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## Commentary

# Restoring Christ-centered medicine through public policy changes centered around subsidiarity and the doctor–patient relationship

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*Many Catholic leaders supported passage of legislation designed to achieve the humanitarian goal of universal or near-universal health coverage. These leaders could not imagine that the resulting law would lead to a severe assault on the practice of Christ-centered medicine. The legislative focus now is on conscience protection and making the Hyde Amendment permanent. But the real change that is needed is a culture that values life and puts doctors and patients, not secular bureaucracies, at the center of healthcare decisions. Many new proposals are being offered with the shared goals of expanding access to affordable health coverage, allowing people to make their own choices without oppressive government mandates, helping the most vulnerable, and protecting the right of citizens and medical professionals to live and work according to their religious values and principles.*

*Keywords:* Conscience protection, Hyde Amendment, Healthcare reform, Affordable Care Act, Contraceptive mandate, Affordable health insurance, Health sharing ministries

Fewer than 50 miles apart in the Eastern Aegean Sea lie the islands of Patmos and Kos. Tradition has it that the former was the place of exile of John the Evangelist, author of the fourth Gospel of Jesus Christ. The latter was the birthplace of Hippocrates, the Platonic philosopher whose oath has served for millennia as the basic statement of the ethics of physicians. The proximity of these sites is an historical accident, but the confluence of the heritage they represent is not. Over the millennia the central message of the Scriptures—“love one another; even as I have loved you” (John 13:34)—merged

powerfully with the Hippocratic ideals of the physician as a minder of tradition, grateful learner, defender of life, guardian of hospitality, and protector of human dignity.

Today the practice of Christ-centered medicine is under severe assault. That this assault came about in tandem with the pursuit of a noble ideal—the goal of universal access to health care in an advanced economy—both explains its progress to date and underscores the irony of its failure. The root of this failure lies in its core defect, which is truly a mortal flaw: neither the system the Affordable Care

Act (ACA) reformed, nor the vast scheme of central government mandates and controls that the ACA represents, honored the sanctity of each and every human life and the character of the patient–doctor relationship.

Describing how the American health-care system, with its robust history of voluntary service, religious commitments, and charity care, arrived at the inordinately expensive and conflict-ridden morass that exists today, is beyond the scope of this paper. Much of that history is reflected in valuable work produced by the Catholic Medical Association<sup>1</sup> and thoughtful critics of current policies and practices. One turning point, however, merits mention because of the specific, national rejection of Christ-centered medicine and the Hippocratic tradition it represents.

#### ABORTION AND THE MOUNTING AFFRONTS TO CONSCIENCE

In the majority opinion of the U.S. Supreme Court in *Roe v. Wade* in 1973, Justice Harry Blackmun recounts how the advance of Christianity transformed the Hippocratic oath's 11 sentences into "an absolute standard of medical conduct."<sup>2</sup> His aim was to poison the historic standard of secular medicine—the first principle of "do no harm"—and reinterpret it as a rigid imposition of religion. From that ruling forward, federal and state legislatures and the courts have engaged in pitched battles over legalizing abortion and the boundaries of conscience that might protect consumers, doctors, institutions, public servants, and others from involvement in a practice they deem antithetical to the human good, but that new legal and social thought recast as a civil right.

Abortion is only the leading edge of the conscience issues at stake in health care. It

epitomizes the deepening of the current struggle, however, because of its status as an area where the consensus over four decades has been to protect conscience. Now that consensus is suffering severe erosion. From 1973 to the end of the previous decade, Congress passed numerous conscience clauses to protect actors at every level of the healthcare system (HHS n.d.)—from medical students to hospital-employed physicians, from nurses to insurance companies—and adopted various forms of the Hyde Amendment, the restriction on federal funding for abortion introduced by U.S. Rep. Henry Hyde that has passed in every Congress since 1976. Although the moral analysis of taxpayer subsidies for participation in practices to which a citizen objects differs in important ways from analysis of direct participation, the Hyde Amendment and its companions can be described as taxpayers' conscience clauses. Accelerated by the Affordable Care Act and its manifold mechanisms both to encourage abortion funding and to conceal that funding, and by renewed assaults in law after law and state after state, conscience protections are now squarely in the crosshairs of forces that led the campaign for legal abortion.

