Heritage Lectures

Published by The Heritage Foundation

No. 850
Delivered June 24, 2004

August 24, 2004

Why It's Time for Faith-Based Health Plans

Phyllis Berry Myers, Richard Swenson, M.D., Michael O'Dea, and Robert E. Moffit, Ph.D.

PHYLLIS BERRY MYERS: Good afternoon. I am Phyllis Berry Myers, Executive Director of the Centre for New Black Leadership. Thank you for joining us. Our presenters will be Dr. Richard Swenson, Mr. Michael O'Dea, and Dr. Robert Moffit.

Dr. Swenson received his M.D. from the University of Illinois School of Medicine. He is currently a researcher, author, and educator. As a physician, his focus is cultural medicine, researching the intersection of health and culture. As a futurist, his emphasis is four fold: the future of the world system, society, faith, and health care. He is the author of six books, including the bestsellers, *Margin: Restoring Emotional, Physical, Financial, and Time Reserves to Overloaded Lives* and *The Overload Syndrome*. He has written and presented widely, including both national and international settings. He is a frequent guest on *Focus on the Family Radio*, and his programs are some of Focus's most popular broadcasts. In 2003, Dr. Swenson was awarded the Educator of the Year Award by the Christian Medical and Dental Associations. Dr. Swenson and his wife, Linda, live in Menomonie, Wisconsin.

Michael O'Dea is founder and Executive Director of the Christus Medicus Foundation, a not-for-profit organization focused on reclaiming Christ-centered health care by reforming corporate and public policy to allow God's people a conscientious choice in selecting health insurance. Mr. O'Dea was formerly president and CEO of the Value Sure Corporation, a unique management resource and benefits consulting firm specializing in pro-life health care. Mr. O'Dea is

Talking Points

- Most people today do not really know what is in their health plans, and many times they do not even know what is being paid for—particularly when it comes to issues regarding abortion.
- In the interest of freedom, policymakers should oppose personal mandates; reform Medicaid and other government insurance programs; and enact parental consent laws.
- A change in the insurance market, coupled with changes in the tax code and the establishment of equity in health care options, could revive faith-based institutions providing health care benefits and faith-based health care delivery.
- Persons should be free to join plans that respect their ethical, moral, or religious values.

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/hl850.cfm

Produced by the Center for Health Policy Studies and the Centre for New Black Leadership

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, D.C. 20002–4999
(202) 546-4400 • heritage.org

an MBA graduate from the University of Detroit. He entered the United States Army in 1967 as a private, attended officer candidate school, and was commissioned in 1968. He served in Vietnam, where he was awarded the Bronze Star.

Dr. Robert Moffit is the Director of The Heritage Foundation's Center for Health Policy Studies. He is a 25-year veteran of Washington policymaking, a former senior official at both the U.S. Department of Health and Human Services and the Office of Personnel Management (under President Ronald Reagan). He specializes in Medicare reform, health insurance, and other health policy issues. Bob received his B.A. in political science from LaSalle University in Philadelphia and his Ph.D. from the University of Arizona.

DR. RICHARD SWENSON: Our health care system is changing in historically unprecedented ways. This is not new to many of us. The dominant change is out-of-control health care costs. There are probably 20 systemic problems that we are facing right now. Our health care system is the best that history has ever seen, but it is besieged by problems.

Most prominently, our system is besieged by increasingly higher costs. Currently, we are paying $1.6 trillion. We are adding $120 billion per year to the health care bill. This is unsustainable. Federal authorities predict that by the year 2012 it will reach $3.1 trillion. However, it will not, because it cannot. It is impossible, and something is going to happen between now and then.

The cost curve approximates an exponential curve. Very seldom do peoples' intuitive abilities penetrate these exponential cost increases. A physicist once said, "The greatest shortcoming of the human race is their inability to understand the exponential function." Now, I would say there are other shortcomings of the human race that exceed that, but, nevertheless, most ordinary people do not understand vertical curves. They are very dramatic and they are very sudden.

Why is the cost of health care going up? Let me summarize it this way: *There are more and more people living longer and longer with more and more chronic diseases, taking more and more medications that are more and more expensive, using more and more technology with higher and higher expectations, in the context of more and more attorneys.* All the convergences are simultaneous and the math is exponential. If you do the math, you will see that nothing is self-correcting.

Much of the rising cost that you see is attributed to the *success* of our health care delivery system. Let's look at the components of this:

- *There are more and more people*. That is not necessarily bad; that is good. Some of my best friends are people.
- *People are living longer and longer.* That is good, too. Two thousand years ago, the average life expectancy was 21 years. In 1900, it was 47 years. Now it is 77 years. That is an exponential curve. It also represents a success of our health care system.
- *There are more and more chronic diseases.* One hundred million Americans have some kind of chronic disease. People used to die of these diseases. They do not die of these conditions anymore, largely because of our health care system.
- *People are taking more and more medications.* New medicines are very expensive, but they do keep people alive. They get them out of the hospital sooner and they keep them from needing to go into the hospital.
- *People have higher and higher expectations.* Our higher and higher expectations are something that we probably need to do something about. Yet we have them.
- *We have more and more attorneys*. In terms of attorneys, litigation, and medical malpractice, the American Medical Association says that its largest legislative priority is the 19 states that are right now in crisis of existing medical malpractice laws: 25 additional states are poised on the brink of crisis.

A New Consumer-Choice Model

We will hit a tipping point, probably sooner rather than later. When that happens, we are either going to go to a single-payer health care system or do "something else." Single payer is politically diffi-

cult for many reasons. It is a possibility, but I would say it is politically difficult. It is not optimal. "Something else" is optimal, and not as politically difficult.

The "something else" is what I would like to see. I believe that the "something else" model is the faith-friendly model—a private-sector, consumer-choice, defined-contribution model. I believe that our health care future will be, and can be, faith friendly. The opposite is not as faith friendly.

What are the rationales and predicted beneficial effects of this consumer-based model? First of all, we have history. We have a long history of churches and religious organizations that date back millennia in terms of health care—starting hospitals, medical schools, clinics, and missions across the world helping the needy, the infirm, the elderly, and the sick.

This model also promises superior performance. Peter Drucker, the nationally renowned management expert, makes the case that the volunteer sector—there are 2 million volunteer agencies in the United States today, including faith-based organizations—has a track record that works. It exceeds the track record of the public sector (government) or the private sector (business).

