: Scope. Disclosure may vary from newspaper notices to the submission of official transaction documents to the attorney general for inclusion in the public record. Some laws require a public hearing prior to the consummation of a conversion transaction for the purpose of informing the community of the conversion plan, or allowing public comment by affected community members.

¹⁰⁵ See, e.g., N.J. STAT. ANN. § 26:2H-7.11(i) (provides for the hiring of an independent health care access monitor by (and at the expense of) acquiring entity to monitor and report quarterly to the state department of health on community health care access by the entity).

¹⁰⁶ For more information about these requirements, see NO STRINGS ATTACHED, *supra* note 1, at 17-19; COMMUNITY CATALYST, COMMUNITY BENEFITS, *supra* note 102.

¹⁰⁷ See, e.g., MASS. REGS. CODE tit. 114.6, §§ 10.01 through 10.12 (notice about eligibility for free care), especially § 10.08 (among other requirements, signs must be posted in “inpatient, clinic, emergency admissions/registration areas and in business office areas that are customarily used by patients, that conspicuously inform patients of the availability of financial assistance”; sign and print fonts must be large enough to be clearly visible and legible by visiting patients).

¹⁰⁸ For more information about licensure generally, see Waltman, *supra* note 68, at § 4.03.

¹⁰⁹ See Waltman, *supra* note 68, at §§ 4.03[3], 4.03[4].

¹¹⁰ It could also be viewed as a “substantial” failure, for those states that explicitly have this substantiality requirement. In some states, an entity’s license can be revoked or suspended only when there is a “substantial failure” to comply with the relevant regulations (not just technical or “de minimis” noncompliance). In determining whether a failure is “substantial,” courts look to “the duration of the violation, the number of times it occurred, whether it was willful, whether it caused actual harm, and whether there is a likelihood of reoccurrence.” TEX. HEALTH & SAFETY CODE ANN. §§ 241.053, 242.061 *as discussed in* Waltman, *supra* note 68, at § 4.03[5][c].

¹¹¹ For more information on JCAHO, see Waltman, *supra* note 68, at § 4.05[2]; JCAHO 2003 Standards, *supra* note 87. JCAHO has different standards for 2004.

¹¹² For more information on NCQA generally, see NCQA, STANDARDS FOR THE ACCREDITATION OF MCOs (effective July 1, 2003), at <http://www.ncqa.org> [hereinafter NCQA 2003 STANDARDS].

¹¹³ See, e.g., 42 C.F.R. § 488.5 (hospitals that meet JCAHO or other accreditation standard are deemed to meet all of the Medicare conditions of participation for hospitals).

¹¹⁴ See, e.g., HAW. REV. STAT. § 432E-11; N.J. ADMIN. CODE tit. 8, § 38-14; N.M. ADMIN. CODE tit. 13, §§ 10.13.19 (utilization review), 10.13.20, 10.13.13; 28 PA. CODE § 9.654.

¹¹⁵ The hospital operates according to a code of ethical behavior and a code addressing marketing, admission, transfer and discharge. JCAHO 2003 STANDARDS, *supra* note 87, at 86 (RI.4; R.4.1). The code addresses the relationship of the hospital to other health care providers, educational institutions and payers. *Id.* (RI.4.2). This could include addressing a nonsectarian hospital’s affiliation with a sectarian one. Leaders provide for hospital planning—services are designed to respond to patient and family needs “and expectations.” *Id.* at 192-93 (LD.1.3; LD.1.3.3). The leaders and, as appropriate, community leaders and the leaders of other organizations, collaborate to design services. *Id.* at 193 (LD.1.3.1). Leaders are responsible for gathering, assessing, and acting on information regarding patient and family satisfaction with services provided. *Id.* (LD.1.3.3.1). Patient care services are provided, either directly “or through referral.” *Id.* (LD.1.3.4.1).

¹¹⁶ NCQA 2003 Standards, *supra* note 112, at RR 6.

¹¹⁷ NCQA 2003 Standards, *supra* note 112, at RR 6.

¹¹⁸ For example, the JCAHO 2003 Standards, *supra* note 87, state: “The hospital addresses ethical issues in providing patient care” (RI.1) (“A mere listing of patient rights cannot guarantee that those rights are respected. Rather, a hospital demonstrates its support of patient rights through processes by which staff members interact with and care for patients”); “The patient’s right to treatment or service is respected and supported” (RI.1.1) (clarifying on page 78 that when a hospital cannot provide the care a patient requests, staff should “fully inform” the patient of his or her needs and the alternatives for care. If it is necessary and medically advisable, the hospital should transfer the patient to another organization); “Patients are involved in all aspects of their care” (RI.1.2); “Informed consent is obtained” (RI.1.2.1) (explaining on page 78 that staff members should “clearly explain any proposed treatment” and “any significant alternatives”); “Patients are involved in resolving dilemmas about care decisions” (RI.1.2.4); The hospital demonstrates respect for following patient needs: resolution of complaints (RI.1.3.4), communication (RI.1.3.6); “Each patient receives a written statement of his or her rights” (RI.1.4) (further explained on page 83 that a written copy must be given when patients are admitted and must be available throughout stay, appropriate to the patient’s age, understanding, and language; the hospital may also post a copy in public areas accessible to patients and their visitors); all consent forms address the information specified in RI.1.2.1.1. through RI.1.2.1.5, RI.3.1.

¹¹⁹ NCQA 2003 Standards, *supra* note 112, at RR1, Element B.4.

¹²⁰ NCQA 2003 Standards, *supra* note 112, at RR 1.

¹²¹ NCQA 2003 Standards, *supra* note 112, at RR 2.

¹²² NCQA 2003 Standards, *supra* note 112, at RR 3.

¹²³ NCQA 2003 Standards, *supra* note 112, at RR 4.

¹²⁴ See *Patient Rights and Organization Ethics*, in JCAHO 2003 STANDARDS, *supra* note 87, at 73-87.

¹²⁵ For a detailed analysis of state developments in unfair and deceptive acts and practices, see NATIONAL CONSUMER LAW CENTER, UNFAIR AND DECEPTIVE ACTS AND PRACTICES (5th ed. 2001 and Supp.) [hereinafter NCLC UDAP Manual]; Albert N. Sheldon, *State Consumer Protection Laws and Unfair Competition*, SG076 ALI-ABA 487 (2002) [hereinafter Sheldon]; State Consumer Protection and Unfair and Deceptive Trade Practices Law chart, prepared by Howrey Simon Arnold & White, LLP in 1999 and updated in 2000 by NWLC intern Traci Douma (on file with NWLC) [hereinafter Howrey & Simon chart]. State UDAP statutes may be found at: ALA. CODE §§ 8-19-1 to 8-19-15; ALASKA STAT. §§ 45.50.470 to 45.50.561; ARIZ. REV. STAT. §§ 44-1521 to 44-1534; ARK. CODE ANN. §§ 4-88-101 to 4-88-207; CAL. CIV. CODE §§ 1750 to 1785; CAL. BUS. & PROF. CODE §§ 17200 to 17581; COLO. REV. STAT. §§ 6-1-101 to 6-1-115; CONN. GEN. STAT. §§ 42-110a to 42-110q; DEL. CODE ANN. tit. 6, §§ 2511 to 2527, §§ 2531 to 2536; D.C. CODE ANN. §§ 28-3901 to 28-3909; FLA. STAT. ANN. §§ 501.201 to 501.213; GA. CODE ANN. §§ 10-1-370 to 10-1-375, §§ 10-1-390 to 10-1-407; HAW. REV. STAT. §§ 480-1 to 480-24, §§ 481A-1 to 481A-5; IDAHO CODE §§ 48-601 to 48-619; 815 ILL. COMP. STAT. 505/1 to 505/12, 510/1 to 510/7; IND. CODE §§ 24-5-0.5-1 to 24-5-0.5-12; IOWA CODE §§ 714.16 to 714.16A; KAN. STAT. ANN. §§ 50-623 to 50-643; KY. REV. STAT. ANN. §§ 367.110 to 367.990; LA. REV. STAT. ANN. §§ 51:1401 to 51:1420; ME. REV. STAT.

ANN. tit. 5 §§ 205-A to 214 and tit. 10, §§ 1211 to 1216; MD. CODE ANN., COM. LAW §§ 13-101 to 13-501; MASS. GEN. LAWS ch. 93A, §§ 1 to 11; MICH. COMP. LAWS §§ 445.901 to 445.922; MINN. STAT. § 8.31, §§ 325D.43 to 325D.48, 325F.67 to 325F.70; MISS. CODE ANN. §§ 75-24-1 to 75-24-27; MO. REV. STAT. §§ 407.010 to 407.307; MONT. CODE ANN. §§ 30-14-101 to 30-14-142; NEB. REV. STAT. §§ 59-1601 to 59-1623, §§ 87-301 to 87-306; NEV. REV. STAT. 598.0903 to 598.0999; N.H. REV. STAT. ANN. §§ 358-A:1 to 358-A:13; N.J. STAT. ANN. §§ 56:8-1 to 56:8-91; N.M. STAT. ANN. §§ 57-12-1 to 57-12-22; N.Y. GEN. BUS. §§ 349 to 350; N.C. GEN. STAT. §§ 75-1.1 to 75-35; N.D. CENT. CODE §§ 51-15-01 to 51-15-11; OHIO REV. CODE ANN. §§ 1345.01 to 1345.13, 4165.01 to 4165.04; OKLA. STAT. tit. 15, §§ 751 to 763 and tit. 78, §§ 51 to 55; OR. REV. STAT. §§ 646.605 to 646.656; 73 PA. CONS. STAT. §§ 201-1 to 201-9.3; R.I. GEN. LAWS §§ 6-13.1-1 to 6-13.1-27; S.C. CODE ANN. §§ 39-5-10 to 39-5-160; S.D. CODIFIED LAWS §§ 37-24-1 to 37-24-35; TENN. CODE ANN. §§ 47-18-101 to 47-18-125; TEX. BUS. & COM. CODE ANN. §§ 17.41 to 17.63; UTAH CODE ANN. §§ 13-5-1 to 13-5-18, 13-11-1 to 13-11-23; VT. STAT. ANN. tit. 9, §§ 2451 to 2480g; VA. CODE ANN. §§ 59.1-196 to 59.1-207; WASH. REV. CODE §§ 19.86.010 to 19.86.920; W. VA. CODE §§ 46A-6-101 to 46A-6-110; WIS. STAT. §§ 100.18, 100.20 to 100.264; WYO. STAT. ANN. §§ 40-12-101 to 40-12-114. For a statute-by-statute analysis of all state UDAP laws, see NCLC UDAP Manual, *supra*, at Appx. A. Commerce Clearinghouse, Inc. (CCH) also publishes a reference guide called *State Unfair Trade Practices Law* and offers monthly updates by subscription, available at <http://onlinestore.cch.com>.

¹²⁶ The phrase is often defined as the “right to be protected against fraudulent, deceitful or misleading information, advertising, labeling and other such practices and the right to be given the facts necessary to make informed choices.” Sheldon, *supra* note 125, at 490.

¹²⁷ See NCLC UDAP Manual, *supra* note 125, at § 7.5.3. Colorado, for example, requires that the challenged practice “significantly impact the public as actual or potential consumers of the defendant’s goods, services, or property.” Hall v. Walter, 969 P.2d 213, 235 (Colo. 1998). Georgia courts have stated that a practice must create a potential harm for the consumer public or have an impact on the consumer marketplace beyond a private dispute. See Chancellor v. Gateway Lincoln-Mercury, Inc., 502 S.E.2d 799 (Ga. 1998). This potential for repeated harm should not be difficult to establish when the practices of institutional health care providers are at issue, as they continually seek to provide health care services to consumers.