The range of conscience assaults is breathtaking and encompasses not only participation in abortion but distribution of contraception and abortifacients, participation in and referral for assisted suicide and euthanasia, and participation in medical procedures related to attempts to alter gender identification. Moreover, the highest court in the land and the federal government are increasingly compliant or dominant in the imposition of these mandates and intrusions (Family Research Council 2016). Examples abound:

- The California Department of Managed Health Care in August 2014 reclassified

abortion as a “basic health service” with the result that all health insurance plans in the state are required to cover elective abortion, including plans provided by Catholic universities and Christian churches. This action resulted in immediate complaints to the Obama Administration’s Department of Health and Human Services (HHS) that the mandate violates the express terms of the Hyde-Weldon amendment, a decade-old federal provision that bars discrimination against any healthcare entity based on its decision not to “provide, pay for, provide coverage of, or refer for abortions.” The Obama HHS deflected the complaints on the finesse that the universities and churches are not “entities” under the amendment and that the insurance companies themselves, which do constitute such “entities,” did not object to providing the coverage.<sup>3</sup>

- The Affordable Care Act contains a mandate for coverage of preventive services that established a process for determining which healthcare services must be provided in all U.S. health plans on a preferred basis, i.e., without coinsurance, co-payments, the application of deductibles, or any other cost to the consumer. As applied by the Obama HHS Health Resources and Services Administration (HRSA), this mandate included contraceptives and drugs asserted by many authorities to have abortifacient properties. Obama HHS regulations implementing the HRSA interpretation allowed only the narrowest of exemption for religious institutions and an accommodation for other objecting entities, including businesses and religiously affiliated institutions. The result to date has been the filing of several dozen suits against the mandate encompassing private corporations, religious non-profits, and non-religious, life-affirming organizations who find the accommodations repugnant to their religious or moral convictions. While some progress has been made in protecting the conscience rights of these organizations, final court decisions have not been rendered and to date full access to contraceptive- and abortifacient-free plans has not been guaranteed.
- In June of this year the Supreme Court rejected a lawsuit by a Washington State pharmacy seeking exemption from a state-passed mandate that it fill prescriptions for Plan B One-Step, a dosing system for oral contraceptive use that the pharmacy’s family ownership believes acts as an abortion-inducing drug. The Court’s 5-3 ruling, which the dissenters labeled “an ominous sign,” let stand a federal appeals court decision that held religious grounds for refusing to comply with the state law did not suffice, even if non-religious grounds for declining to supply the same drug were permissible. Washington State, long in the vanguard of policy to advance abortion, has three times passed through one house a “Reproductive Equity Act” that would require all health insurance plans in the state to cover elective abortion if they cover maternity care. As the healthcare system evolves toward more central governmental control and as cost pressures reduce the number of insurers, the opportunity for individuals, families, and institutions alike to obtain plans or to work with insurers that honor conscience is all but disappearing.
- The State of Vermont Department of Health has published guidance on Act 39, a law that legalized assisted suicide in the Green Mountain State. The guidance asserts that the participation of physicians in assisted suicide is voluntary, but contradictorily, it instructs physicians that individuals seeking information about the practice “must make a referral or otherwise arrange for the

patient to receive all relevant information” ([Vermont Department of Health 2015](#)). This requirement, which purports to protect conscience but in effect sharply limits it, tracks the tendency of enforced participation emerging elsewhere in North America where assisted suicide is advancing ([Wardle 2016](#)).

### ASSAILING THE CORE OF TAXPAYER CONSCIENCE

To these widespread and seemingly accelerating developments must now be added the efforts of a major political party and related organizations to repeal the federal Hyde Amendment. In its present form and variants, the amendment ensures that federal funds do not subsidize elective abortions or underwrite plans, particularly managed care plans for the poor, in which elective abortion is offered. On July 25, 2016, the Democratic Party, for the first time in its history, adopted a national platform explicitly committing the party “to oppose — and seek to overturn — federal and state laws and policies that impede a woman’s access to abortion, including by repealing the Hyde Amendment” ([Drabold 2016](#)).