Equally important, the relationship between voluntary faith-based health plans and the delivery systems is, and should be, a natural development. Faith equals health. There are now over 1,000 studies that investigate the link between faith and health. Almost all show a positive association. Therefore, one could make the case that faith equals health. This is not rote, once-a-year faith, but intrinsically meaningful faith that translates into good health benefits. The savings may be around 25 percent. I once asked the late Dr. David Larson about this, and he said it was possibly as high as 75 percent. I would never go that high, but, nevertheless, we could see real savings there.

Pre-existent Natural Synergies

Let me spend some time on the pre-existent natural synergies between the mission of faith and the needs of a health care system.

- First, churches are a center of community. Maybe they are the last remaining centers of community in America. You need a tradition that stretches into the past with durable, stable relationships in the present and a shared vision for the future. Churches have that.
- Second, churches are already helping the ill. Already you have parish nurses. Many churches have been experimenting with this concept. You also have church assistance with hospital visits or post-surgical care. Sadie, who is 85 years old, needs cataract surgery, and her extended family is 1,000 miles away. She just comes and stays at our house for two days. Churches do it all the time.
- Third, faith-based organizations can provide meals during sickness, respite care, retirement homes, assisted living, nursing homes, hospice for the dying, prescription plans, prayer, and credibility. They also provide care for the poor and even help for the uninsured. It goes on and on and on.
- Finally, they also offer dependable and secure bioethical standards. We will be talking about that today.

The Single-Payer Health Care Model

Let's look at the predicted adverse effects of a single-payer system on both faith and freedom. I don't want to be too one-sided about this and say that a single-payer system would be automatically hostile to issues of faith. Yet I do believe there is enough of both theoretical and practical evidence to suggest that it would be very problematic.

First of all, we are a wildly pluralistic society. I do not believe we used to be as pluralistic in the past, but we clearly are today. This has profound consequences. The cultural and moral polarization that we see today is actually quite extreme. Meanwhile, we are poised on the threshold of a whole host of ethical conundrums that are going to hit us all very soon—within the next 10 years.

Here is a question for Congress and federal policymakers. Why in the world would the federal government want to set itself up as the arbiter of these inescapable ethical decisions, knowing that no matter what decisions they make, they are going to alienate certain large segments of their constituencies?

Some of the decisions that a single-payer system would require would certainly violate the tenets of one faith tradition or another. Certainly, I would expect that many of my most deeply held faith beliefs and doctrines would be violated by such a monolithic structure.

Consider *Roe v. Wade* and its aftermath. It has been suggested by some commentators—Peggy Noonan most recently—that perhaps our "culture wars" started in 1973 with *Roe v. Wade*. The public policy debate on abortion then was not taking place on the cultural level (leaving years to be worked out through public debate and discussion); instead, it was imposed.

Would you want *Roe v. Wade* 20 times over? That is what I am suggesting we would be facing in a government-run health care system.

The Bio-Ethical Challenge

We have already touched on abortion. Yet partial birth abortion to me supercedes any other ethical marker. It does not need to go any further than that. As a physician, I have delivered many babies. What does partial birth abortion entail? This may be a nine-month baby, totally healthy. Yet the abortionist holds the head in the cervix, and he punctures the skull and sucks the brains out. However, we cannot decide as a nation today that this is morally wrong.

That tells me something about where we are as a nation today with regard to making moral decisions. I am not sure that I really want to trust all the other upcoming major moral decisions to a national governmental health system that cannot make a judgment on this one.

Just consider some of the other issues:

- **Assisted Suicide.** Oregon is the only state in which assisted suicide is legalized right now. Just recently, you saw the courts overturn the Justice Department's objection to this practice. The Justice Department was saying, "No, the doctors there cannot use medicines to kill their patients." It will not be long. Other states will follow Oregon.
- **The Challenge of the Elderly.** What are we to do with the elderly? We face a whole set of new challenges, particularly in dealing with the elderly. Financing and delivery of care for the growing number of elderly is already a very difficult issue. Thus far, it has not been solved in a socially or fiscally stable manner. Yet in the future, we are going to have our grandmothers taking care of their grandmothers. We are going to have super-longevity. By the year 2030, we are going to have a doubling of the seniors, and each senior is going to be spending twice as much in Medicare dollars as he or she does today. Those are real dollars. In other words, by 2030, we will have four times as much spending. Given such economic pressures, assisted suicide is going to happen, but not in my health care system—not in the one that I want to join.
- **Stem Cell Research.** Stem cell research has been in the front of the news for a long time. It is very difficult for us to make a decision about that. There are some ways to explore embryonic versus adult stem cell research. If we do adult research, and we use non-federal spending, then we could pursue a lot of work and perhaps make some real progress in an ethical way. Yet many politicians want the federal spending and they want that funding for embryonic research.
- **Prenatal Screening.** There are 35,000 genes in the human genome. We now can get portions of the baby's genetic imprint by chorionic villus sampling done between eight and twelve weeks of gestation. We have also found ways of maximizing the recovery of fetal DNA in the mother's bloodstream. In addition, very sensitive sonograms can now tell us things about that fetus at eight to 12 weeks.

  Consider: There are 4,000 single-gene inherited defects. Out of 35,000 genes, there are 4,000 diseases that are defective in only one gene. They are, for example, cystic fibrosis, Tay-Sachs disease, Duchenne's muscular dystrophy, and sickle cell anemia—just to name a few.

  If you are going to get a gene imprint of that baby at eight or 10 weeks, and you have a federal system with some rationing in place, and you find out that this child has a gene that would predispose her for Alzheimer's or prema-

ture coronary vascular disease or breast cancer, the government officials might tell you, "Well, you can go ahead and have the baby. We are not saying that you cannot have the baby, but we would have to exempt this baby from our government insurance program because it is going to be very expensive. As a nation, we cannot foot that bill." That would be a very difficult situation. It is not unlikely. On the front page of the June 20 edition of *The New York Times*, reporter Amy Harmon writes about the "agonizing" personal choices that result from finding fetal defects through early genetic screening.