¹²⁸ For an overview of state standards regarding failure to disclose, see NCLC UDAP Manual, *supra* note 125, at § 4.2.14.

¹²⁹ See *Exposition Press, Inc. v. F.T.C.*, 295 F.2d 869, 872 (2d Cir. 1961) (appropriate standard for evaluating the tendency of language to deceive is whether the least sophisticated reader would be misled, not the most sophisticated reader); *Lavie v. Procter & Gamble & Co.*, 129 Cal. Rptr. 2d 486, 498 (Cal. Ct. App. 4th 2003) (appropriate standard to be applied to unfair competition and false advertising claims under California law is “ordinary consumer acting reasonably under the circumstances,” not the “least sophisticated consumer” standard); *Oswego Laborers’ Local 214 Pension Fund v. Marine Midland Bank*, 85 N.Y.2d 20, 26 (1995) (“deceptive acts and practices” are limited to those acts or practices likely to mislead a reasonable consumer acting reasonably under the circumstances).

¹³⁰ See, e.g., *Zanakis-Pico v. Cutter Dodge, Inc.*, 47 P.3d 1222, 1232 (Haw. 2002) (consumer may recover damages incurred as a result of a deceptive act or practice without actually purchasing goods or services); *Wisconsin v. Amoco Oil Co.*, 293 N.W.2d 487, 493 (Wis. 1980) (point-of-sale disclosures do not remedy deceptive advertisements that lead consumers to a seller’s business premises).

¹³¹ Because CPCs hold themselves out as clinics that provide unbiased information and services, deliberately choosing misleading names such as “Women’s Resource Center” and placing advertisements for free tests and services without indicating that their goal is to prevent women from obtaining abortions, advocates have been able to challenge such practices through consumer protection laws. The number of CPCs in the United States has been increasing in recent years, rising from an estimated 2,000 in 1994 to 3,200 in 1998. NARAL FOUNDATION, *DECEPTIVE ANTI-ABORTION CRISIS PREGNANCY CENTERS* 9 (1999), available at http://www.naral.org/mediaresources/fact/pdfs/crisis_pregnancy.pdf. Common practices among CPCs include forcing women to watch videos with graphic though inaccurate depictions of abortion procedures before receiving the results of their pregnancy tests and providing women with false information about the risks and health consequences of abortion, such as claiming links between abortion and breast cancer. In 1991 the U.S. House of Representatives Subcommittee on Regulation, Business Opportunities, and Energy, Committee on Energy also held hearings on the problem of deceptive practices of crisis pregnancy centers. See Testimony of the National Women’s Law Center (Sept. 20, 1991) (on file with NWLC).

¹³² See *Mother & Unborn Baby Care of N. Tex. v. State*, 749 S.W.2d 533 (Tex. Ct. App. 1988) (affirming trial court’s ruling that the CPC violated the state’s Deceptive Trade Practices Act, TEX. BUS. & COM. § 17.45, by advertising under “Abortion Information and Services” in the phone book and leading consumers to believe that it was an abortion clinic when it was not; the court also affirmed the trial court’s order that the CPC disclose in its advertisements that it does not perform abortion, its impositions of civil penalties, and award of attorneys’ fees); *Roe v. San Diego Pregnancy Services*, No. 657592, 1994 WL 498012, at *1 (Cal. Ct. App. Super. June 10, 1994) (court prohibited CPC from: implying that it was a health care facility or performed pregnancy tests, advertising that test kits are free when a condition of obtaining a kit is counseling or listening to a presentation, advertising that it provides “abortion education,” listing its services under misleading directory headings such as “clinics” or “abortion service providers,” and performing pregnancy testing unless licensed to do so; court also required the CPC to disclose to callers that it does not perform abortions or give abortion referrals). The New York Attorney General has investigated CPCs that were suspected of deceiving women about their services or practicing medicine without a license in violation of state health and consumer protection laws. One consent decree required that the CPCs refrain from practicing medicine without a license and provide accurate information about their services to callers and in their advertisements. See *Stipulation of Settlement*, *Hughes v. Abrams*, Ind. No. 88-970 (N.Y. Sup. Ct. Aug. 17, 1995) (on file with NWLC). In 2002, the Attorney General reached a settlement agreement with one of the CPCs, Birthright of Victor, that appeared not to be complying with the consent decree, in which the center agreed to explicitly state in its advertising and interactions with callers and visitors that it is not a medical facility, as well as to inform potential clients that the pregnancy tests it offers are “self-

administered" and that it does not perform abortions nor does it refer women to clinics where they may obtain abortions or contraception. State of New York, Office of the Attorney General, Re: Birthright of Victor New York, Inc. at 1-3 (Feb. 28, 2002)(on file with NWLC).

¹³³ Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240, 243-44 (Cal. Ct. App. 1989).

¹³⁴ 256 Cal. Rptr. at 243 (the fact that the doctor did not inform her about pregnancy prevention generally or the time limit for emergency contraception does not amount to violation of California's unfair practices law).

¹³⁵ Amended Complaint, *Victa v. Kaiser Permanente*, No. 301998 (Cal. Super. Ct. July 17, 2000), discussing CAL. BUS. & PROF. CODE §§ 17200-17509 [hereinafter *Victa Amended Complaint*].

¹³⁶ *Victa Amended Complaint*, *supra* note 135, at 3, 13-18 (citing several print and television advertisements by Kaiser indicating that patients' health care services would be determined by physicians on the basis of medical need without influence of administrators or financial incentives), as discussed in Tom Abate, *Kaiser Faces Lawsuit Over Ad Campaign*, S.F. CHRON., Mar. 16, 1999, at C1. But see *Evanston Hospital v. Crane*, 627 N.E.2d 29, 35 (Ill. App. Ct. 1993) (rejecting plaintiff's claim that hospital's patient guide stating it was committed to providing "high quality patient care" when plaintiff did not receive such care violated the state's consumer protection act; court ruled statute was unavailable as additional remedy when plaintiff's damages arose from alleged medical malpractice).

¹³⁷ Laura B. Benko, *A Look Inside: Settlement Requires Kaiser Permanente to Publish Info on Doc's Decisionmaking*, MOD. HEALTHCARE, Jan. 27, 2003, at 8; *Kaiser Permanente Settles False-Advertising Suit with Consumer Group*, AM. HEALTH LINE (Jan. 24, 2003), available at <http://www.americanhealthline.com> (requires subscription). Kaiser also agreed to publish on its website information on how it determines salaries and bonuses for doctors, to cease its practice of offering financial incentives to telephone clerks for limiting access to care, and to allocate more resources toward recruiting doctors to increase members' access to physicians. *Kaiser Permanente Settles False-Advertising Suit with Consumer Group*, AM. HEALTH LINE (Jan. 24, 2003), available at <http://www.americanhealthline.com> (requires subscription).

¹³⁸ Some UDAP laws do not use the phrase "trade or commerce," and instead specify coverage for sales of "goods," "merchandise," "services," or limit their application to transactions involving "personal, family, or household use." See NCLC UDAP Manual, *supra* note 125, at §§ 2.1.1 to 2.1.8.

¹³⁹ See, e.g., NEB. REV. STAT. § 59-1601 ("trade and commerce" is "the sale of assets or services and any commerce directly or indirectly affecting the people of the State of Nebraska"); WASH. REV. CODE § 19.86.010 (2) ("trade or commerce" is "the sale of assets or services, and any commerce directly or indirectly affecting the people of the State of Washington").

¹⁴⁰ *Karlin v. IVF Am., Inc.*, 712 N.E.2d 662, 668 (N.Y. 1999) (New York's highest court interpreted state's UDAP law to allow a claim by former patients against operators of an in vitro fertilization program for alleged misrepresentations of the program's services; in allowing law to apply to providers of medical services, though not explicitly covered by the statute; the court found that when health care providers "choose to reach out to the consuming public at large in order to promote business... they subject themselves to the standards of an honest marketplace....")

¹⁴¹ *Chalfin v. Beverly Enter., Inc.*, 741 F. Supp. 1162, 1174-77 (E.D. Pa. 1989) (patient's purchase of health care services from nursing home is within purview of state UDAP statute).

¹⁴² See, e.g., *Macedo v. Dello Russo*, 819 A.2d 5, 8-9 (N.J. Super. Ct. 2003) (plaintiffs may bring state UDAP claims against medical professionals who allegedly misrepresented their credentials, even without allegations of physical injury. "When professionals engage in common commercial activity designed to attract the patronage of the public, they should be held to the same standards of truth and completeness that govern the sales activities of all other persons or entities."); *Hampton Hosp. v. Bresan*, 672 A.2d 725, 731, n.3 (N.J. Super. Ct. 1996) (claims relating to hospital's delivery of patient services do not fall within purview of state UDAP statute, but implying that a claim in which a patient selected a hospital on the basis of false, misleading or deceptive advertising would); *Mother & Unborn Baby Care of N. Tex. v. State*, 749 S.W.2d 533 (Tex. Ct. App. 1988) (crisis pregnancy center's advertising in the yellow pages intended to draw in women considering abortion, distribution of goods in the form of pamphlets, distribution of services in the form of pregnancy tests, counseling and other assistance constituted "trade or commerce" under the Texas UDAP statute).

¹⁴³ Cf. *Nelson v. Ho*, 564 N.W.2d 482, 486 (Mich. Ct. App. 1997) (allegations of unfair, unconscionable, or deceptive methods, acts, or practices in the conduct of the entrepreneurial, commercial, or business aspect of a physician's practice may be brought under the state's UDAP law); *Wright v. Jeckle*, 16 P.3d 1268 (Wash. Ct. App. 2001) (a doctor's entrepreneurial acts involving promotion and sale of diet drugs fell within the purview of the state's consumer protection statute). See generally William A. Kraiss, *Docs Who Exaggerate Face Claims Beyond Malpractice*, NAT'L L. J., June 18, 2001, at B9.

¹⁴⁴ See, e.g., *Quimby v. Fine*, 724 P.2d 403 (Wash. Ct. App. 1986) (medical negligence claim could not be brought under the state UDAP law, but lack of informed consent could be allowed under the law; the court reasoned that negligence claims are based on breach of the professional standard of care, while lack of informed consent can be based, as it was in this case, on deceptive and unfair practices used to attract patients and enhance business without fully informing patients of risks and alternatives of procedures).

¹⁴⁵ *State Farm Fire & Cas. Co. v. Huynh*, 962 P.2d 854 (Wash. Ct. App. 1998) (chiropractor liable to insurance company for submitting false injury reports and fraudulent billings in violation of state UDAP law); *Elder v. Fischer*, 717 N.E.2d 730, 735 (Ohio Ct. App. 1998) (billing practices of a residential care facility constitute a "consumer transaction" subject to the state's consumer protection law).

¹⁴⁶ North Carolina's statute, for example, exempts from its definition of commerce "professional services rendered by a member of a learned profession." N.C. GEN. STAT. § 75-1.1(b). Courts have interpreted this provision to exempt services rendered by medical professionals. *Cohn v. Wilkes Gen. Hosp.*, 767 F. Supp. 111, 114 (W.D.N.C. 1991) (chiropractor could not enjoin municipal hospital and its medical staff from denying him medical privileges because unfair trade practices statute did not apply to medical professionals); *Cameron v. New Hanover Mem'l Hosp.*, 293 S.E.2d 901, 920-21 (N.C. Ct. App. 1982) (consideration of whom to grant hospital privileges is exempt under North Carolina's unfair trade practices statute because it involves rendering of professional services; since the reviewers must evaluate applicants' qualifications and competency to ensure the delivery of quality health care at the hospital, this process is not commercial in nature).