The impact of such a change would be immense. It would affect every element of the plans created under the Affordable Care Act, including plans for federal employees, exchange-based insurance plans ([Donovan and Grossu 2015](#)), and community health center funds. It would likewise affect every state Medicaid program, the majority of which currently exclude funding of elective abortion using taxpayer dollars. Moreover, due to the ACA and its incentives for Medicaid expansion, the proportion of the public who would have immediate access to publicly funded abortions would rise to levels far above those that prevailed in the 1970s

at the time of the enactment of Hyde and its companion laws. As a recent congressional report pointed out, Medicaid covers nearly 72 million Americans and as many as 98 million in any given year.<sup>4</sup> One estimate by the Planned Parenthood Action Fund is that the ACA made Medicaid coverage available to an additional 4.6 million women of childbearing age ([Planned Parenthood 2016](#)).

### MEASURES TO RESTORE CORE PROTECTIONS

In its comprehensive statement in 2004, the Catholic Medical Association (CMA) recognized that no single measure could repair all of the damage wrought by decades of legal, cultural, and moral battery against the core tenets of Catholic medicine in American society. The CMA Health Care Task Force concluded, “[T]he work of transformation is both gradual and individual. Steps must be taken one by one to reform existing structures and to allay the fears of change that tighten the gridlock of politics and the grip of bureaucracy. Increments of patient–physician–centered, value–driven healthcare reform can and should be applied to every existing program” ([CMA 2004](#)). In the spirit of that exhortation, diverse initiatives to protect conscience and affirm the sanctity of human life are necessary at every level of government and within institutions themselves in the exercise of their charters. Individuals and families, including physicians, must exercise their freedom and informed judgment to re-establish and assert these rights wherever governments or private bodies seek to infringe upon them.

The first initiative is to strengthen rights of conscience at the federal level and to introduce a private right of action to vindicate conscience. Beginning with demands

to participate in acts of induced abortion, conscience protection must ultimately be extended to requirements to engage in the provision of abortifacients and contraceptive drugs and devices as conditions of licensure, participation in commerce, provision of insurance, and other sectors of health care. The Conscience Protection Act introduced in the House of Representatives and passed there by vote of 245-182 on July 13, 2016, reflects what was once a bipartisan consensus in national policy with respect to abortion.<sup>5</sup> While a private right of action provides recourse to the judicial system and its utility there will depend on the make-up of that branch, this mechanism offers the prospect of preserving conscience rights regardless of the vagaries of unresponsive or even hostile bureaucracies. The Catholic Medical Association is leading an effort to encourage a vote in the U.S. Senate on the Conscience Protection Act.

Second, public policy should continue to strengthen and extend the Hyde Amendment, first enacted at the federal level in 1976 and now public policy in 32 states with respect to state as well as federal tax revenue. The necessary federal step is to make the amendment permanent (that is, not subject to annual attachment to departmental spending bills) and to apply it to any and all forms of healthcare financing, including premium-support mechanisms like those in the current ACA and expanded Health Savings Accounts.<sup>6</sup> This approach is generally embodied in H.R. 7 (*No Taxpayer Funding of Abortion and Abortion Insurance Full Disclosure Act of 2015*), legislation approved by the U.S. House of Representatives in 2015 by margins similar to those accorded the Conscience Protection Act (2015).<sup>7</sup>

Adoption of either of the foregoing measures will be difficult. Even more challenging, but of equal import, will be new efforts to reverse the expansion of abortion

funding that has occurred in states that include (typically by state court order) elective abortion in their health insurance programs for the poor. The most aggressive of these states are precisely those in the vanguard of imposing severe conscience limitations and, for example, fresh assaults on the freedom of religious colleges to reflect their teachings on sexual behavior in their practices on student admissions and disciplinary codes (*Adams 2016*).<sup>8</sup> In these ways, it is increasingly clear that efforts to protect the conscience rights of physicians and other healthcare personnel at the core of their practice decisions are ultimately matters of survival for Catholic and other Christian medical and educational institutions.

#### THE ACA: HARM TO THE COMMON GOOD

None of the announced goals of national healthcare reformers—achieving universal coverage, ending actual discrimination in access to or pricing of health care, providing protections for the very sick and others previously subject to denial of coverage, even preferred coverage of controversial practices—required the simultaneous assaults on individual and institutional providers operating on the Hippocratic standard of medical ethics. Indeed, in a system that has historically derived massive fiscal and societal benefit from these ethically driven providers with their living traditions of voluntary service and charity, the assault on their ability to act in keeping with their core tenets is contrary to the goal of expanded and affordable care. Resistance to these impositions is not, therefore, some exercise of social revanchism or moral posturing. It is sound policy in service to the common good.