- **Pre-Implantation Genetic Diagnosis.** Maybe there has been a genetic problem in the family. Therefore, what they do is take eggs from the mother and sperm from the father. They create maybe eight embryos in a Petri dish. Then they do genetic testing on all of those and find out which ones to implant. If that is to avoid genetic problems, maybe that is one rationale. Yet what if they are starting to look for genes for I.Q. or genes for athletic performance or genes for eye color? This is getting into eugenics.
- **Human Genome Project.** The Human Genome Project has been a spectacular success in so many ways. Dr. Francis Collins said this research should not, however, be used for cloning or for trait optimization. Yet, obviously, at some point, it will be used for cloning and trait optimization. In a recent issue of *The Futurist* magazine, authors speculate: "What parent is not going to want to use this to increase the I.Q. of their child, or maybe to change the hair coloring, or the eye coloring; or"—get this—"the skin coloring, or to add height?"
- **Gene Therapy.** Gene therapy has been disappointing so far, but later on, it will be more successful. If you can do gene therapy and solve the problem of cystic fibrosis, who could be against that? Yet where do you stop? Where do gene therapy, genetic manipulation, and genetic engineering stop? How do you stop short of eugenics?
- **Rationing of Care.** There is simply too much need in America, as long as you define "need" broadly—not just critical need, but non-critical need, elective need, cosmetic need, and hypochondriacal need. The needs greatly exceed what we could possibly deliver in terms of the resources required to meet them. Therefore, there will be rationing. There will be some form of "managed care." There will be some medical priorities that have to be established. Who is going to decide what kind of rationing system we will have? Who is going to define exactly who gets the care and who doesn't? I think that kind of decision is much more sensitively handled if it is in a voluntary, private, faith-based scenario.
- **Creating Life.** This is no joke. Some researchers are attempting to do this with single-cell organisms of 350 genes: They are attempting to create life.
- **"Post-human" Species and Transhumanism.** "Post-human" species are being talked about, and it will probably happen. There was a major 2003 conference at Yale University, and the closing keynote address for the "Transhumanism" conference was, "Who's Afraid of Post-Humanity? The Politics and Ethics of Genetically Engineering People."
- **Transgenic Species and Chimeras.** Researchers have already mixed pigs with humans, and sheep with humans. The reason they are doing this is to try to create a species to be used for transplantation. You could use the "pig" liver, for example. They found some very interesting results. They had some totally normal pig cells, some totally normal human cells, and the others had very strange mixtures of DNA—human and pig together. Incidentally, they also speculated that this might be an entry point for some viruses, such as HIV.
- **Germ Cells.** These will change the genetics and the genetic pool of the human species that follows.
- **Reproductive Options.** There are now 25 different ways to make a child. Just recently researchers created an embryo without any male genes whatsoever.

- **Resurrections from the Dead, or Giving Birth to Yourself.** A bull in Japan sired 350,000 calves. They decided to clone this bull. They made six clones of this bull and one of the clones has now been cloned. Now you have some immortality. If bulls, why not humans?

I think you have a sense that we are on the threshold of a whole host of cascading ethical dilemmas. We need consensus at a time in which we really do not have national consensus. In the meantime, the practical impact of these issues on our personal lives would be much better handled if it were done in a situation in which each person could affiliate with an affinity group that would carry their own insurance. They could have reliable bioethical standards.

MICHAEL O'DEA: I have been in the health care business for 34 years. What we pay for is what we get in health care, and I am going to demonstrate that. I want to go back to 1987. That is when I actually got involved in this struggle. My wife and I run a pregnancy center. I have done a lot of work with young teenagers who find themselves pregnant.

Through counseling one young lady, her mom told me that financing was not a problem, because whether they had the baby or whether it was aborted, their insurance would pay for it. It knocked me out of my seat when I heard that. From that day, I have been trying to find out why our health plans are subsidizing and promoting a culture of death.

When I started my work, some people I ran into in Chicago handed me a health plan that the National Organization for Women (NOW) put together. In this health plan information, there was data showing that NOW testified before Congress in favor of an "economic equity" act for women. In this proposed plan, there was coverage regardless of marital status or sex, coverage for elective abortions, and coverage for surgical and non-surgical birth control. If we just think about that today, that has become the standard health plan in our country.

The current health care culture was shaped by the Alan Guttmacher Institute, along with partners in the private industry, government, and insurance industry. Their objective was to have abortion services, contraceptives, sterilization, and infertility services included in regular health insurance and they have accomplished a very significant part of this.

The Loss of Parental Control

In 1993, we entered a great debate about health care reform under the Clinton Administration. There was the push for national health care. Yet even back in 1993, 86 percent of all types of typical plans routinely covered tubal ligation and at least two-thirds covered abortion services when considered "medically necessary or appropriate" by the health care provider. If you look at the data on health maintenance organizations (HMOs), they are more likely to have billing and claims processing procedures that allow spouses and non-spouse dependents, such as teenagers, to obtain "confidential" reproductive health service. As early as 1993, between 64 percent and 71 percent of HMOs were already providing "confidential" abortion coverage. You can imagine how that has undermined parents and the impact it has had on corrupting our children and destroying the family.

Analysts at the Alan Guttmacher Institute then said that this coverage for abortion and other such "confidential" services was uneven and unequal. They said that it was not enough. There should be 100 percent coverage for all reproductive services, all dependents, and at any age—and no parental involvement in it. You had preventive programs without deductibles and co-pays to assure that "confidentiality"; therefore, parents or spouses could not be even involved in the process.

The Clinton Administration, of course, wanted to require abortion coverage in its proposed nationalized standard health care plan. As we all know, that 1993 Clinton health care reform package did not pass. Yet a couple of years later, President Clinton said that incrementally we are going to accomplish the same thing. In 1996, the analysts at the Alan Guttmacher Institute went back and developed a whole new plan to incrementally achieve national health insurance with these confidential "reproductive" services.

The first program was the State Children's Health Program (S-CHIP). Now, I do not object to the State Children's Health Program. Congress, when they passed that legislation, imposed no legal requirement for abortion for any reason. There was no requirement for contraception or sterilization. However, when it was rolled out across the country, every state except Pennsylvania covered abortion and contraception. In my state, they offered sterilization. I do not know how many other states offered sterilization. Yet remember this: This is all "confidential coverage" to children under 19—without parental knowledge.

Religious organizations, particularly Catholic health care providers, are encouraged to implement health plans that provide these procedures. They are establishing bypass arrangements to remain an arms-length away from cooperating. In order to accomplish this, they hire a third party to collect the premiums so they do not have any direct involvement. Yet they are still getting the money to pay for these procedures by having a third party collect the premium and distribute the necessary funds to the providers when these procedures are performed. Most of the insured in these religious plans are not aware that these procedures are being funded. The abortionists know, and because it is kept confidential from parents, they get their money.