¹⁴⁷ See, e.g., *Quimby v. Fine*, 724 P.2d 403 (Wash. Ct. App. 1986) (medical negligence claim could not be brought under the state UDAP law, but lack of informed consent could be allowed under the law; the court reasoned that negligence claims are based on breach of the professional standard of care, while lack of informed consent can be based, as it was in this case, on deceptive and unfair practices used to attract patients and enhance business without fully informing patients of risks and alternatives of procedures).

¹⁴⁸ See, e.g., NEB. REV. STAT. § 59-1617 (UDAP does not apply to acts permitted by law as administered by the Director of Insurance, the Public Service Commission, the Federal Energy Commission or any other regulatory body acting under statutory authority of the state or the United States); WASH. REV. CODE § 19.86.170 (conduct regulated by a state regulatory body or officer of Washington State is not subject to UDAP laws). Although New Jersey's UDAP statute does not specifically exempt activity regulated by the state, the courts have ruled that claims concerning the quality of a hospital's services are not covered because the state has extensive regulations governing the quality of care provided by health care professionals and facilities. *Hampton Hosp. v. Bresan*, 672 A.2d 725, 728-29, 731, n.3 (N.J. Super. Ct. 1996) (claims relating to the quality of a hospital's services delivered to patients do not fall within purview of the state UDAP statute because those services are regulated by the state department of health, but the court implied that claims in which patients selected hospitals on the basis of false, misleading or deceptive advertising would). For a further discussion of the UDAP application of conduct regulated elsewhere, see generally NCLC UDAP Manual, *supra* note 125, at § 2.3.3.

¹⁴⁹ See NCLC UDAP Manual, *supra* note 125, at § 2.3.5.

¹⁵⁰ See, e.g., *Schiff v. Amer. Assoc. of Retired Persons*, 697 A.2d 1193 (App. D.C. 1997) (sale of goods by nonprofit organization to its members is not within the purview of UDAP law); *Bd. of Regents of the Univ. of Wis. v. Mussallem*, 289 N.W.2d 801 (Wis. 1980) (state UDAP law did not apply to student loan because the loan was issued by a nonprofit institution rather than a private institution).

¹⁵¹ *Planned Parenthood v. PP Inc.*, 498 N.E.2d 1044 (Mass. 1986) (nonprofit crisis pregnancy center was not engaged in "trade" or "commerce" because it did not charge for its services and thus did not fall within the purview of the UDAP statute).

¹⁵² *Mother & Unborn Baby Care, Inc. v. State*, 749 S.W.2d 533 (Tex. Ct. App. 1988).

¹⁵³ See, e.g., GA. CODE ANN. § 10-1-372; OHIO REV. CODE ANN. §§ 4165.01-4165.04. See generally NCLC UDAP Manual, *supra* note 125, at § 4.2.4.

¹⁵⁴ See, e.g., FLA. STAT. ANN. § 501.211(1), *construed in* *Macias v. HBC of Florida, Inc.*, 694 So. 2d 88 (Fla. Dist. Ct. App. 1997) (Florida's provision that plaintiff be aggrieved requires showing of actual loss).

¹⁵⁵ See, e.g., TENN. CODE ANN. § 47-18-109(a)(1); WIS. STAT. § 100.18(1)(b)(2); OHIO REV. CODE ANN. § 4165.03; OKLA. STAT. tit. 15, § 761.1. See generally NCLC UDAP Manual, *supra* note 125, at § 7.5.2.

¹⁵⁶ See, e.g., *Brashears v. Sight 'n Sound Appliance Ctrs, Inc.*, 981 P.2d 1270 (Okla. Civ. App. 1999) (loss of time, inconvenience, and travel and telephone expenses are cognizable claims for actual damages under Oklahoma UDAP law).

¹⁵⁷ For example, Connecticut and Massachusetts allow recovery for non-monetary losses once the threshold requirement of loss of money or property is met. See *Simms v. Candela*, 711 A.2d 778 (Conn. 1998); *American Shooting Sports Council v. Attorney Gen.*, 711 N.E.2d 899 (Mass. 1999). The Texas UDAP law, however, excludes damages for bodily injury or death in most cases. TEX. BUS. & COM. CODE ANN. §§ 17.50, 17.49(e) (limiting recovery to economic damages and mental anguish, and excluding damages for bodily injury or death in most cases). Some courts have also interpreted requirements that a consumer suffer ascertainable loss of money or property as a precondition of a UDAP suit to prohibit compensation for physical injury. See, e.g., *Ass'n of Wash. Pub. Hosp. Dists. v. Philip Morris*, 241 F.3d 696 (9th Cir. 2001); *Kirksey v. Overton Pub., Inc.*, 804 S.W.2d 68 (Tenn. Ct. App. 1990).

¹⁵⁸ See, e.g., *Laurents v. Louisiana Mobile Homes*, 689 So. 2d 536 (La. Ct. App. 1997) (allowing recovery of damages under state UDAP law for mental anguish, distress and humiliation); *Latham v. Castillo*, 972 S.W.2d 66, 69-70 (Tex. 1998) (mental anguish damages may be recovered under the Texas UDAP law without first proving economic injury); *Verinakis v. Med. Profiles Inc.*, 987 S.W.2d 90 (Tex. Ct. App. 1999) (to recover mental anguish damages in the absence of resulting physical injury, consumer must show that defendants committed violation "knowingly").

¹⁵⁹ See, e.g., WASH. REV. CODE § 19.86.090; *Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co.*, 719 P.2d 531, 539 (Wash. 1986) (plaintiff must demonstrate proof of injury to prevail in a private Consumer Protection Act claim, but "[t]he injury involved need not be great").

¹⁶⁰ See, e.g., CAL. BUS. & PROF. CODE § 17204; D.C. CODE ANN. §§ 28-3904, 28-3905.

¹⁶¹ DEL. CODE ANN. tit. 6, § 2531; GA. CODE ANN. § 10-1-370; HAW. REV. STAT. § 481A; 815 ILL. COMP. STAT. ANN. 510; ME. REV. STAT. ANN. tit. 10, § 1211; MINN. STAT. ANN. § 325D.43; NEB. REV. STAT. § 87-301; OHIO REV. CODE ANN. § 4165.01; OKLA. STAT. ANN. tit. 78, § 51. These states are modeled after the Uniform Deceptive Trade Practices Act (UDTPA). The current version of the UDTPA is available at 7A Uniform Laws Annotated 265 (West, Master Edition, 1985 and Supp.). See generally NCLC UDAP Manual, *supra* note 125, at § 7.2.3, n.27 and accompanying text. All nine states with UDTPA-type statutes also have a second UDAP statute that provides an explicit damages remedy for consumers; see note 125 *supra*.

¹⁶² See *Holloway v. Bristol-Myers Corp.*, 485 F.2d 986 (D.C. Cir. 1973); *Carlson v. Coca-Cola*, 483 F.2d 279 (9th Cir. 1973).

¹⁶³ See *Serbin v. Ziebart Intern. Corp., Inc.*, 11 F.3d 1163 (3rd Cir. 1993) (consumers do not have standing to bring claims under the Lanham Act); *Colligan v. Activities Club of N.Y., Ltd.*, 442 F.2d 686 (2d Cir. 1971) (consumers do not have standing to bring claims under the Lanham Act); *but see Ameson v. Raymond Lee Org., Inc.*, 333 F. Supp. 116, 120 (C.D. Cal. 1971) (granting standing to a consumer to bring a claim under the Lanham Act).

¹⁶⁴ See notes 171-173 *infra* and accompanying text.

¹⁶⁵ 15 U.S.C. § 45(a)(1).

¹⁶⁶ See *F.T.C. v. Sperry & Hutchinson Co.*, 405 U.S. 233, 244 n.5 (1972); *Spiegel, Inc. v. F.T.C.*, 540 F.2d 287, 293 (7th Cir. 1976). See generally 54A AM. JUR. 2d *Monopolies and Restraints of Trade* § 1156 (rev. 2003).

¹⁶⁷ See, e.g., *Southwest Sunsites, Inc. v. F.T.C.*, 785 F.2d 1431, 1435 (9th Cir. 1986); *Charles of the Ritz Distrib. Corp. v. F.T.C.*, 143 F.2d 676, 680 (2d Cir. 1944). See generally 54A AM. JUR. 2d *Monopolies and Restraints of Trade* § 1156 (rev. 2003).

¹⁶⁸ See, e.g., *Simeon Mgmt. Corp. v. F.T.C.*, 579 F.2d 1137, 1145 (9th Cir. 1978); *American Home Products Corp. v. F.T.C.*, 695 F.2d 681 (3d Cir. 1983).

¹⁶⁹ See *Resort Car Rental System, Inc. v. F.T.C.*, 518 F.2d 962, 964 (9th Cir. 1975) (law is violated if the first contact is secured through deception even if truth is disclosed to the consumer before a contract is formed); *Exposition Press, Inc. v. F.T.C.*, 295 F.2d 869, 873 (2d Cir. 1961) (law is violated if the first contact is secured through deception even if truth is disclosed to the consumer before a contract is formed).

¹⁷⁰ See *F.T.C. v. Indiana Fed. of Dentists*, 476 U.S. 447 (1986); *American Med. Ass'n v. F.T.C.*, 638 F.2d 443, 448 (2d Cir. 1980).

¹⁷¹ The U.S. Supreme Court addressed the issue in 1999, holding that a nonprofit professional association was subject to FTC Act jurisdiction because it was organized to provide, and did provide, substantial economic benefit to its profit-seeking members. *California Dental Ass'n v. F.T.C.*, 526 U.S. 756, 767 (1999). See also *American Med. Ass'n v. F.T.C.*, 638 F.2d 443, 448 (2d Cir. 1980) (FTC Act applied to a nonprofit organization even though the "business aspects" of its activities were considered secondary to its non-business aspects); *F.T.C. v. Nat'l Comm'n on Egg Nutrition*, 517 F.2d 485 (7th Cir. 1975) (FTC Act applied to a nonprofit association organized to provide profit to the egg industry). See generally *Trade Regulation and Unfair Trade Practices*, in FEDERAL PROCEDURE, LAWYERS EDITION, at § 75:10 (2003) (FTC Act does not apply to nonprofit corporations that do not have shares of capital, do not engage in business for other than charitable purposes, and do not derive any profit for themselves or their members).

¹⁷² See CATHOLICS FOR A FREE CHOICE, CATHOLIC HMOs AND REPRODUCTIVE HEALTH CARE 10 (2000) (reporting that more than half of the Catholic managed care plans it identified through a survey operate as for-profit entities).

¹⁷³ One health care company, Tenet Healthcare Corp., has agreed to follow the *Directives* at the Catholic hospitals it purchases, even though it is a nonsectarian, for-profit health care corporation. See Deanna Bellandi, *Tenet Adding Two Catholic Hospitals*, MOD. HEALTHCARE, June 11, 2001, at 6. For further discussion of Tenet's practices, see note 23 *supra* and accompanying text.

¹⁷⁴ 15 U.S.C. § 1125(a)(1)(B).

¹⁷⁵ See *Gordon & Breach Science Publishers v. American Inst. of Physics*, 905 F. Supp. 169 (S.D.N.Y. 1995); *Birthright v. Birthright*, 827 F. Supp. 1114 (D.N.J. 1993); *Nat'l Artists Management Co. v. Weaving*, 769 F. Supp. 1224, 1231-32 (S.D.N.Y. 1991).