This discussion has concerned itself primarily with practical limits on an

understanding of medicine as merely a social contract whose worth is solely measured by its universality. This is not the Catholic understanding of medicine, society, or the human person. Conscience protections and funding limits like the Hyde Amendment are necessary but not the summa bona of Catholic moral and social teaching, which at its core is an evangelistic model based in natural law reasoning and the commandments to love God and our neighbors as ourselves. The ultimate triumph of campaigns for conscience will be seen in the disappearance of the need for them and in the appearance of legal and social norms that reflect and respect the true nature of the common good. We seek not safe harbor but the subsiding of the storms that have buffeted Catholic health care and its mission of love to everyone from conception to natural death.

Many Catholic leaders supported passage of the ACA in the belief that it would achieve the stated and humanitarian goal of universal or near-universal coverage for health insurance. Most leaders could not imagine that those advancing the law would break their promise to protect religious liberty and would require that contraception and abortifacients be covered under the law. But dozens of lawsuits against the ACA's contraceptive and abortifacient mandate are testimony to the betrayal of that promise. The law now makes it much more difficult and sometimes impossible for Catholic physicians, nurses, pharmacists, and countless other medical professionals to practice in accordance with their faith.

The law has in fact had serious negative consequences across the range of stakeholders. The ACA has dramatically increased the cost of health care by encouraging mergers and acquisitions, which has led to consolidation in the marketplace, increasing costs due to lack of

competition (Yang 2014). It threatens the very identity of Catholic health care (USCCB 2009). Changes in the way physicians are employed has led to loss of physician autonomy and enabled employers, driven by overbroad and intrusive government rules, including putative civil rights statutes that enforce behavioral ideology, to force compliance even if it violates an individual physician's conscience. The costs of services have increased markedly and the costs to families and individuals have soared due to rising premiums and significantly increased deductibles (Blase et al. 2016). These increases limit patient access to health care, which is morally unjust, as is the law's effect of narrowing provider networks, forcing patients to travel a great distance to find appropriate specialty care while facing even higher out-of-pocket charges.

The law also has reduced the need for charity care by expanding the number of people who are receiving health coverage that is either partially or totally financed through government programs (Badger 2015). But the trade-off again is that government is ratcheting down payment rates to the point that medical practices and facilities will find it increasingly difficult to survive financially. "By 2040," according to the Medicare trustees in their 2016 report, "simulations suggest that approximately half of hospitals, 70 percent of skilled nursing facilities, and 90 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries" (FHI 2016, 194).

Both people who consume healthcare services and those who provide services should be treated equitably under the law. Individuals who have the means should take responsibility for paying the bills they incur, either directly, through the purchase of insurance or, most commonly, some combination of both insurance and

personal funds. Public programs should focus on providing assistance to the most vulnerable and needy. Providers of care, though constrained by Christian charity to help those in need, also have a moral claim to be paid for the services they provide. Health reform proposals that merely shift burdens from consumers to medical professionals and facilities by paying them less than the cost of providing care are both flawed and unsustainable.

### TOWARD A CULTURE OF LIFE: POLITICAL TENSION AND SOUND PROPOSALS

While it is essential to continue to oppose the incursion of the many legislative and regulatory measures that threaten religious providers and institutions, we also must begin the process of changing the culture toward one that respects and protects life. Without a fundamental change in the underlying policies that drive our current health system, Catholics, Christians, and millions of others who value life will constantly be on the defensive in trying to stop the advance of government control over health decisions and the inevitable loss of our right to live and work according to our religious values and principles.

The contrast in political views about this central issue could not be sharper. As noted earlier, the Democratic Party states in its 2016 platform, “We believe unequivocally, like the majority of Americans, that every woman should have access to quality reproductive health care services, including safe and legal abortion—regardless of where she lives, how much money she makes, or how she is insured...We will continue to oppose—and seek to overturn—federal and state laws and policies that impede a woman’s access to abortion, including by repealing the Hyde Amendment” (Democratic Party 2016).