Government Mandates

Next, we had the 1997 Equity in Prescription Insurance and Contraceptive (EPICC) mandate—contraceptives in the Federal Employees Health Benefits Plan (FEHBP). That was the real beginning of the political push for contraceptive mandates throughout the country. To date, 21 states have contraceptive mandates. Keep in mind, when we talk about contraceptive mandates, we are talking about "confidential" coverage to children of any age in this process. One thing to note about the federal contraceptive mandate for federal employees is that there was a "conscience" exemption in it. Very few states have conscience exemptions, and the states that do have ineffective ones.

Then we have the Health Insurance Portability and Accountability Act (HIPAA). Proponents of reproductive rights had as a goal to ensure "confidentiality" to children, particularly to vulnerable populations, such as Medicaid recipients. Initially, HIPPA, under the Clinton Administration, denied parents medical information about their minor children. In April of 2001, Secretary of Health and Human Services Tommy Thompson announced that President George W. Bush was revising HIPPA to assure that parents would have access to information about the health and welfare of their children.

I mentioned the S-CHIP program, which was rolled out across the country in 1998, to be administered in the states. Let me tell you what happened in Michigan. Initially S-CHIP (known statewide as MIChild) offered abortion, sterilization, and contraception (which included chemicals and mechanical devices that induce abortion) available without parental consent or knowledge. We did remove mandatory sterilization from our plan, and we also removed abortion for rape and incest. Now people say, "You cannot have abortion. The federal government will not allow that." Although not required by the federal government, S-CHIP offered abortion for rape, incest, and saving the life of the mother, which is the only type of abortions federal funds can be used for. I can tell you from my work with pregnant moms that the categories of rape and incest are so manipulated that it is difficult to prove, in most cases, that women were not raped. Insurance companies in Michigan, if they wanted to participate in S-CHIP, had to agree to participate in these procedures.

In 1997, Planned Parenthood started pushing the idea of nationwide contraceptive mandates based on the idea that employers and insurers would save money. On an economic basis, the contraceptive pill costs about $300 a year—one birth, about $4,000. In October of 2000, the Associated Press reported that major national insurance companies said they would cover RU-486. For those of you that do not know what RU-486 is, it is a drug that women take which causes them to abort the child. Health insurers have generally agreed to cover this newly approved procedure, which is, again, available to children without parental knowledge and is very dangerous. The Equal Employment Opportunity Commission (EEOC) ruling of December 13, 2002, about contraception spurred further momentum for

employer-paid contraception and nationwide contraceptive mandates.

Practical Solutions

What can we do to redirect what we finance in health care? We now have Health Savings Accounts (HSAs) available that really empower individuals to become more directly involved in their health care. HSAs will also enhance the relationship between physicians and patients, which we so desperately need.

Therefore, we need to start developing new health plans that use this new benefit, and that deal with both the moral and economic crises in health care. We can immediately implement a new health plan by individually underwriting it, administering it, and passing the risk on to a large insurer (a re-insurer).

I propose that faith-based organizations (e.g., the Christian and Catholic Medical Associations, the Knights of Columbus, Christian Management Association), with the assistance of health insurance experts, test the market in a limited number of states that would be the most favorable to a free market, faith-based individual health plan. They could then expand marketing to other states and faith-based organizations. After a large pool is formed, faith-based organizations can establish their own health insurance companies to take risks, experience rate, underwrite, and administer in those states.

Let me outline for you the major criteria for the establishment of nationwide, faith-based, and self-insured health plans.

First of all, we have to have a health care plan that is totally committed to spreading the Gospel of Life. The question is: Do people of faith really have the will to actually step forward and do this?

Next, you need critical mass. Anybody who knows the insurance business knows it is all about the spread of risk. It is out there among faith-based communities. They just have to have the will to pool that critical mass together. The plan design is key, and the plan design must be truly in line with the beliefs of the faith-based organizations. They must also make sure that they control health plan administration. The problem in health care today is that people really do not know what is in their health plans, and many times they do not even know what is being paid for—particularly when it comes to issues regarding abortion, contraception, or sterilization. That is all kept "confidential."

Somebody needs to be willing to take on the risk. There are numerous people that would take on that risk in the industry—as long as they had a commitment of the critical mass. Conscience and parental rights must be protected in law.

In Michigan, four bills are pending that have passed through the U.S. House of Representatives. At the federal level, the Abortion Non-Discrimination Act has now passed in the House. It awaits Senate action and a presidential signature. In the interest of freedom, policymakers should oppose new EPICC contraceptive mandates (and reverse the passage of the current mandates); reform S-CHIP, Medicaid, the EEOC ruling on contraceptive mandates, and HIPAA; and enact parental consent laws.

The President's Program

There are different programs that President Bush has proposed in his State of the Union Address that are critical for the establishment of faith-based health plans.

First, it is taking care of the uninsured by making sure they have some economic fairness in the marketplace. President Bush wants to see that everyone gets treated the same with tax dollars when purchasing health care, as most Americans do now through their employers. He also wants to see the uninsured get tax credits so that they can afford to buy insurance.

Second, the President favors association health plans. This legislation would preempt the 21 states that have mandated contraception, because association health plans will be self-insured plans under the guidance of the Employee Retirement Income Security Act.

A final comment about HIPAA: President Bush did come out very strongly against the way HIPAA was set up under the previous administration. HIPAA language said that parents no longer had the rights to their children's medical information

unless the child consented. President Bush went public and said that he was going to change that. He said all parents will be protected and have the right to their children's medical information.

The real problem with HIPAA is that President Bush did not change what was happening at the state level: States have taken that right to medical information away from parents, so parental rights is a state-to-state battle. The other major battle that must be fought about HIPAA is to reverse the federal mandate that no longer requires authorization from patients for the release of their medical information to insurance companies and governmental organizations

It is ironic to me that we have patients' health protection, when, in fact, the government and the insurers can get the information without any authorization. People think that they are being protected under this law. We really have got a lot of work to do in this area to awaken America.