¹⁷⁶ Lanham Act jurisdiction extends to all commerce that may be regulated by Congress; it does not apply to a dispute that is purely intrastate. However, Lanham Act jurisdiction is established if defendant's intrastate conduct substantially affects plaintiff's interstate commerce. See, e.g., *Jellibeans, Inc. v. Skating Clubs of Georgia, Inc.*, 716 F.2d 833, 838-39 (11th Cir. 1983) (jurisdiction established even though defendant's business activities were purely intrastate because plaintiff's business drew customers from out of state and received free publicity in national magazines). See generally J. Thomas McCarthy, MCCARTHY ON TRADEMARKS AND UNFAIR COMPETITION § 27:47 (4th ed., updated 2003).

¹⁷⁷ *American Council of Certified Podiatric Physicians & Surgeons v. American Bd. of Podiatric Surgery, Inc.*, 185 F.3d 606, 613 (6th Cir. 1999). See generally Courtland L. Reichman & M. Melissa Cannady, *False Advertising Under the Lanham Act*, 21 SPG FRANCHISE L.J. 187 (2002).

¹⁷⁸ See, e.g., *Brandt Consol., Inc. v. Agrimar Corp.*, 801 F. Supp. 164, 174 (C.D. Ill. 1992); *Williams Electronics, Inc. v. Bally Mfg. Corp.*, 568 F. Supp. 1274, 1282 n.24 (N.D. Ill. 1983).

¹⁷⁹ *Pizza Hut, Inc. v. Papa John's Intern., Inc.*, 227 F.3d 489, 497 (5th Cir. 2000); American Council of Certified Podiatric Physicians & Surgeons, 185 F.3d at 618.

¹⁸⁰ *Pizza Hut, Inc. v. Papa John's Intern., Inc.*, 227 F.3d at 497.

¹⁸¹ American Council of Certified Podiatric Physicians & Surgeons, 185 F.3d at 614-18.

¹⁸² *Minnesota Mining & Mfg. Co. v. Rauh Rubber, Inc.*, 943 F. Supp. 1117, 1132 (D. Minn. 1996).

¹⁸³ See, e.g., *Lance v. Wade*, 457 So. 2d 1008, 1011 (Fla. 1984).

¹⁸⁴ See Seth William Goren, *A Pothole on the Road to Recovery: Reliance and Private Class Actions Under Pennsylvania's Unfair Trade Practices and Consumer Protection Law*, 107 DICK. L. REV. 1, 13-14 nn.50-51 and accompanying text (2002).

¹⁸⁵ See RESTATEMENT (SECOND) OF TORTS § 552 (1977) ("One who, in the course of his business, profession, or employment, or in any other transaction in which he has a pecuniary interest, supplies false information for the guidance of others in their business transactions, is subject to liability for pecuniary loss caused to them by their justifiable reliance upon the information, if he fails to exercise reasonable care or competence in obtaining or communicating the information.") See also *Yale New Haven Hosp. v. Vignola*, No. CV0004447875, 2002 WL 377675, at *1 (Conn. Super. Ct. Feb. 15, 2002) (denying motion to dismiss claim that hospital negligently responded to patient's inquiries regarding the sufficiency of her insurance coverage to pay for services rendered).

¹⁸⁶ See, e.g., *Eckhardt v. Charter Hosp. of Albuquerque*, 953 P.2d 722 (N.M. 1997) (denying the patient's claim against a hospital for fraudulent misrepresentation, reasoning that evidence did not show that the hospital intended to mislead the patient, but affirming the award based on negligent misrepresentation, finding that the hospital should have foreseen the patient's harm as a result of its representations regarding its staff).

¹⁸⁷ For more information about using nonprofit corporation law to challenge religious restrictions in the context of health care mergers and other affiliations, see generally NWLC CHARITABLE ASSETS, *supra* note 25, especially at 20-22. The material in the paragraph in the text is from this source.

¹⁸⁸ For more information about using charitable trust law to challenge religious restrictions in the context of health care mergers and other affiliations, see generally NWLC CHARITABLE ASSETS, *supra* note 25, especially at 17-20. The material in the paragraph in the text is from this source.

¹⁸⁹ For more discussion of using antitrust theories to challenge religious restrictions in hospital mergers, see notes 37, 87 *supra*.

¹⁹⁰ Generally, if the transaction involves assets valued at more than \$50 million, it must be reported to the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) before it can be completed. Pub. L. No. 106-553, 114 Stat. 2762, § 630(a) (Dec. 21, 2000). The amendment also requires that transactions valued at over \$200 million regardless of the size of the parties, be submitted to pre-merger review. 18 U.S.C. § 18a(a).

¹⁹¹ As part of its federal antitrust enforcement authority, FTC Chair Timothy Muris has expressed a strong interest in not only the impact of the health care market on competitors, but in consumer issues such as the availability of health information and its impact on consumer decision-making, and the quality and delivery of services. See Muris, *supra* note 25, at 5. See also note 39 and accompanying text *supra* regarding recent FTC merger activities.

¹⁹² See Internal Revenue Service, Field Service Advisory, IRS FSA 200110030 (Mar. 9, 2001) (exempting hospitals' compliance with U.S. Treasury Regulation § 1.501(c)(3)-1(c)); *IHC Health Plans v. Comm'r of Internal Revenue*, 325 F.3d 1188, 1199-1201 (10th Cir. 2003) (denying tax-exempt status to three HMOs because they did not operate primarily to promote health for the benefit of the community; they did not furnish direct health care services or offer free or below-cost health care services, nor did they conduct research or offer free educational programs to the public and two of the three HMOs did not offer their plans to the general public).

Section III: How to Bring a Challenge for Improper Notice: Allies and Available Remedies

¹⁹³ See NARAL, WHO DECIDES?, *supra* note 42 (this publication provides information on various state officials and their stance on reproductive rights). State websites sometimes indicate whether the office is especially active in certain areas of enforcement. For a listing of websites, see Appendix B of this report.

¹⁹⁴ See Sections II.A and II.B of this report.

¹⁹⁵ N.Y. COMP. CODES R. & REGS. tit. 10, § 405.7, as discussed in Waltman, *supra* note 68, at § 4.03[4][vi]. In some states, some regulators encourage patients or families to file complaints about care and then follow up by either investigating the complaints themselves or requesting explanations from the facilities involved. Waltman, *supra* note 68, at § 4.03[5] (citing CAL. HEALTH & SAFETY CODE §§ 1419, 1420; FLA. STAT. ANN. § 395.006).

¹⁹⁶ A Washington State law gives people the right to gain access information on hospital inspections, investigation results and complaints, through the state's Department of Health Hospital Complaint Hotline (800-633-6828), as discussed in *New Law Provides for Public Access to Hospital Complaint, Inspection Data*, Health Care Pol'y Rep. (BNA) Vol. 8, No. 40, at 532 (Apr. 3, 2000); NATIONAL CONFERENCE OF STATE LEGISLATURES, MAJOR HEALTH CARE POLICIES: 50 STATE PROFILES, 2002, 21-24 (11th ed., 2003) (table indicating whether states have report cards on managed care companies).

¹⁹⁷ In 1998, CMS launched a nursing home report card website called "Nursing Home Compare," available at <http://www.Medicare.gov/NHCompare/home.asp>. But see UNITED STATES GEN. ACCOUNTING OFFICE, NURSING HOMES: PUBLIC REPORTING OF QUALITY INDICATORS HAS MERIT, BUT NATIONAL IMPLEMENTATION IS PREMATURE 2-3 (GAO reviewed CMS initiative to publicly report additional information on its "Nursing Home Compare" website and recommended that it delay national reporting of quality indicators to allow time to resolve important issues about appropriate indicators for public reporting and to assess how information is presented and to improve assistance available through consumer hotlines). See also UNITED STATES GENERAL ACCOUNTING OFFICE, NURSING HOME QUALITY: PREVALENCE OF SERIOUS PROBLEMS, WHILE DECLINING, REINFORCES IMPORTANCE OF ENHANCED OVERSIGHT (2003). There are other governmental report cards or other guides for health care consumers. For example, AHRQ now has a quality measures website, available at <http://www.qualitymeasures.ahrq.gov>, which allows searches for quality measures related to a specific disease, condition, treatment, age range, gender, vulnerable population, setting of care or contribution organization. See also AHRQ, Expanding Patient-Centered Care to Empower Patients and Assist Providers, at <http://www.ahrq.gov/qual/ptcareria.htm> (last visited July 24, 2003); AHRQ et al., Talking to Consumers About Health Care Quality, <http://www.talkingquality.gov> (last visited July 24, 2003); U.S. Dep't of Health & Human Servs., Guidelines for Ensuring the Quality of Information Disseminated by HHS Agencies, at <http://www.hhs.gov/infoquality>; Press Release, Health Care Concerns Identified in State Report, Office of N.Y. Attorney General Eliot Spitzer (Jan. 2002) (announcing report of state's Managed Care Consumer Assistance Program (MCCAP), available at http://www.oag.state.ny.us/health/2002_health_care_helpline_report.pdf (last visited July 24, 2003)); N.Y. STATE INS. DEPT., NEW YORK CONSUMER GUIDE TO HEALTH INSURERS (2002), available at <http://www.ins.state.ny.us/acrobat/hg2002.pdf>.

¹⁹⁸ Joseph W. Thompson et al., *Health Plan Quality-of-Care Information is Undermined by Voluntary Reporting*, 24 J. AM. PREVENTIVE MED. 62 (2003) (using women's health indicators, study compared performance results for managed care and found that those that publicly reported their results had better quality of care than those that restricted public access of data).

¹⁹⁹ See Joseph Baker & David Sharpe, *The Health Care Bureau: Empowering Health Care Consumers*, N.Y. ST. B.A. HEALTH L.J. 21 (Spring 2003); Robert Wild et al., *Other Views on the Role of the AG in Health Care*, N.Y. ST. B.A. HEALTH L.J. 37 (Spring 2003). See generally Section III.B of this report, NWLC CHARITABLE ASSETS, *supra* note 25, NWLC ANTITRUST REPORT, *supra* note 37, for discussion of these attorney general responsibilities.

²⁰⁰ See Section II.B.I of this report for these Medicare and Medicaid notice requirements.

²⁰¹ Cf. 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.206(c), 431.200 to 431.250 (grievance procedures for the Medicaid program); 42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. Part 438 (grievance procedures for the Medicaid managed care program). For example, providers must inform patients that they may file complaints with governmental surveyors if the providers fail to comply with the PSDA requirements about advance directive 42 C.F.R. §§ 417.436(d)(1), 483.10(b)(8), 489.102(e) 483.10(b)(7)(iv), 484.10(f), 489.102(a)(1)(ii)(c), 489.102(a)(4); 60 Fed. Reg. at 33281-82. See also Appendix B of this report for CMS contact information for Medicare and Medicaid questions.

For information about long-term care ombuds programs, see 42 U.S.C. § 3058g (state long-term care ombuds program); National Long Term Care Ombudsman Resource Center, at http://www.ltombudsman.org/static_pages/ombudsmen.cfm (last visited June 11, 2003) (state map links directly to state long-term care ombudsman) at <http://www.aoa.gov/ltombudsman> and <http://www.ncchr.org> (can click on state and go directly to that state's long-term care ombuds program). For information about protection and advocacy programs for rights of individuals with developmental disabilities, see 29 U.S.C. § 794e, 42 U.S.C. § 10801. For information about government or private ombuds programs (also called consumer health assistance programs) generally, see FAMILIES USA, CONSUMER HEALTH ASSISTANCE PROGRAMS: REPORT ON A NATIONAL SURVEY (2001) available at <http://www.familiesusa.org/site/DocServer/survey.pdf?docID=661> [hereinafter CHAP]; Health Assistance Partnership Website (a project of Families USA), at <http://www.healthassistancepartnership.org> (see the program locator section of the website to find the ombuds or health assistance program in the relevant state).