The Republican Party, in contrast, emphasizes in its 2016 platform that, “American taxpayers should not be forced to fund abortion...We call for a permanent ban on federal funding and subsidies for abortion and healthcare plans that include abortion coverage.” It also emphasizes that, “America’s healthcare professionals should not be forced to choose between following their faith and practicing their profession...We support the ability of all organizations to provide, purchase, or enroll in healthcare coverage consistent with their religious, moral, or ethical convictions” (Republican Party 2016).

The good news is that many public policy initiatives are being offered that would move toward a culture that values life and puts doctors and patients, not secular bureaucracies, at the center of healthcare decisions.

The Catholic Medical Association offered its own reform proposal, “Health Care in America: A Catholic Proposal for Renewal,” in 2004, which showed that the serious problems in our health system long predate the ACA and simple repeal of the law will do nothing to change the underlying momentum of our health sector toward greater and greater collectivism and more and more loss of individual freedom (CMA 2004). The CMA subsequently has taken positions on many proposed health reform efforts. This overview from the CMA website distills the core principles from the organization’s statements:

1. “While health-care financing and delivery systems in the United States suffer from significant flaws impacting cost and access which have accumulated over the years, the entire system is not broken. Reform legislation should address specific issues; not on replacing or overhauling the entire health-care system at one time.

2. “While attention is rightly paid to the socio-economic aspects of the crisis in health care and delivery, it is essential to acknowledge and respect the fundamental ethical principles at stake. Above all, it is necessary at this time to ensure that any national health-care reform legislation provides respect for human life (e.g., by not funding or mandating abortion as a ‘health-care benefit’) and respect for the conscience rights of health-care professionals (e.g., providing nothing less than the current protections in federal and state law—and preferably more).
3. “Health-care reform legislation must respect the integrity of the physician-patient relationship. This means that people should be free to choose physicians and health insurance coverage which accord with their values and needs. This also means that physicians must not be prevented—by the force of government regulations—from respecting their patients’ privacy or from offering the attention and treatments patients require based on the physician’s professional judgment.
4. “Ancillary (but significant) Issues. Any healthcare reform legislation must be carefully monitored to ensure that interest groups do not take the opportunity afforded by comprehensive legislation to insert provisions that harm the dignity of individuals or the family or that inappropriately serve the agenda of a particular group or ideology.” ([Catholic Medical Association n.d.](#))

In addition, many detailed proposals have been offered by members of Congress and public policy research organizations that would protect religious and ethical values. Their common goals are expanding access to health coverage, making care and coverage more affordable, and expanding the ability of people to make their own

choices without oppressive government mandates. They are organized around what Catholics call the principle of subsidiarity—devolving decisions to the level closest to the individual and the family. Underlying their plans is the belief that individuals and families can make choices about the care and coverage that works for them rather than having their “choices” dictated by government officials.

The most recent and one of the most comprehensive health reform proposals was offered in June of 2016 by House Speaker Paul Ryan on behalf of the Health Care Reform Task Force, made up of four leading committee chairmen and many members serving on key committees in Congress. The “Better Way” plan they offered starts with the premise that, “Americans deserve an accessible and affordable healthcare system that promotes quality care and peace of mind” ([better.gop 2016](#)). The House leadership’s plan would extend coverage options to those who do not have access to insurance through their jobs and to those who do not qualify for existing public programs and would lead to many more choices in insurance coverage. Those on Medicaid could choose private insurance, and Medicare would be strengthened and improved so it will be there to provide coverage for senior citizens in the future.

Some proposals are sponsored by leading committee chairmen from the House and Senate. Sen. Richard Burr, Sen. Orrin Hatch, and Rep. Fred Upton introduced the “Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act” in February of 2015 ([Burr, Hatch, and Upton 2015](#)). Rep. Tom Price and Sen. John McCain introduced the “Empowering Patients First Act” (2015) in 2015. And last year Rep. Phil Roe introduced on behalf of himself and the House Republican Study Committee the “American Health Care Reform Act of 2015” (2015). All of these legislative

proposals would support greater freedom for individuals and conscience protection for healthcare providers to be able to practice medicine while adhering to cherished religious values.