DR. ROBERT E. MOFFIT: The most important issues in health care today are personal freedom and the preservation of human dignity. If you look at what is really frustrating many doctors and patients throughout the health care system, it is the loss of personal or professional control over key decisions in an increasingly bureaucratized system. Likewise, a biomedical science unrestrained by traditional morality, as Dr. Swenson indicated, threatens—in a very profound way—human dignity.

Doctors are constantly finding themselves on the receiving end of decisions made by third-party payment, whether it is Medicare, Medicaid, or private insurance. Patients, more than ever before, find themselves in a situation in which the privacy of their medical records, the range of treatment options available to them, or (as our panelists have pointed out) the very morality of certain medical procedures that they are required to finance, are things over which they have little or no control.

The absence of personal control is rooted in the structure of the insurance market; and the structure of the insurance market, in turn, is rooted in the tax treatment of health insurance. The unfairness in the existing tax treatment of health insurance, which Mike O'Dea alluded to, creates an unlevel playing field and thus compromises personal freedom—including the freedom to choose a health plan that is compatible with your ethical, moral, or religious convictions. We provide $188 billion each year in tax relief for the purchase of health insurance, as long as you get it through the place of employment. This means that as long as you get your insurance through your employer, and your employer makes all of the key decisions with regard to your health care plan, you get tax relief. Yet if you are working for a firm that does not offer you health insurance and you tried to buy a faith-based health insurance plan on your own (without the employer's sponsorship), you would get no tax break. There is a profound unfairness in the tax treatment of health insurance.

The recent enactment of health savings accounts is a welcome change in the tax treatment of health insurance. It is a start in the right direction. Yet there is much more to be done in transforming the conventional health insurance market into a system that is consumer driven and genuinely competitive.

Finally, we are plagued by the growing bureaucratization of health care delivery, the growth in administrative cost, and the growth of regulation, red tape, and paperwork requirements—particularly for physicians. This is contributing to a dangerous demoralization of the medical profession. I will repeat it: This is contributing to a dangerous demoralization of the medical profession.

Not one of you can go to a medical meeting or a professional medical association meeting and not feel (tangibly, on the part of physicians) the sense that they are overwhelmed by what they have to deal with in Medicare, Medicaid, and private insurance. Now they are increasingly faced with grave ethical problems as well; questions of not only what they can or cannot do, but also what they should or should not do. I will just mention, for example, the recent pressures on future obstetricians and gynecologists to participate in abortion procedures as part of their medical education. The very suggestion would have been scandalous

not many years ago. Now, it is actually something that is somehow legitimate, if not routine. So much for the Oath of Hippocrates.

The Way Forward

Federal tax policies largely shape the health insurance market. All roads to real health care reform ultimately lead to the reform of the tax code in the health insurance system. A simple syllogism: If you want to reform the health care system, you have to reform the health insurance markets. If you want to reform the health insurance markets, you must reform the tax treatment of health insurance. You simply cannot get to a consumer-driven, patient-centered system, which allows for the creation of faith-based health plans, without such a change. Period.

What is wrong? The current tax treatment undermines the affordability of health insurance and restricts consumer choice because the insured person has nothing to do whatsoever with the policy. The employer owns the policy; the consumer does not. It hides the true cost of health care. Actually, many people do not know what they are paying for. As Mike O'Dea pointed out, Americans are paying for all kinds of things they would never pay for if they actually had to make that transactional cost.

The current system fuels the rapidly rising health care costs that Dr. Swenson noted, because it encourages employees to seek more comprehensive and expensive benefits because those benefits are tax-free. It favors those who have high incomes. If you are upper income and you work for a large corporation, you get a big chunk of tax-free income as a result of the current tax treatment of conventional health insurance. If you work for a small firm with a smaller benefits package, you do not get such a big tax break. If you are a worker in a small firm without insurance coverage, and you try to buy health insurance on your own, you get nothing. Basically, upper-income people do just great under the current system; lower income people do not. Again, for most of you, if you do not get insurance at the place of work, and you try to buy health insurance on your own, you are in trouble. If you are looking for a faith-based health plan, forget it.

What are the needed tax changes? First and foremost, a health care tax credit, preferably replacing existing tax breaks. A health care tax credit system would be portable, and it could be universal or targeted. Several years ago, my colleagues at The Heritage Foundation, Stuart Butler and Edmund Haislmaier, developed a comprehensive and universal health care tax-credit system, and that plan became the basis of major legislation introduced in 1993 in the House and Senate. Twenty-five senators co-sponsored the legislation. Today, President Bush is proposing a more targeted tax credit, aimed at individuals and families without workplace health insurance. In any case, whether policymakers adopt a comprehensive or a targeted approach, that is, frankly, a matter of political prudence.

Yet the basic policy is simple enough: Give taxpaying citizens direct assistance, in terms of tax relief, for the purchase of insurance or medical services, or give vouchers to low-income people to offset the cost of insurance. My preference would be to extend this direct assistance to offset out-of-pocket medical costs and help expand access to health savings accounts. If we are going to have neutrality in the tax code, the tax treatment should apply to all of these health care options, including new options sponsored by religious institutions or faith-based organizations.

Policymakers will also have to set some conditions. If you are going to establish tax relief for insurance, the insurance should be real insurance, and that means it should cover you for catastrophic events. My own preference is that the size of tax credits should be based roughly on need. All individuals or families would qualify for a basic credit, but beyond a basic credit, you could vary its size according to income or health care needs. In other words, if you are lower income, and you have higher health care costs, policymakers may want to vary the credit amount accordingly, making it more generous. The more persons covered under private health insurance, the less dependence there will be upon government health or welfare programs. You would also have to make insurance and regulatory reform changes compatible with the new health care tax credit system.

The Creation of Faith-Based Health Plans

Let's think big. What if you did have universal tax credits, as opposed to the disjointed system that we have today? How would it affect the insurance market? How would it affect the subject we are discussing today—faith-based health insurance plans?

Think about this. You would have a genuine diversity of health options on a national or regional level. You would have a wide variety of health insurance options—associations, fraternal organizations, plans sponsored by unions and trade associations, as well as ethnic organizations and religious and faith-based institutions. Atheists, too, could have their own association plan. You would have a real diversity of plans and options, increasingly tailored to personal needs and values—including ethical, moral, or religious values. You would also intensify the demand for information about quality and, on the basis of that information, you would also intensify the level of competition that is most desirable—the competition among doctors and hospitals themselves in the efficient delivery of high-quality care.