²⁰² 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.12. See also Waltman, *supra* note 68, at § 4.04[3][a].

²⁰³ See Section II.B.3 *supra* for discussion of these accrediting requirements.

²⁰⁴ JCAHO, WEAVING THE FABRIC: STRATEGIES FOR IMPROVING OUR NATION'S HEALTH CARE 12 (2000) ("If health care consumers are to become informed partners in setting future directions in health care, they will need information.... The Joint Commission... will work to develop credible information products and services that can help leverage productive and constructive change...."); JCAHO, 2003 Standards, *supra* note 87, at 20-24, 28 (JCAHO prepares and makes available to the public quality of care and service performance reports on all accredited organizations, and also requires organizations to provide members of the public with the opportunity to participate in the survey and evaluation process). Both JCAHO and NCQA have consumer advisory committees (one of the authors of this report serves on the NCQA committee).

²⁰⁵ See FTC contact information in Appendix B of this report.

²⁰⁶ See, e.g., ALA. CODE § 8-19-8 (granting authority to the district attorney as well as the attorney general to bring an action for a temporary restraining order or injunction); CAL. BUS. & PROF. CODE § 17204 (granting authority to district attorney as well as the attorney general to bring an action for relief); KAN. STAT. ANN. § 50-632(a) (granting authority to any county or district attorney as well as the attorney general to bring an action to enforce the Act).

²⁰⁷ See note 201 *supra* for general information on consumer health assistance programs.

²⁰⁸ See *Serbin v. Ziebart Intern. Corp., Inc.*, 11 F.3d 1163 (3rd Cir. 1993) (consumers do not have standing to bring claims under the Lanham Act); *Colligan v. Activities Club of New York, Ltd.*, 442 F.2d 686 (2d Cir. 1971) (consumers do not have standing to bring claims under the Lanham Act); *but see Ameson v. Raymond Lee Org., Inc.*, 333 F. Supp. 116, 120 (C.D. Calif. 1971) (granting standing to a consumer to bring a claim under the Lanham Act).

²⁰⁹ See, e.g., CRISTINA PAGE, NARAL/NY FOUNDATION, *THE WOMAN'S GUIDE TO HMOS: HOW TO CHOOSE AND USE YOUR PLAN TO GET THE CARE YOU NEED* 8, 12, 13, 16, 17, 18, 22, 27, 28, 39, 57-66 (2000); STUDENT BODIES, *supra* note 8, at 32-37 (lists by university the Catholic university health center responses to the CFFC questionnaire about the scope of reproductive health services they cover); Family Planning Advocates of New York State, *Emergency Care for Sexual Assault Survivors*, at <http://www.fpaofnys.org/education/ecsurvey2003.html> (last visited July 30, 2003) (interactive map allows consumers to check the policies of their local hospitals regarding emergency contraception); NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES ET AL., *THE HEALTH PLAN GUIDE FOR WOMEN* 6-8 (undated), available at <http://www.nationalpartnership.org/library/HealthPlanGuideforWomen%2Epdf>. The National Health Law Program also has a web site designed to help consumers make health care choices, at <http://www.healthcarecoach.com> (includes information on choosing a hospital and women's health generally); see also National Health Law Program, *Access to Reproductive Health Services: A Checklist for Consumers and Advocates* (2000), available at <http://www.healthlaw.org/pubs/200006reprochecklist.html> (last visited July 30, 2003).

²¹⁰ Organizations are likely to have standing to sue if they represent members who have suffered harm. See *Warth v. Seldin*, 422 U.S. 490, 511 (an association may have standing as a representative for its members), *affirmed by Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). If an organization does not have members, asserting standing is more difficult (especially in federal court). See Charles D. Kelso & R. Randall Kelso, *Standing to Sue: Transformations in Supreme Court Methodology, Doctrine and Results*, 28 U. Tol. L. Rev. 93, 120-46 (1996) (providing a review of modern federal standing doctrine). However, organizations may be successful in asserting standing if they can demonstrate that their purpose is frustrated or resources are diverted by the complained of action; this assertion is usually tied to a tangible effect on the organization's ability to provide services consistent with its purpose. See, e.g., *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 372 (1982) (an organization has standing to sue because defendant's discriminatory practices "perceptibly impaired" the organization's mission of improving equal housing opportunity); *Molovsky v. Fair Employment Council of Greater Wash.*, 683 A.2d 142, 147 (D.C. 1996) (an organization promoting equal employment opportunity had standing to sue for defendant's discriminatory conduct because that conduct caused the organization to increase its counseling of sex discrimination victims); *cf. Crescent Park Tenants Ass'n v. Realty Equities Corp.*, 275 A.2d 433, 434 (N.J. 1971) (noting that "New Jersey cases have historically taken a much more liberal approach on the issue of standing than have the federal cases").

²¹¹ 15 U.S.C. § 1125(a)(1).

²¹² See *Dovenmuehle v. Gildorn Mortgage Midwest Corp.*, 871 F.2d 697, 700 (7th Cir. 1989); *Smith v. Montoro*, 648 F.2d 602, 608 (9th Cir. 1981); *Johnson & Johnson v. Carter-Wallace, Inc.*, 631 F.2d 186, 190 (2d Cir. 1980); *Quabaug Rubber Co. v. Fabiano Shoe Co., Inc.*, 567 F.2d 154, 160 (1st Cir. 1977). For a general review of standing requirements under the Lanham Act, see Elizabeth Williams, *Standing to Bring False Advertising Claim or Unfair Competition Claim Under § 43(A)(1) of Lanham Act (15 U.S.C.A. § 1125(A)(1))*, 124 A.L.R. FED. 189 (1995).

²¹³ See note 87 *supra* for a brief discussion of legal tools to protect physician advocacy.

²¹⁴ For example, hospital trustees may be liable under charitable assets laws for violating their duties to the hospital. See NWLC, *CHARITABLE ASSETS*, *supra* note 25, at 11-12, 20. See also *Barnes v. Pelham Family Servs.*, No. 16474/88 (N.Y. Sup. Ct. March 13, 1989) (court denied a trustee's request to be dismissed from a suit alleging negligent oversight of the process of employing health care personnel as required by New York's hospital operating requirements), as discussed in *Waltman*, *supra* note 68, at § 4.03[4] n.27.

²¹⁵ Even when statutes do not include explicit remedies for private parties, advocates should consider asking courts to *imply* that these parties have a remedy (referred to as an "implied private right of action"). However, the strength of these arguments varies by context. Courts typically look at four factors that must exist to imply a private right of action when federal statutes are violated: 1) the plaintiff must be in a class for whose benefit the statute was enacted, 2) there is an indication (implicit or explicit) of legislative intent to create a private remedy, 3) it is consistent with the underlying purpose of the statute to imply such a remedy for the plaintiff, and 4) it is not the type of cause of action that is traditionally relegated to state law (because, if it were, it would be inappropriate to infer a cause of action based solely on federal law). *Cort v. Ash*, 422 U.S. 66, 78 (1975). For further discussion on implied right of action, see *Cannon v. Univ. of Chi.*, 441 U.S. 677, 688-96 (1979) (finding implied right of action in Title IX of the Education Amendment of 1972, the statute that bars sex discrimination in educational programs or activities that receive federal funding), and *Touche Ross & Co. v. Redington*, 442 U.S. 560, 569 (1979) (finding no implied right of action in reporting requirement provision of Securities Exchange Act).

In the recent case of *Alexander v. Sandoval*, 532 U.S. 275 (2001), the Supreme Court focused on the need to find that Congress intended to create a private right of action. In that case it held that there is no such right to enforce the disparate impact regulations issued under Title VI of the Civil Rights Act of 1964, which bars discrimination on the basis of race, religion and national origin in programs or activities that

receive federal funding. The holding was based on the fact that Title VI had previously been interpreted to prohibit only intentional discrimination, as opposed to unintentional disparate impact discrimination. Therefore, Sandoval does not prevent implying a private right of action when conduct is prohibited by statute or by regulations that authoritatively construe a statute. See also Donna L. Goldstein, Note, *Implied Private Rights of Action Under Federal Statutes: Congressional Intent, Judicial Deference, or Mutual Abdication?*, 50 *FORDHAM L. REV.* 611 (1982). The main difference between application in the federal and state context is that the fourth prong does not apply when the issue concerns implying a private right of action concerning a state statute, rather than a federal statute. *Napoletano v. Cigna Healthcare of Conn., Inc.*, 680 A.2d 127, 145 (Conn. 1996), *cert denied*, 520 U.S. 1103 (1997) (determining whether state law governing managed care confers a private right of action and concluding that the fourth factor listed in *Cort v. Ash*—whether cause of action [is] one traditionally relegated to state law—does not apply when the case involves a state law).

Under this four-part test, advocates could argue, in appropriate cases, that the patients are clearly in a class meant to be protected by patients' rights provisions; that there is an implicit legislative intent to create a private remedy; that implying the remedy is consistent with the statute's underlying purpose; and that it is not the type of cause of action traditionally relegated to state law. These arguments have been advanced in similar contexts and have sometimes been successful; for example, courts have found an implied right of action in provisions of the Medicaid Act that protect patients' rights through the threat of cessation of federal funds. See, e.g., *Roberson v. Wood*, 464 F. Supp. 983, 988-89 (1979) (finding an implied right of action in Medicaid provisions of the Social Security Act that protect nursing home residents against transfers without notice by threatening cessation of federal funds). See also *Oliner v. Lenox Hill Hosp.*, 431 N.Y.S.2d 271, 272 (N.Y. Sup. Ct. 1980) (interpreting N.Y. PUB. HEALTH LAW § 2803-c, which guarantees that "every patient's civil and religious liberties . . . shall not be infringed" specifically in nursing homes, "logically must be interpreted to include hospitals" as well).

However, advocates should recognize that courts have refused to find an implied private right of action in certain contexts. For example, several courts have refused to imply a private right of action for parties aggrieved under the Federal Trade Commission Act, holding that the explicitly administrative nature of the statute belies the possibility for private enforcement. See *Holloway v. Bristol-Myers Corp.*, 485 F.2d 986 (D.C. Cir. 1973); *Carlson v. Coca-Cola*, 483 F.2d 279 (9th Cir. 1973). Additionally, some courts have found that certain Medicaid provisions of the Social Security Act similarly prohibit implying a private right of action. See *Chalfin v. Beverly Enters., Inc.*, 741 F. Supp. 1162 (E.D. Pa. 1989); *Harding v. Summit Med. Ctr.*, 41 Fed. Appx. 83, 84 (9th Cir. 2002) (Medicaid Act does not imply a private right of action, as Medicaid legislation is directed primarily at the states and enforced by discontinuing federal funds).

Additionally, advocates can advance a "third party beneficiary" argument when statutes do not include explicit remedies for private parties. For an examination of this theory in the context of health care consumers enforcing Medicare and Medicaid requirements, see Toker, *supra* note 37, at 291, 302 & n. 97-98 (citing Restatement (Second) Contracts § 2, 71); see also Steve Hitov & Gill Deford, *The Impact of Privatization on Litigation*, Clearinghouse R. 590, 591 & n.4 (Jan.-Feb. 2002) [hereinafter Hitov] (noting also that not every state has adopted the Restatement). Section 302 provides as follows:

- (1) Unless otherwise agreed between promisor and promisee, a beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate to effectuate the intention of the parties and either (a) the performance of the promise will satisfy an obligation of the promise to pay money to the beneficiary; or (b) the circumstances indicate that the promise intends to give the beneficiary the benefit of the promised performance.