A number of public policy research organizations, sometimes called “think tanks,” also have developed comprehensive free-market health reform proposals. Joseph A. Antos from the American Enterprise Institute (AEI) and nine colleagues from AEI and other leading think tanks offer specific and detailed reform proposals in their plan, titled “Improving Health and Health Care: An Agenda for Reform” (Antos et al. 2015). Like many of the other conservative plans, they offer policy prescriptions to achieve shared goals of health reform—such as making sure people will not lose their coverage or face soaring premiums if they get sick—but without the heavy rules and freedom-crushing mandates of the Affordable Care Act.

Health policy expert Avik Roy wrote, for the Manhattan Institute, a plan titled “Transcending ObamaCare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency” (Roy 2014). And William Kristol and Jeffrey Anderson developed a reform plan, “A Winning Alternative to Obamacare,” for the 2016 Project (Kristol and Anderson 2014).

Other plans offer policies and principles for reform. “How to Get a Health Care System That Answers to the Patient” was published by the Heritage Foundation in 2014, and the Conservative Reform Network produced a monograph on “Replacing ObamaCare with Consumer-Centered Health Reforms,” released in February of 2016 (Turner 2014, 2016).

These policy prescriptions take a markedly different approach to reform, but with the same goals of expanding coverage, making care and coverage more affordable, protecting the most vulnerable,

and putting doctors and patients at the center of healthcare decisions. They show that there are serious and developed alternatives to the Affordable Care Act and that the choice is not between doing nothing and encroaching government control that robs individuals and medical professionals of their right to live and work according to their conscience.

### THE CORE CONCEPTS OF “COMMON-GOOD HEALTH CARE”

Many of these reform plans share key elements, largely centered around financing and regulatory flexibility:

- Repealing federal mandates that dictate what medical services must be covered by health insurance
- Providing refundable tax credits to support the purchase of health insurance by people without employer coverage or eligibility for publicly financed health programs such as Medicaid and the Children’s Health Insurance Program
- Giving people more choices of insurance by encouraging genuine competition
- Devolving regulation of health insurance to the states where citizens can more actively influence the public policy process
- Eliminating the mandate that individuals purchase government-sanctioned health insurance and replacing it with “guaranteed renewal” that assures people they will be able to keep their health insurance as long as they maintain continuous coverage and thereby will be protected from being rejected for pre-existing conditions
- Encouraging cost transparency, competition, and choice in health insurance and medical care
- Allowing individuals and providers to follow their religious beliefs in their lives and livelihoods

## SOUND POLICY: PUBLIC AND PRIVATE EXAMPLES

But are these ideas tested? The answer is yes. Here are a few examples of public sector programs:

In 2003, Congress passed and President George W. Bush signed the Medicare Modernization Act (MMA) that created two programs based upon the principles of consumer choice and competition.

First came Health Savings Accounts (HSAs). These accounts allow people to put aside money tax free that they can use to purchase routine health services as long as they are protected by a “catastrophic” health insurance policy that would protect them against larger bills. In a competitive market, the premiums on these high-deductible policies are lower, and people can put the money they save into their HSAs. The money is theirs and rolls over, with interest, every year. Preventive services also can be covered under the insurance contract.

Nearly 20 million people currently have HSA-qualifying health insurance policies and have invested more than \$33 billion in their accounts. Many more Americans likely would have these accounts if the ACA and the Obama administration were not trying to thwart them with regulations that make them much less attractive or even unavailable to some citizens (Braverman 2016).

The MMA also created a prescription drug benefit for Medicare, called Part D, that was based on consumer choice and competition. This broke from Medicare’s traditional model of deciding what services seniors would be eligible to receive and how much providers or suppliers would be paid. Instead, Part D set basic standards and allowed private plans to compete in offering the best benefits for the lowest prices. Seniors could choose the plan that works best for them.

The result has been remarkable. More than nine out of 10 seniors say they are satisfied or highly satisfied with their Part D benefit (Jackson 2012), and the program is saving seniors and taxpayers money. In 2004, the Medicare trustees had estimated that Medicare beneficiaries would pay an average of \$61 a month for their Part D benefit by 2013. Instead, the average premium has remained steady at about \$30 a month for the last several years. And the Part D program has saved taxpayers money as well. In 2003, the Congressional Budget Office projected that net federal spending for the Medicare Part D prescription drug program would be \$99 billion in fiscal year 2013; actual spending was \$50 billion, or nearly 50 percent less than anticipated (USCBO 2014).