Second, with a national tax credit system, you would have the creation of large, national pools for persons employed in large companies. Indeed, a key structural benefit of a national tax credit system is that it would lay the groundwork for large national pools. Think about the possibilities for faith-based institutions. Imagine the possibility of a large national pool—let's say, the Southern Baptist Convention, which has 17 million members, sponsoring health insurance. Imagine that kind of a pool.

If you start to include the millions of uninsured in these national pools, you are going to introduce a downward pressure on average claim costs. We know a lot about the uninsured. We probably know more about the uninsured than we know about any other group within the population. We can count the hairs on their heads. They have been studied to death, not only by my colleagues at The Heritage Foundation, but also by researchers at the Kaiser Family Foundation, the Commonwealth Fund, and the Robert Wood Johnson Foundation. The uninsured are not well off financially, but, as a group, they are fairly healthy. So, as a group, when you start to include them in the insurance pool, you will start to drive down average claims costs.

Finally, you will have a long-awaited revolution in consumer relations in the health care system. Right now, you get what your employer gives you. (In the case of government programs, like Medicare or Medicaid, it is what Congress or civil servants say you will or will not have.) The insurance company is an agent of your employer, not you. But this new set of tax and insurance proposals facilitates a major change in the entire relationship between you and your health insurance company. You own the policy, not your employer. You become the principal, and your insurance company becomes your agent. Once you start establishing this kind of relationship, carriers have a powerful incentive to retain your business. You will start to see the writing of long-term health insurance contracts, accompanied by a powerful economic incentive on the part of insurance companies to keep you healthy as long as possible. In the meantime, you will be able to access increasingly sophisticated information, not only about the health benefits, quality, and service of your insurance plan, but also about the performance of doctors, hospitals, and clinics retained by your plan. You can expect, with the rapid and continuing expansion of information technology, for all of this to increase.

Back to the Future?

When it comes to faith-based insurance plans, are we talking about something that is unrealistic? Not at all. Sue Blevins, President of the Institute for Health Freedom, recently sent me a book called *The Fraternal Insurance Compend of 1926,* which is relevant to our topic.

What a lot of us in the policy community have forgotten is that, in the late 19th and early 20th centuries, when it came to insurance—old age, disability, dismemberment, and sickness benefits—there were numerous fraternal societies in the United States that sponsored insurance and social services, and they covered millions of Americans. Many of these were faith-based organiza-

Faith Based Plans: Back to the Future?

Aid Association for Lutherans (1902). Offered sickness and disability benefits; 45,000 members; open to male and female members of the Lutheran Church; total insurance in force: $47 million.

Bohemian Roman Catholic Union of Texas (1877). Offered life insurance to men of Bohemian birth or descent; total insurance in force: $3 million.

Catholic Aid Association of Minnesota (1878). Offered life and disability benefits to men and women; total insurance in force: $12.5 million.

German Baptists Life Association (1883). Offered life, accident, disability and dismemberment benefits to German Baptist men and women; total insurance in force: $2.3 million.

Independent Order of Brith Shalom (1925). Offered life and old age benefits to Hebrew men and women; total insurance in force: $11.7 million.

Independent Order Free Sons of Israel (1871). Offered life, old age, and disability benefits to Hebrew men ages 18 to 50; total insurance in force: $5.1 million.

Lutheran Brotherhood (1917). Offered life, disability and death benefits to Lutheran men and women; total insurance in force: $9.3 million.

Polish Roman Catholic Union of America (1887). Offered life and survivors benefits to Roman Catholic men and women of Polish birth or descent; total insurance in force: $61 million.

The Roman Catholic Mutual Protective Society of Iowa (1879). Offered life and old age benefits to Catholic men and women; total insurance in force: $4.3 million.

Slavonic Evangelical Union of America (1896) Offered life insurance to Evangelical Slovak men and women of the Augsburg Confession; total insurance in force: $8.7 million.

—*From* The Fraternal Insurance Compend of 1926.

tions. My personal favorite is an interesting group called the Bohemian Roman Catholic Union of Texas, serving men of Bohemian birth and descent. Their total insurance was valued at $3 million in 1925 dollars.

There were many other faith-based groups, providing similar services: the Aid Association for Lutherans; the Catholic Aid Association of Minnesota; German Baptist Life Association; the Independent Order of Brith Shalom; the Independent Order of the Free Sons of Israel; the Lutheran Brotherhood; the Polish Roman Catholic Union of America; and the Slavonic Evangelical Union of America.

None of this is fanciful. America was once rich with such institutions. They were flourishing. America is, as Alexis de Tocqueville observed, a nation of "joiners." We still are today. With the change in the insurance market, coupled with the proposed change in the tax code and the establishment of equity in the way in which we deal with health options, we could revive similar institutions in an increasingly diverse 21st century America, with the possibility of uniting health insurance with the faith-based health care delivery. Think about that.

One more point: Today, Roman Catholics, Lutherans, Seventh Day Adventists, and Jewish organizations already have many sophisticated hospital systems throughout the United States. One of the criticisms of the current health care system is that it is often disjointed, and that there is often a disconnect between the existing systems of financing and continuity—a lack of coordination that compromises the provision of quality in the care of individual patients. As many of you know, sometimes on the basis of painful personal experience, these criticisms are often correct.

By making key changes in health care tax policy and regulation and by aligning the economic incentives correctly, we can promote a powerful integration, a real and effective integration of insurance and delivery systems. We could have a natural marriage of private health care delivery and private health insurance, of large pooling and personal freedom, and a commitment to quality care combined with adherence to traditional ethical, moral, and religious values. What could be better?

Question and Answer Session

QUESTION: Could there be a problem now with homosexual marriage taking place? I'm wondering about a group like the Metropolitan Community Church, which is geared specifically towards homosexuals. They might be a much greater risk from a scientific or medical viewpoint: Could there be discrimination there?

RICHARD SWENSON: I don't think discrimination is really the issue there because you would open enrollment, and people would have voluntary choice about which health plan they would subscribe to.

For example, the Southern Baptists might serve as a good illustration. Today, 175 million Americans get their insurance through their place of employment. If, all of a sudden, instead of a defined benefit they had defined contribution (the employer gives you the money and you shop yourself), every person would shop according to the configuration of his or her needs.