RESTATEMENT (SECOND) OF CONTRACTS § 302. The beneficiary is that party that will "benefit from the performance promised by the promisor. The beneficiary is not a party to the contract between promisor and promisee. Beneficiaries may be 'intended' or 'incidental.' The distinction is important, as an intended beneficiary is entitled to sue on the contract, while an incidental beneficiary is not." Hitov, *supra*, at n.95 (citing *Gray v. Manhattan Med. Ctr., Inc.*, 18 P.3d 291, 294 (Kan. App. 2001)). The third party beneficiary theory holds that if third parties are the intended beneficiaries of an agreement between two other parties, then the third parties are legally empowered to enforce the agreement.

For example, in the health care context, Medicaid and Medicare "conditions of participation" requirements are technically part of a funding agreement between the government and health care facilities; the government agrees to provide the facilities with Medicare and Medicaid payments as long as the facilities comply with the Medicare and Medicaid conditions of participation. See Section II.B.1 *supra* for a further discussion of Medicare and Medicaid notice requirements. However, health care consumers are actually the people who are intended to benefit from this agreement (i.e., the "intended beneficiaries") and, as such, may be legally empowered to sue to enforce those provisions. These arguments have been advanced in similar contexts and upheld by some courts.

For example, courts have found an intent to benefit public housing recipients from a contract between the U.S. Department of Housing and Urban Development and private contractors; similarly, courts have found an intent to benefit Medicaid recipients from a contract between a state government and a private nursing home. See *Holbrook v. Pitt*, 643 F.2d 1261, 1271 (7th Cir. 1981) and *Smith v. Chattanooga Med. Investors, Inc.*, 62 S.W.3d 178 (Tenn. Ct. App. 2001), as discussed in Hitov, *supra*, at 592-93. However, it is important to note that "intent" is not defined as a desire to confer a benefit on a third party, but rather as an assumption of an obligation that confers a benefit upon a third party; the motive, purpose or desire of parties is different from "intention" for these purposes. See Toker, *supra* note 37, at 302-07. Courts have also found intent to benefit third parties when a contracting party owes a preexisting duty to a third party. See Hitov, *supra*, at 592 & n.7 (noting that at least two courts have held that Medicaid recipients are the "intended beneficiaries of contracts between the state and private entities because the state had a pre-existing duty to offer coverage to Medicaid-eligible members of the public," citing *Fuzie v. Manor Care Inc.*, 461 F. Supp. 689 (N.D. Ohio 1977), and *Price v. Pierce*, 823 F.2d 1114 (7th Cir. 1987)).

Finally, it is important for advocates to distinguish between congressional intent to create an implied cause of action, and the implied intent of parties to contract to benefit a third party, when deciding which argument to pursue. See *Hitov*, *supra*, at 592 (citing *Brogdon v. Nat'l Healthcare Corp.*, 103 F. Supp.2d 1322 (N.D. Ga. 2000)), which recognized that third-party beneficiary standing is separate from congressional intent to create an implied private right of action).

²¹⁶ State licensure rules often require that the facility have a mechanism for resolving patient complaints; some even require the entity to provide the state health departments with copies of patient care complaints. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 10, § 405.3(d)(8). If the hospital does not have an effective mechanism to resolve patient complaints about religious restrictions, advocates could assert that it violated this specific requirement in addition to the underlying problem of not providing appropriate notice.

²¹⁷ See generally NCLC UDAP Manual, *supra* note 125, at § 7.5.4.

²¹⁸ Most state UDAP statutes allow for recovery of attorneys' fees and costs, although it is mandatory in some states and merely discretionary in others. See, e.g., MASS. GEN. LAWS ch. 93A, § 9(4) (in a private action by consumers or competitors, the petitioner shall receive attorneys' fees and costs if the court finds that a violation occurred); MO. REV. STAT. § 407.025 (courts may exercise discretion in whether or not to award attorneys' fees to the prevailing party). Some state courts have also interpreted UDAP damages provisions to allow recovery for attorneys' fees and costs. See, e.g., *Laurents v. Louisiana Mobile Homes*, 689 So. 2d 536 (La. Ct. App. 1997); *Brashears v. Sight 'n Sound Appliance Ctrs, Inc.*, 981 P. 2d 1270 (Okla. Civ. App. 1999). *BJM Insulation & Constr., Inc. v. Evans*, 671 A. 2d 603, 605 (N.J. Super. Ct. 1996) (court interpreted New Jersey's Consumer Fraud Act, which requires a consumer plaintiff to demonstrate injury in the form of "ascertainable loss," to include reasonable attorneys' fees, filing fees and reasonable costs of the suit without an additional showing of monetary damages). As noted above, private parties bringing a False Claims Act can receive attorney fees and court costs. Some states have patients' rights statutes to protect residents of long-term care facilities that include recovery of attorneys' fees and costs. See ERIC CARLSON, *supra* note 79, at §10.16; OKLA. STAT. ANN. tit. 63, § 1-1918(F) (authorizing attorneys' fees for violation of nursing home patient rights statute); N.J. STAT. ANN. 30:13-4.2 (authorizing reasonable attorneys' fees for violation of nursing home patient rights statute). Some state elder abuse statutes also allow for attorneys' fee recoveries. See ERIC CARLSON, *supra* note 79, at § 10.16 (discussing elder abuse statutes in Arizona, California and Florida that include a private right of action with recovery of attorneys' fees). The Lanham Act also authorizes payment for court costs. 15 U.S.C. §§ 1116(a), 1117(a). Awards of attorneys' fees for Lanham Act violations are only appropriate in cases where violations are deliberate, willful, malicious, or fraudulent. 15 U.S.C. § 1117(a); *Ferrero v. Ozak Trading, Inc.*, 952 F.2d 44, 47-48 (3d Cir. 1991). See generally Robin C. Lerner, Annotation, *Award of Attorneys' Fees Under § 35(a) of Lanham Act (15 U.S.C. § 1117(a)) Authorizing Award in "Exceptional Cases,"* 82 A.L.R. Fed. 143 (1987). One court also refused to award attorneys' fees in a Lanham Act case where both parties were nonprofit organizations, stating that where the parties are motivated by political and social concerns rather than that profit, such an award is not warranted. *Birthright v. Birthright*, 827 F. Supp. 1114, 1144 (D.N.J. 1993). 31 U.S.C. §§ 3730(d)(1), 3730(d)(2).

²¹⁹ The basic remedy for dissemination of false advertisements under the FTC Act is a cease and desist order that will enjoin the illegal conduct and prevent future violations of the law 15 U.S.C. § 53. If merely stopping the false advertisements is insufficient to dispel consumers' misperceptions, the FTC may order corrective advertisements. See, e.g., *Wamer-Lambert Co. v. F.T.C.*, 562 F.2d 749 (D.C. Cir. 1977); *In re Unocal Corp.*, 117 F.T.C. 500 (1994); *In re Eggland's Best, Inc.*, 118 F.T.C. 340 (1994). The FTC may also require that accurate information be made available to consumers through disclosures in product information, direct notification to distributors and consumers, as well as public education campaigns. Joel Winston, *Federal Trade Commission Advertising Enforcement*, 777 P.L.I./Comm 100-01 (1998) [hereinafter Winston].

²²⁰ See, e.g., N.Y. PUB. HEALTH LAW § 12 (allowing health department commissioner to impose civil penalties for violation of health laws or regulations).

²²¹ See, e.g., 15 U.S.C. §§ 1116(a), 1117(a) (Lanham Act violations include injunctive relief as deemed necessary by the court).

²²² For example, many state UDAP laws provide some form of injunctive relief to stop the prohibited activity, and allow both attorneys general and private parties to obtain injunctions. See, e.g., MICH. COMP. LAWS. §§ 445.905(5)(1), 445.911(1)(1). See also NCLC UDAP Manual, *supra* note 125, at § 8.6.

²²³ For example, as discussed earlier, states could refuse to grant a certificate of need or could refuse to approve a conversion. Also, federal or state entities could refuse to grant pre-merger clearance. Cf. 42 U.S.C. § 1320a-7a (detailing conditions in which individuals and entities can have civil monetary penalties imposed); 42 C.F.R. § 422.750 (detailing types of sanctions that may be imposed for Medicare program violations, including civil money penalties, suspension of enrollment, and suspension of payment); *Boozang* 1996, *supra* note 98, at 90, 94 ("[T]he state should not indulge religious beliefs at the expense of patient care; the state should honor the community's right to basic health care services by refusing to approve merger or managed care proposals that interfere with access to those services... [T]he state should require the religious hospital to provide the required health services, or condition licensure or certificate of need approval of the merged entity on the arrangement of an alternative provider of services").

²²⁴ 42 U.S.C. § 1320a-7 (detailing conditions in which individuals and entities will be excluded from participation in Medicare and state health care programs); 42 C.F.R. § 422.750 (detailing types of sanctions that may be imposed for Medicare program violations, including civil money penalties, suspension of enrollment, and suspension of payment); 42 U.S.C. §§ 1395 w-21, 1395 w-22, 1395 w-27(g) (sanctions concerning Medicare + Choice).

²²⁵ See, e.g., 42 C.F.R. §§ 438.102, 438.700 to 438.730 (sanctions concerning Medicaid managed care). For further discussions of sanctions and penalties for Medicaid violations, see Waltman, *supra* note 68, at § 4.04[3]; U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, WORK PLAN: FISCAL YEAR 2003 12, 31 (explaining enforcement actions against nursing home and amount of penalties).

²²⁶ Although some state laws use the phrase "civil penalties" to refer to mandated minimum damage awards available to private plaintiffs, see, e.g., KAN. STAT. ANN. §§ 50-634, 50-636, others use the term to refer to payments made to the government. N.Y. PUB. HEALTH LAW § 2801-d(10)(d).

²²⁷ See notes 225 and 226 and accompanying text *supra*. See also 18 U.S.C. § 286 (imposing fines or imprisonment for conspiracy to defraud the government); 18 U.S.C. § 287 (imposing fines and imprisonment for making false, fictitious, or fraudulent claims to the government); 18 U.S.C. § 1035 (imposing fines and imprisonment for making false statements relating to health care).

²²⁸ CAL. HEALTH & SAFETY CODE § 1293.2. For example, entities that do not cooperate with state licensing surveyors' investigations of complaints could face both misdemeanor charges and penalties. See, e.g., N.Y. PUB. HEALTH LAW § 2806 (detailing suspension and revocation of hospital operating certificates). For more on enforcement action, plan of corrections, and penalties relating to licensure, see Waltman, *supra* note 68, at § 4.03[5].

²²⁹ Some conversion laws impose fines for failure to notify the attorney general or to any other appropriate state agency that a conversion transaction is taking place; some also impose fines for failure to comply with agreements with the state government to provide access or charity care. See COMMUNITY CATALYST, PROTECTING HEALTH, *supra* note 94, at 17-19.

²³⁰ Some state laws use the phrase "civil penalties" to refer to mandated minimum damage awards available to private plaintiffs, see, e.g., KAN. STAT. §§ 50-634, 50-636, while others use it to refer to payments to the government. See, e.g., MO. REV. STAT. § 407.100(6) (authorizing the court to award to the state a civil penalty of not more than \$1000 per violation). See generally NCLC UDAP Manual, *supra* note 125, at § 10.7.3. For UDAP violations, these provisions include civil penalties for initial violations as well as failure to comply with terms of injunctions or other court orders. See, e.g., MO. REV. STAT. § 407.100(6) (authorizing the court to award to the state a civil penalty of not more than \$1000 per violation); MO. REV. STAT. § 407.110 (authorizing the court to award to the state a civil penalty of not more than \$5000 per violation for violating the terms of an injunction, orders to make restitution or other court order issued under MO. REV. STAT. § 407.100). See generally NCLC UDAP Manual, *supra* note 125, at §§ 10.7.2.4, 10.7.3.1.