Finally, the Medicare Advantage program allows seniors the opportunity to select a private health plan to cover their medical needs rather than rely on Medicare’s traditional fee-for-service program that often leaves seniors exposed to high co-payments and potentially large medical bills. Plans compete to offer seniors the best value at the lowest cost. Today, nearly 20 million seniors have voluntarily enrolled in these private Medicare Advantage plans for the cost savings and the more comprehensive care they provide.

There are a number of examples where this works in the private sector as well, such as: *Direct primary care*: Some physicians have stopped taking health insurance and instead charge patients a flat monthly or annual fee or accept direct cash payments for services. Most find they can see patients for less because they spend much less time justifying their treatment decisions to outside payers and battling for (delayed or denied) payments. And because they are dealing directly with their patients, they do not face outside mandates that can violate their ethical and religious beliefs.

For example, Dr. Lee Gross and colleagues founded Epiphany Health, a membership-based primary care program that provides the basic essentials of routine health care for a flat monthly fee.<sup>9</sup> They operate on the principle that routine medical care is not an insurable but a routine expense. Patients pay an affordable flat monthly fee, no co-payments, no deductibles, and no pre-existing condition exclusions, and they have a direct patient–physician relationship not influenced by outside forces.

A growing number of patients are also opting to “self pay,” asking physicians, laboratories, diagnostic clinics, and even hospitals for discount prices if they pay directly and, often, in advance. Many providers will offer more affordable services when they operate outside of the third-party payment system.

Health Care Sharing Ministries: Several hundred thousand committed Christians are joining together to share the costs of medical expenses and provide prayer and moral support through cards, letters, and other volunteer services. Members can live consistently with their beliefs by joining with fellow believers to receive financial support for their medical expenses through this non-insurance approach of organized sharing of medical bills. That means that members are not forced into insurance policies that pay for abortions, abortifacient drugs, and services that violate their beliefs. A specific provision was included in the ACA to allow people who participate in health care sharing ministries to be in compliance with the law’s individual mandate.<sup>10</sup>

The largest organization in the Alliance for Health Care Sharing Ministries<sup>11</sup> is Samaritan Health Ministries.<sup>12</sup> Every month, the more than 61,000 households with 200,000 people share more than \$17 million in medical needs directly—one household to another. The monthly share for a family of any size has never exceeded

\$405, and is less for singles, couples, and single-parent families.

Members themselves will often negotiate with medical providers and facilities for cash-only prices, often receiving large discounts that, in turn, help their fellow ministries participants (Hamilton 2016).

Competition and consumer choice work in health care if there is genuine competition among plans and providers and if consumers are allowed to purchase plans that meet their needs. Consumer protections are needed but not to the point that these market forces are suffocated, as they are under the ACA.

Universal coverage is possible when subsidies are targeted to those who need them to purchase coverage and if incentives are reset so that people have more coverage options that are attractive and affordable. And most importantly, when people are able to make their own choices, apart from government dictates through legislation and regulation, they have the freedom to choose health coverage that comports with their values and religious beliefs.

## NOTES

- 1 The resource pages of the web site maintained by the Catholic Medical Association contain a wide variety of articles and statements that record the history of service to society performed by Catholic healthcare institutions. <http://cathmed.org/resources/>. See also Condit (2012).
- 2 Csank (1977, 85), citing *Roe v. Wade*, 410 U.S. 113 (1973), pp. 131-132.
- 3 The full text of the Hyde-Weldon Amendment, enacted in the annual HHS spending bill since December 2004, can be found at [http://www.hhs.gov/sites/default/files/ocr/civilrights/understanding/ConscienceProtect/publaw111\\_117\\_123\\_stat\\_3034.pdf](http://www.hhs.gov/sites/default/files/ocr/civilrights/understanding/ConscienceProtect/publaw111_117_123_stat_3034.pdf).
- 4 [better.gop](http://better.gop) (2016, 23). A statistical review of Alaska’s Medicaid expansion by Michael New, Ph.D. concluded that it