Therefore, the Southern Baptists could come together. Maybe 5 million out of 16 million would decide to get their insurance through the Southern Baptists, and they would set it up the way they want to set it up. Catholic groups would do that. The Sierra Club could do that. You could have any kind of group that could do that. Therefore, people would have a wide range of choices and they would obviously choose a program in which they are not discriminated against. I really do not think it is an issue of discrimination.

QUESTION: This question is primarily for Dr. Swenson. You mentioned that different groups could make their own decisions on the really controversial issues. If one group makes very radical decisions for its own members—say, one group decides in favor of abortion, human cloning, and stem cells—how would that keep other groups from saying, "Well, we believe that is wrong, and we do not think you can choose those things?"

If another group decides to support abortion, and I do not agree with that, I just have to say, "Well, they just have it for their own group. I cannot do anything about it."

RICHARD SWENSON: You would basically have a two-track approach. If you wanted to just look at politics, morality, or the national discussion, you would do that using a two-track approach. One would be a track in which each individual would be able to opt into the program that fits his or her affinities, that fits his or her moral beliefs and the tenets of his or her faith. That would be very comforting to me to have such a system: I could examine it, and decide that this is the plan or program that matches up very well with my own conscience on these particular issues.

The second track is where you continue on with a national debate about these particular kinds of issues. The federal government will still have a role; the state governments will have a role; the Supreme Court will have a role. Just because one group on the side should decide things that are scandalous for the entire nation does not mean that we would not have some kind of national debate about that. It is best to look at a two-track process.

If you do not allow individuals the opportunity to go where their affinities are, and you have instead a single-payer system, then you have no option. You have to belong to something. Politicians will pass different laws that will be contested, and this will be very frustrating for certain faith groups.

I do not care what faith groups you are talking about. No matter if you are way off to the right, way off to the left, somewhere in the middle, or on the planet Mars. You will have a law that will come down that will alienate you. Therefore, it will serve

only to increase the level of cultural and political conflict in America.

MICHAEL O'DEA: This whole public policy in health care is not just government policy. It is policy that has happened in the private industry. People will come to me and say, "Mike, I just don't think you are right. Most health plans are not paying for abortion. Mine doesn't. Look. Here is this exclusion that says we do not pay for elective abortion."

Well, "elective" does not have any definition whatsoever; neither does "voluntary" or "medically necessary." A lot of people just do not know. They really believe that they are not paying for abortion. I bet if you were to survey most Americans, and they had a choice between a health plan that did not pay for abortion and one that did, I think, overwhelmingly, they would not want to pay for it in their health plan. If you surveyed them, they overwhelmingly do not know that they are paying for it. It is something that has been done behind the scenes and all that information is being kept confidential. That is happening with a lot of areas of health care.

QUESTION: The Lutheran Brotherhood and others have combined. I think it is called "Thrivent." Is that a good example of the kind of approach you have in mind? Do any of you have any other prime examples of what is going on right now?

RICHARD SWENSON: Personally, I don't look at transitional models. I look at post-paradigm models. The paradigm we have now is not sustainable—it is going down. Once it goes down, which way is health policy going? It will go to either single payer or something else. So that is what I look at.

When you try to do "transitional" models that bridge "here" and "there," you must realize that we live in such a destabilized and hyper-volatile time that, no matter what system you invent, it is going to have conflict on many different fronts.

I do not spend a lot of time, therefore, looking at transitional models. I am looking ahead to the time when the paradigm indeed changes. It will change, I think, quite dramatically. The reason I think it is going to change in the consumer-choice, consumer-driven, defined-contributions direction is because we are the only country in the world that has a system that is employer-based. That started in World War II and there are historical reasons for it.

Employers cannot wait to shed costs that they have no control over. They have to do something about it. They will be the change agents. I do not think it is going to be the federal government. I do not think it is going to be physicians or hospitals. I believe it is going to be corporate America. Once they figure out there is a way to change this that is politically acceptable (so they will not get some kind of horrible political and public relations black eye out of it), then I think the change is going to happen very quickly. That is a post-paradigm model, such as defined contributions. There is no exact post-paradigm model that exists now, because we are not post-paradigm yet.

ROBERT E. MOFFIT: I want to follow up on this a bit. The basic question is: Where are we going?

Right now, there are services that are being delivered through religious institutions. Black churches in the inner city, for example, have health-screening programs. They are going on right now. Among African-Americans, the rate of cardiac disease is roughly three times the rate of cardiac disease among the white population. Among Mexican-Americans, for example, there is a very high rate of diabetes. The consequence is that there have been a large number of amputations in the Mexican-American community because of diabetes. They were not getting the best care for a variety of reasons, including cultural barriers and problems communicating with doctors. Minority populations, particularly when they are depending upon conventional employment-based insurance or government health programs, often find that the existing institutions do not make allowances for ethnic differences or disease patterns.

The question is: How could you build a health care system that would be more effective in responding to these kinds of demographic differences? This means responding in the right way, with the right care, and at the right time. It means responding in such a way that you will not incur even more massive costs down the road, through Medicaid or other government programs.

Black churches readily come to mind, because you have here a social institution in which there is a great deal of affinity, emotional attachment, and authority. That is to say, members perceive that the institution is legitimate and what is being said to them is important and sincere: "You will have vaccinations. You are going pursue a wellness program. You are going to control your blood pressure. We care about your health and well-being."

If you were to tie that social authority to a new system, a consumer-directed system in which the black church would be in a position of evaluating health plans for that community, you would have a major breakthrough with an intermediary organization to do this kind of work. This function would likely be the norm in a patient-centered, consumer-directed system. Right now, you have an organization called the National Association of Retired Federal Employees. They annually rank private health plans for retirees in the FEHBP. They evaluate these plans according to their ability to deliver certain kinds of medical services for disease conditions that are prevalent among retired Americans. There is no reason why faith-based organizations or ethnic organizations could not do something similar for their own members.

That is the kind of role that faith-based institutions can play in a revitalized, consumer-directed health care system. It is a role that they are not playing now—health insurance companies being rated by religious institutions or ethnic organizations in terms of their ability to deliver services to the community in accordance with the moral values of that community.

QUESTION: Dr. Swenson, you mention that a plethora of biomedical and ethical issues are poised to cascade within the next decade. I have been thinking that for several decades already! Yet public indignation on a lot of these issues seems to be declining. People become more accustomed to things that used to shock them. Do you have anything more encouraging than hope for me?