²³¹ Under the FTC Act, the FTC and the U.S. Attorney General may seek civil penalties for violations of FTC orders. 15 U.S.C. §§ 45(l) to 45(m); Winston, *supra* note 219, at 103.

²³² 31 U.S.C. §§ 3729, 3730(b)(1), as discussed in ERIC CARLSON, *supra* note 79, at § 10.06[2]. False claims can include knowingly making a false record or statement to obtain payment from the federal government, whether through actual knowledge, deliberate ignorance, or reckless disregard of truth or falsity. 31 U.S.C. § 3729. Medicare or Medicaid FCA cases typically involve fraudulent billing (e.g., billing for a service that was not provided).

²³³ United States v. NHC Healthcare Corp., 115 F. Supp. 2d 1149, 1152-57 (W.D. Mo. 2000) (rejecting facility's motion to dismiss relevant to allegations based on False Claims Act); United States v. NHC Health Care Corp., 163 F. Supp. 2d 1051, 1054-58 (W.D. Mo. 2001), as discussed in ERIC CARLSON, *supra* note 79, at § 10.06[2][b][ii] n.78.1 (citing secondary authorities). False Claims Act suits are prohibited when they are based on allegations or transactions that have been publicly disclosed. This public disclosure occurs when the allegations or transactions are the subject of a criminal, civil or administrative hearing; when they are the subject of a congressional, administrative, or Government Accounting Office report, hearing, or investigation; or when they appear in the news media. 31 U.S.C. § 3730(e)(4)(A). The Ninth Circuit Court of Appeals has ruled that nursing home surveys evaluating whether the quality of care being provided met legal standards and did not qualify as public disclosures, and thus did not bar a False Claims Act suit. See United States ex rel. Foundation Aiding the Elderly v. Horizon West, 265 F.3d 1011 (9th Cir. 2001). For further discussion of FCA and substandard quality of care, see Mikes v. Straus, 274 F.3d 687 (2d Cir. 2001); ERIC CARLSON, *supra* note 79, at § 10.06[2][b][ii]; Mark Taylor, *Policing Quality: Federal Prosecutors Increasingly Are Looking to Prosecute Providers Who Defraud Government Programs Via Inadequate Patient Care*, MOD. HEALTHCARE, June 30, 2003, at 24, 28 (citing U.S. attorney as saying that there is prosecutorial interest in using FCA to pursue hospital violations of patients' rights).

²³⁴ 31 U.S.C. §§ 3729(a)(1), 3729(a)(2), as discussed in ERIC CARLSON, *supra* note 79 at § 10.06[2][b][ii] nn.81, 83 and accompanying text (but notes that violations alone do not create cause of action under False Claims Act; rather, issue is "false certification of compliance which creates liability when certification is a prerequisite to obtaining a government benefit" (n.83) (citations omitted)).

²³⁵ 31 U.S.C. §§ 3729(a), 3730(d)(1), 3730(d)(2), as discussed in ERIC CARLSON, *supra* note 79, at § 10.06[2][b][i] (noting that if action is brought by a private party on behalf of the government and prevails, then the private party receives a share of the damages award, as well as award of reasonable attorneys' fees and costs).

²³⁶ 31 U.S.C. §§ 3730(d)(1), 3730(d)(2), as discussed in ERIC CARLSON, *supra* note 79, at § 10.06[2][b][i].

²³⁷ See CAL. GOV'T CODE §§ 12650-55, as discussed in ERIC CARLSON, *supra* note 79, at § 10.06[2] n.74 (citing California and other state false claim statutes).

²³⁸ The remedies available for Lanham Act violations include any damages sustained, as well as an additional award of defendant's profits from the violation. See 15 U.S.C. §§ 1116(a), 1117(a). It is important to remember, as discussed earlier, however, that plaintiffs bringing suit for Lanham Act violations likely need a commercial or business claim, rather than a private consumer claim.

²³⁹ See Anthony Szczygiel, *Beyond Informed Consent*, 21 OHIO N.U. L. REV. 171, 184 (1994).

²⁴⁰ For example, if legally required components of informed consent are not provided because the facility prohibits certain communication because of religious restrictions, and an individual health care provider in this facility subsequently gets sued for failing to obtain informed consent, the individual health care provider might be able to sue the facility on the grounds that it prevented him or her from fulfilling professional obligations. For a discussion of physician advocacy issues, see text and note 87 *supra*. Even if the individual practitioners are not themselves sued, they might be able to sue the facility to enjoin interference in their ongoing relationships with patients.

²⁴¹ MASS. GEN. LAWS ch. 111, § 70E (medical malpractice action allowed under ch. 231, §§ 60(B) to 60(E), for violations of patients' rights statute). Cf. N.C. GEN. STAT. § 131E-123 (private individuals and representatives can institute a civil action for injunctive relief to enforce nursing home patients' rights provision, but provision does not establish standard of care from which a nursing home could be found liable in a private right of action), as discussed in *Makas v. Hillhaven*, 589 F. Supp. 736, 742 (M.D.N.C. 1984); *McCain v. Beverly Health & Rehab. Servs.*, 2002 WL 1565526, at *1 (E.D. Pa. 2002) (abrogating part of *Chalfin v. Beverly Enters., Inc.* and holding that policies expressed in patients' rights statutes and regulations could form basis of negligence per se, even without a private cause of action).

²⁴² Elder abuse protections might apply if life-sustaining treatment is provided in violation of patient preferences because of institutional religious policies against withholding or withdrawing it. For further discussion about explicit remedies/penalties in elder abuse statutes and nursing home patients' rights statutes, see ERIC CARLSON, *supra* note 79, at §§ 10.16, 2.112; Cohen, *Nursing Home Patients' Rights*, *supra* note 79. For examples of nursing home patients' rights statutes with explicit private rights of action for damages, see GA. COMP. R & REGS. rr. 290-5-39-.14 to 290-5-39-.16 (violation of nursing home patients' rights can be challenged through a grievance process set forth in state regulations; resident may file a lawsuit based on violation of rights and may recover damages and attorneys' fees); N.J. STAT. ANN. §§ 30:13-8, 30:13-4.2 (award of actual and punitive damages, plus reasonable attorneys' fees, for nursing facility's violation of patients' rights statute); OKLA. STAT. ANN. tit. 63, §§ 1-1939(A)-(C), 1-1918(F) (upon violation of resident rights, nursing facility subject to award of actual damages, punitive damages, and/or attorneys' fees; specifically grants class action status).

²⁴³ See 31 U.S.C. §§ 3729(a), 3730(d), as discussed in ERIC CARLSON, *supra* note 79, at §10.06[2][b][i].

²⁴⁴ See NCLC UDAP Manual, *supra* note 125, at § 7.2.1.

²⁴⁵ See, e.g., N.Y. EXEC. § 63(12); 73 PA. CONS. STAT. § 201-4.

²⁴⁶ 15 U.S.C. §§ 1116(a), 1117(a).

²⁴⁷ See generally NCLC UDAP Manual, *supra* note 125, at § 8.3.

²⁴⁸ Washington State, for example, awards up to treble damages of actual damages, not to exceed \$10,000. WASH. REV. CODE 19.86.090. Many states with multiple damages provisions limit such awards to cases where intent, willfulness, or bad faith is shown. See generally NCLC UDAP Manual, *supra* note 125, at § 8.4.2.

²⁴⁹ See NCLC UDAP Manual, *supra* note 125, at § 8.1, nn.4-7 (citing cases).

²⁵⁰ See note 125 *supra*.

²⁵¹ See, e.g., CONN. GEN. STAT. § 42-110g(b); N.M. STAT. ANN. § 57-12-10(E); R.I. GEN. LAWS § 6-13.1-5.2(b).

²⁵² See, e.g., GA. CODE ANN. § 10-1-399; LA. REV. STAT. ANN. § 1409; MISS. CODE ANN. § 75-24-15.

²⁵³ See generally Annotation, *Right to Private Action Under State Consumer Protection Act*, 62 A.L.R. 3d. 169 (1975); NCLC UDAP Manual, *supra* note 125, at § 8.5.

²⁵⁴ Public Health Counsel, Resolution Regarding CON Application of Seton Health Systems (Sept. 23, 1994) (on file with NWLC); see also *In re Amelia E. v. Public Health Council*, Verified Petition, No. 7062-94 ¶ 105 (N.Y. Sup. Ct., Dec. 2, 1994) (on file with NWLC) [hereinafter *Amelia E.*, Verified Petition]. Before the merger, Leonard's outpatient clinics provided contraceptive counseling and services including emergency contraception, and referrals for abortion services and surgical sterilization. *Amelia E.*, Verified Petition *supra*, at ¶ 42. For further discussion of this case, see also Boozang 1996, *supra* note 98, at 91, 95; Heather L. Carlson, *Freedom at Risk: The Implications of City of Boerne v. Flores on the Merger of Catholic and Non-Catholic Hospitals*, 17 ST. LOUIS U. PUB. L. REV. 157, 163 (1992); NATIONAL WOMEN'S LAW CENTER, HEALTH CARE PROVIDER MERGERS AND THE THREAT TO WOMEN'S HEALTH SERVICES: USING CERTIFICATE OF NEED LAWS TO FIGHT BACK (June 2002), available at <http://www.nwlc.org/pdf/CertificateOfNeedJune02.pdf>.

²⁵⁵ The woman went to Seton's outpatient clinic to get a contraceptive shot, as she had done for the three previous years, but at that visit, she was told that she could not get the shot or any other contraception at the newly Catholic clinic. Steve Nelson, *Cutting Family Service Hurts Poor, Says Client*, RECORD (Troy, N.Y.), May 16, 1996, at 1. Certificate of Need approval is bestowed by the Public Health Council, an agency that oversees the New York CON process. Amelia E., Verified Petition, *citing* N.Y. Pub. Health Law § 2801. It should be noted that in this case, the plaintiff brought suit against the government agencies that had approved the conditional Certificate of Need, not the health care facility itself.

²⁵⁶ The complaint alleged violations of Medicaid and other regulations requiring family planning services or referrals and regulations requiring that a CON review include an examination of community impact, informed consent laws; and the state constitution, which requires the state to “protect and promote” its citizens’ health. Amelia E., Verified Petition, *supra* note 254 at ¶¶ 7-9.

²⁵⁷ *In re* Amelia E. v. Public Health Council, Memorandum of Understanding Between Seton Health Systems, Inc. and the New York State Department of Health (May 9, 1996) (on file with NWLC). Seton agreed (a) to provide patients who request or may need sterilization and/or contraceptive services with a list of available providers; (b) to make follow-up calls to the providers to whom they refer patients; and (c) to advise patients for whom it is appropriate that pregnancy prevention may be in their best interests and that they may receive natural family planning services from Seton or receive a list of other practitioners from whom they can obtain alternative forms of family planning. As of 2003, Seton is still circulating a brochure entitled “What Every Woman Should Know About OB/GYN” that claims Seton’s women’s health program provides “comprehensive health care services to women of all ages,” but says nothing about its restrictions on reproductive health services. See Seton Health for Women, What Every Woman Should Know About OB/GYN, *available at* <http://www.setonhealth.org/pdf/OBGYN.pdf> (last visited August 8, 2003).