- would place an additional 10,000 to 15,000 women of childbearing age on a program that funds elective abortion and pays for a high percentage of abortions performed there. See New (2015). Seventeen states currently pay for elective abortion via their Medicaid program (Kaiser 2015).
- 5 H.R. 4828, introduced on March 25, 2016, in the 114<sup>th</sup> Congress by Rep. John Fleming (R-La); at <https://www.congress.gov/bill/114th-congress/house-bill/4828/actions>.
  - 6 The need to apply the amendment to health savings accounts (HSAs) or proposed variants is acknowledged, fortunately, in the recent report produced for the House Republican Caucus (better.gop 2016, 14).
  - 7 Introduced on January 21, 2015, and approved in the House of Representatives by a vote of 242-179 on January 22, 2015.
  - 8 While the California legislator who first introduced this measure modified it substantially in August to preserve a religious exemption, he did so only under intense pressure from religious leaders and with the promise of active state monitoring of the way in which religious colleges interpret and apply their teachings on sexual behavior (Gryboski 2016).
  - 9 <http://www.epiphanyhealth.org/>.
  - 10 This complies with the ACA, U.S. Public Law 111-148, requirement that most individuals must have health insurance or pay a penalty-tax (see 26 United States Code Section 5000A, (d), (2), (B)). Members of healthcare sharing ministries demonstrate their exemption by using IRS Form 8965 when filing their tax return. A comprehensive evaluation of the advantages of the leading healthcare sharing ministries, analyzing their recent growth, was carried out by the Charlotte Lozier Institute. See Daniels (2015).
  - 11 <http://www.healthcaresharing.org/>.
  - 12 <http://samaritanministries.org/>.
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## APPENDIX

### Key Questions Catholics Must Ask of Healthcare Reform Proposals

Proposals to advance life-affirming, conscience-protective, and socially responsible reforms of the current U.S. healthcare system take many forms. There are core questions that must be asked, however, to assess whether the plans will both protect religious values and also achieve the necessary goals of health reform. We offer 21 questions as a guide:

1. Does the proposal respect the sanctity of human life, especially the sanctity of those at the dawn of life and the twilight of life (i.e., from conception to natural death)?
2. Are people free to choose healthcare arrangements that comport with their values, religious beliefs, and consciences?
3. Are individuals encouraged to take responsibility for themselves and their families so that resources are available to care for the most vulnerable among us?
4. Does the proposal permit individuals and families to associate and acquire coverage based on shared values, behaviors, and belief systems?
5. Does the proposal provide comprehensive respect for conscience—of individuals and employers as purchasers of insurance, of hospitals and clinics as providers of care, and of physicians and other providers as deliverers of services?
6. Does the proposal support marriage and the family as the cornerstone of civil society? Does it penalize family size?
7. Does the proposal encourage people to help the less fortunate among them through charitable services?
8. Are people able to choose plans that include the physicians, hospitals, and other healthcare providers of their choice?
9. Does the proposal keep healthcare decision making accountable by vesting the maximum authority possible in non-governmental and governmental units closest to the people and accessible to citizen participation in policy determinations?
10. Does the proposal facilitate overall affordability of care and coverage?
11. Does the proposal place extraordinary burdens on future generations to pay for

- today's spending, compromising their ability to achieve their potential as productive members of society?
12. Are people secure in knowing that they can keep the health plans and healthcare arrangements of their choice?
  13. Are people with pre-existing conditions able to obtain coverage?
  14. Does the proposal avoid discrimination based upon genetics or disability?
  15. Does the proposal encourage a market for insurance products and other healthcare arrangements that allow individuals and families to obtain coverage that meets their needs?
  16. Does the proposal respect the doctor–patient relationship by allowing sufficient time for doctor–patient interaction, fostering continuity of care, and appropriately respecting patient confidentiality?
  17. Does the proposal afford the physician sufficient income to allow him or her to decide the best mode of practice, including independence as a family or community provider?
  18. Does the proposal tend toward universal coverage and does it do so by making care and coverage affordable, without resorting to mandates on individuals and families to purchase any specific product or service?
  19. Is the proposal rooted in a definition or understanding of health that is grounded in a full recognition of the worth of every human being and not in a collective understanding that the community is valued over the individual?
  20. Does the proposal foster growth in the number of insurers and competition among them as a means both to protect subsidiarity and to prevent waste of resources and exploitation of the insured population?
  21. Do government financing mechanisms afford individuals and families maximum provider choice and treat taxpayers equitably in exercise of that choice?