RICHARD SWENSON: Dr. Edmund Pellegrino of Georgetown University is here. Dr. Pellegrino, may I call upon you? I'm very glad that you are in the audience today. I believe you are the foremost medical ethicist in the United States during the past 50 years. I know you are concerned with the doctor-patient relationship. You are concerned about the managed care issue. You write often from a vantage point of faith. You know more about the ethical issues and the conundrums than anyone else. Would you want to take a minute or two and say something about these issues? You might disagree with everybody up here. Personally, I think something fundamental has changed, and we are facing a plethora of imminent bioethical challenges.

DR. EDMUND PELLEGRINO: I want to congratulate you on dealing with one of the major ethical problems with the current health care system very, very well.

I work in ethics. I am a physician. I work in the field of ethics and I am as concerned as you are over the fact that ethical issues are now being settled in the public realm by the courts, and, of course, in the marketplace, in the way you have indicated.

I would have questions about whether one needs to link the avoidance of those particular problems with the particular system that you proposed—an economic system. I think that is an open question. I would be prepared to discuss on other occasions ways in which it might be done in a different way.

Finally, the question running through my mind over and over again is the recurrence of the phrase "market-driven." This concerns me because I have written on the commodification of health care, and I am concerned about that. The second question is whether there can be true freedom on the part of a patient seeking help when he or she is in the middle of illness—or, when you are not ill, the possibility of your projection into the future of what you will, in fact, need.

Therefore, I question not just your plan, but any plan, or whether a consumer can really be educated. I do not like the word "consumer." Yet I do want to applaud what you are doing in trying to get us out of this terrible morass. I also agree with

you very, very definitely that the medical profession is totally demoralized. I have been in it 60 years, and I have never seen it this way before. People are cynical about physicians. Yet I think it is because we feel we cannot do for patients what we think they need. I have just stepped out of my clinic because I feel I cannot provide what the patient needs. That is another moral issue. What is the moral status of our ability to provide for those that are ill in this country?

RICHARD SWENSON: I believe this is a special moment in history. This is not like 1960. This is not like 1975. This is not like 1990. This is 2004. The scientific ethical issues are there, they are overwhelming, and we have to start dealing with them. I do not think we have a national consensus about how to deal with them. Therefore, I think they are better dealt with on an association plan basis as opposed to a one-size-fits-all national government system. That is all the hope I can provide.

MICHAEL O'DEA: I just wanted to make a comment, because I have been following this and working in this area for years. I totally agree with Dr. Swenson. I think we are at a moment in time when we are going to go one way or the other. The decisions will be made in this decade.

One of the things that really has got people starting to think about this—how our personal liberties are being taken away from us in health care—is that recent California ruling about the Catholic church. They are being told by the courts in California that they must violate their religious convictions by the mandating of contraception in their health plan. That has awakened a lot of people.

The moral issue is going to move people even more than the economic issue. Both of them together are at a crisis. People are starting to recognize it. That is why I think the moment for change is now.

QUESTION: In the early 20th century, you had a rich, vibrant civil society, with all the different fraternal organizations, and other helping groups. People went to those institutions because that was where you could get some help. Then we got the great protectors, the state and the federal government, which said, "We are the insurer of last resort, or first resort, and we will take care of you." The older organizations were "crowded out."

More recently, efforts to expand civil society have run against another problem: Getting into bed with the government begins to change the very nature of what you are supposed to be doing in its pure form. You are more of a vendor or a partner of the state, rather than the kind of institution that enables you to do what you do best.

In structuring the type of future system you are talking about, what underpinnings are needed in order to allow these types of faith-based plans to operate? What makes them work best, as opposed to being kind of a pale imitation of what might seem to be, in effect, a non-profit, faith-based sector?

ROBERT E. MOFFIT: That is a tough challenge. Unlike the current system, which is largely a third-party prepayment system through employers, I favor direct individual assistance—whether it is individual health care tax credits, or vouchers, or defined contributions—simply because it maximizes the freedom of the person. Individuals make the key decisions in the system.

You are never going to get the government completely out of health care. That is not going to happen. Even when it comes to health insurance, an insurance system is not going to work unless there are common ground rules for all the players. That is the job of government. Meanwhile, however, you have got to maximize personal freedom.

You are right. These older fraternal institutions were indeed "crowded out." They were "crowded out" by the transformation of the American economy, the growth in employer-based health insurance, and a variety of other social, economic, and political changes. In this context, I was talking to Phyllis Berry Myers earlier about the black fraternal organizations. It is an incredible story. Dave Beito, a professor of history at the University of Alabama, has written about this story, and the stories of other such organizations, in a book entitled *From Mutual Aid to the Welfare State*, a remarkable study of fraternal societies and social services from 1890 to 1967.

Professor Beito writes, for example, about the Order of the Twelve Knights and Daughters of Tabor, or the Taborites, a black religious fraternity very prominent in the South. They built hospitals because the public hospitals in the South were segregated, and the quality of care for African-Americans was so poor in public hospitals that it was a crying necessity. To paraphrase their message: "We are living in a hostile culture. This culture does not treat us fairly. With the help of God—literally—we are going to chart an independent path." Therefore, the Taborites built hospitals. It was an impressive achievement. It was also a declaration of social and economic independence from an aggressive, hostile, segregated state. The Taborites' story, as the story of other fraternal societies, constitutes an inspiring chapter in American social history.

RICHARD SWENSON: Earlier, I was asked a question about hope. I do not think I have given an integrated answer. I have a lot of hope for a post paradigm health care system—for three reasons.

First, if this system goes to a defined contribution approach, you have first dollar decision-making by the patient. Doctors have been screaming for that for as long as I have been in medicine, which is 34 years. They have been saying, "Patients must have more upfront responsibility about spending their money." That is a major corrective.

Second, for those of us in a faith-based alliance, if we were to join an insurance program aligned with that, there would be additional savings as well as wonderful emotional affinities.

Finally, I think the future will see a radical democratization of health care, in which people become their own primary care provider. Through the Internet, for example, you can already order 5,000 different kinds of tests you can do on yourself. If you want to check your cholesterol tonight, you simply check your cholesterol tonight.

These are dramatic things. I see a lot of hope. When I speak to physicians, I see a lot of weeping and gnashing of teeth. There is a lot of anguish right now. Yet post-paradigm, positive change could decompress many of the stressors for almost every element in the health care delivery system.