²⁵⁸ These restrictions on care would have the potential to limit options for services to patients of Sharon Hospital that were referred to St. Francis, as well as influence the programs and services available at Sharon Hospital. For example, advocates learned that St. Francis might also run the pharmacy at Sharon Hospital, which could mean that women seeking emergency contraception would be unable to obtain it due to religious restrictions. St. Francis would also participate in the hiring process for doctors and other health care providers at Sharon, and advocates feared that St. Francis would insist on hiring doctors only if they agreed to adhere to the Catholic *Directives*. Finally, advocates were concerned that the relationship between Sharon and St. Francis would inhibit the development of new services at Sharon, such as any new treatments for infertility or other reproductive technology. Telephone Interview with Ruth Pulda, Livingston, Adler, Pulda, Meiklejohn & Kelly PC (Apr. 1, 2003).

²⁵⁹ Press Release, Connecticut Attorney General’s Office, June 29, 2000. The state’s hospital conversion law prohibits the sale of a non-profit hospital to a for-profit entity unless the state attorney general’s office and the state Office of Health Care Access (OHCA) gives prior approval. CONN. GEN. STAT. § 19a-486b.

²⁶⁰ CONN. GEN. STAT. § 19a-486e.

²⁶¹ CONN. GEN. STAT. § 19a-486a. Intervener status allowed advocates to engage in discovery and present evidence during the hearing process and ensured that advocates received copies of all filings and communications among the parties and other interveners during the conduct of the case.

²⁶² See Connecticut Coalition for Choice, Petition to be Designated an Intervenor in the Essent Health Care/Sharon Hospital Conversion Proceedings (Feb. 8, 2001) (on file with NWLC); Connecticut Permanent Commission on the Status of Women, Petition to be Designated an Intervenor in the Essent Health Care/Sharon Hospital Conversion Proceedings (Feb. 8, 2001) (on file with NWLC). The Coalition, the Commission, and others were granted intervenor status on June 29, 2001. See State of Connecticut, Office of the Attorney General, *In re: The Purchase of Sharon Hospital, Inc. by Essent Healthcare, of Connecticut, Inc.*, Docket No. 01-486-01 (Nov. 26, 2001), at 11, *available at* <http://www.cslib.org/attygenl/mainlinks/tabindex6.htm>.

²⁶³ Specifically, this disclosure required “a discussion of any limitations on the scope of services created by the institution’s secular or religious mission... and internal ethical policies or directives.” State of Connecticut, Office of the Attorney General, *In re: The Purchase of Sharon Hospital, Inc. by Essent Healthcare, of Connecticut, Inc.*, Docket No. 01-486-01 (Nov. 26, 2001), at 108, *available at* <http://www.cslib.org/attygenl/mainlinks/tabindex6.htm>. This notice requirement differs from the one proposed in the Attorney General’s October 29, 2001 decision, which stated that Essent and St. Francis would develop an “informed consent document to be read and signed by any patient of Sharon Hospital who is referred for services to St. Francis Hospital.” In this proposed version, the Attorney General specified that “[t]he form must fully and clearly explain all limitations on services and care, including, but not limited to reproductive and ‘end-of-life’ healthcare, that the patient may be subject to by virtue of application of the Catholic *Directives* upon referral to St. Francis.” State of Connecticut, Office of the Attorney General, *In re: The Purchase of Sharon Hospital, Inc. by Essent Healthcare, of Connecticut, Inc.*, Docket No. 01-486-01 (Oct. 29, 2001), at 103, *available at* <http://www.cslib.org/attygenl/mainlinks/tabindex6.htm> (last visited July 16, 2003).

The final notice requirement does not specify the method of providing the notice, but applies to any institution that Essent enters into a relationship with and extends beyond the restrictions required by the Catholic *Directives* to include limitations on the scope of services for almost any reason related to mission or ethical policies. The Office of Health Care Access (OHCA) issued its final decision on October 17, 2001 and a revised final decision after the Attorney General released his decision on November 26, 2001. OHCA’s decisions do not specifically address the notice requirement, but they are not in conflict with, nor do they supercede, the Attorney General’s final decision. See Office

of Health Care Access, Certificate of Need Application, Purchase of Sharon Hospital by Essent Health of Connecticut, Inc., Docket No. 01-533 (Mar. 27, 2002), available at <http://www.ohca.state.ct.us/CONFiles/CONDecisions/01-533dec.pdf>.

²⁶⁴ A certificate-of-need application is required whenever a Connecticut health care facility intends to transfer all or part of its ownership or control, introduce any additional function or service into its health care program, or terminate a health service or decrease its total bed capacity. CONN. GEN. STAT. § 19a-638(a).

²⁶⁵ State of Connecticut Office of Health Care Access, Certificate of Need Application for Essent Health Care, Docket No. 01-553, Testimony of Ruth Pulda on behalf of the Permanent Coalition on the Status of Women and the Connecticut Choice Coalition, March 21, 2002 (on file with NWLC).

²⁶⁶ Office of Health Care Access, Certificate of Need Application, Purchase of Sharon Hospital by Essent Healthcare of Connecticut, Inc., Docket No. 01-533 (March 27, 2002), available at <http://www.ohca.state.ct.us/CONFiles/CONDecisions/01-533dec.pdf>.

²⁶⁷ See Office of Health Care Access, Certificate of Need Application, Purchase of Sharon Hospital by Essent Healthcare of Connecticut, Inc., Docket No. 01-533 ¶ 15 (Mar. 27, 2002), available at <http://www.ohca.state.ct.us/CONFiles/CONDecisions/01-533dec.pdf>. While Essent and St. Francis still propose establishing a tertiary care relationship, including physician recruitment services by St. Francis, at the time this report went to press, Essent was continuing to provide the full range of reproductive health services available at Sharon Hospital; negotiations for an agreement with the University of Connecticut, under which it would provide advanced reproductive health services and end-of-life care that is unavailable at Sharon or St. Francis, were still underway. Telephone Interview with Ruth Pulda, Livingston, Adler, Pulda, Meiklejohn & Kelly PC (Apr. 1, 2003).

²⁶⁸ For more information on this case, see NWLC, CHARITABLE ASSETS, *supra* note 25, at 32-34; NATIONAL WOMEN'S LAW CENTER, HEALTH CARE PROVIDER MERGERS AND THE THREAT TO WOMEN'S HEALTH SERVICES: USING CERTIFICATE OF NEED LAWS TO FIGHT BACK 2 (June 2002), available at <http://www.nwlc.org/pdf/CertificateOfNeedJune02.pdf>.

²⁶⁹ N.Y. NOT-FOR-PROFIT CORP. LAW §§ 510, 511.

²⁷⁰ Letter from JoAnn Smith, Executive Director, Family Planning Advocates of New York State et al. to Jennifer Brown, Director, Reproductive Rights Unit, Office of the New York State Attorney General (Dec. 29, 1999) (on file with NWLC and MergerWatch).

²⁷¹ Notice of Appearance and Affidavit of Attorney General at 2-3, *In re Episcopal Health Serv.*, No. 2000-3327 (N.Y. Sup. Ct. Feb. 16, 2000) (on file with NWLC); *In re Episcopal Health Serv.*, No. 2000-3327, at 3-4 (N.Y. Sup. Ct. Feb. 18, 2000) (order authorizing sale of hospital) (on file with NWLC).

²⁷² New York's Certificate of Need Statute is N.Y. PUB. HEALTH LAW § 2801 *et seq.* As a condition of approving the sale, EHS was required to notify doctors, patients, health plans in which St. John's is a participating provider, and the general public that the sale would reduce the availability of certain reproductive health care services and that the hospital's religious dictates may supercede patients' written requests regarding their end-of-life care. The court also conditioned the sale upon the approval of the New York Department of health. See *In re Episcopal Health Serv.*, No. 2000-3327, at 3-4 (N.Y. Sup. Ct. Feb. 18, 2000).

²⁷³ For more information on this case, see NWLC, CHARITABLE ASSETS, *supra* note 25, at 23-26.

²⁷⁴ Under the proposed transaction, Sutter would be allowed to continue providing tubal ligations, contraceptive services, family planning, and emergency contraception. For more information, see NWLC, CHARITABLE ASSETS, *supra* note 25, at 34.

²⁷⁵ CAL. CORP. CODE §§ 5914 to 5925. Under the regulations implementing the statute, the mandated attorney general pre-transaction review and approval specifically included an assessment of the proposed transaction's effect on access to reproductive health services. CAL. CODE REGS. tit. 11, § 999.5(e)(6)(A). When the Attorney General was reviewing this transaction, these regulations had not yet been formally adopted.

²⁷⁶ See Memorandum from Susan Berke Fogel, Legal Director of the California Women's Law Center; Lourdes A. Rivera, Managing Attorney, NHeLP & Mara Youdelman, Staff Attorney, NHeLP to Women's and Health Advocates (Apr. 16, 2001); Deanna Bellandi, *Reproductive Services Kept in CHW Deal in California*, MOD. HEALTHCARE, Apr. 23, 2001, at 4. Mercy officials felt they could not make these promises because proposed changes in the *Directives* could result in service elimination. *Id.* The Attorney General conditioned his consent to the transaction on Mercy agreeing to submit a plan for his review that would "ensure the continued availability of any such reproductive health service" if a change in the *Directives* resulted in a reduction in reproductive health services. Letter from Bill Lockyer, Attorney General of California, by Mark J. Urban, Deputy Attorney General, to Laurence Dempsey, Assistant General Counsel, Sutter Health (Mar. 30, 2001). The most recent development in this area is passage of a new California law that precludes the seller of a nonprofit hospital from placing restrictions on the types of medical services that the new owners (either nonprofit or for-profit) will be permitted to offer. S.B. 932, 2003-2004 Sess. (Cal. 2003) (to be codified at CAL. CORP. CODE § 5917.5).

²⁷⁷ Letter from Bill Lockyer, Attorney General of California, by Mark J. Urban, Deputy Attorney General, to Laurence Dempsey, Assistant General Counsel, Sutter Health (Mar. 30, 2001). Despite the changes in *Directives*, discussed in the Section I of this report, however, no changes in the delivery of reproductive health care were reported as this report went to press. E-mail from Bethany Leal, California Women's Law Center to Elena Cohen, National Women's Law Center (Apr. 8, 2003) (on file with NWLC).

Truth or Consequences:

Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care



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Certain sectarian health care institutions have long prohibited the provision of reproductive and other key health care services based on religious principles. These entities usually impose the bans on nonsectarian institutions that merge or otherwise affiliate with them. However, women and other health care consumers often do not know about these limitations, and their health suffers as a result.

Federal and state laws can be used to require that health care institutions that restrict services warn consumers about these bans in a clear, accurate, and timely way or face legal sanctions. Use of notice provisions in consumer protection laws to expose these religious bans is largely untested. Nevertheless, these extensive federal and state legal disclosure rules offer significant potential for accomplishing that goal.

Truth or Consequences: Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care is a useful resource guide, designed to provide health care advocates and others seeking to preserve access to reproductive health services with an understanding of how to use the nation's consumer protection laws to challenge institutional restrictions.

The report begins by examining the nature and scope of the problems created by the spread of religious restrictions and the public's unfamiliarity with them (Section I.). Section II describes the four types of laws that can be used to warn consumers about institutional religious restrictions on health care. Section III discusses the strategies advocates can use to expose an institution's notice practices concerning its religious restrictions. The report also contains practical tools, such as a contact information for important governmental agencies and helpful national organizations, as well as a sample letter to the enforcement agencies, to assist advocates in making their case.

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