Executive Summary
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Patients' Freedom of Conscience: The Case for Values-Driven Health Plans

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Ethical and moral issues are inseparable from health care and are usually addressed by employers' health insurance plans, government agencies, and national and state lawmakers. Through the deliberations of their elected representatives, Americans will define and refine the laws concerning abortion, medical care at the end of life, and such other complex and difficult topics as the use of genetic information, embryonic stem cell research, the use of fetal tissue, and the legitimacy of physician-assisted suicide. Public debate on biomedical ethical issues is necessary and should not be confined to experts. Every American has a stake in these issues, which involve tax dollars as well as private dollars for health insurance and medical care.

Primacy of Conscience. Regardless of how health policy issues are resolved legally, Americans must retain their individual right not only to dissent from existing public policies, but also to make personal health care decisions—including how money is spent for health benefits, medical treatments, and procedures—according to the dictates of their consciences. This is why, regardless of their differing views on many controversial health issues, all Americans should work together to protect patients' freedom of conscience in health care. Recent debates on the rights of conscience have focused on providers, not patients, but freedom of conscience for every person should be the rule in health care, which is emerging as the central arena of new and profoundly serious scientific and ethical issues. Americans should have the option to control their health care dollars and to participate in plans that respect their values and deliver medical benefits that are consistent with those values.

But most Americans, as a practical matter, do not have that kind of control. Third-party payers—administrators of government and private health insurance plans—generally set the rules for coverage: which plans are offered, what benefits are included, and how they are funded. Many Americans are rightly concerned that they are progressively losing control over the key decisions that affect their health care.

Biomedical Advances. The fruits of biomedical research will be incorporated rapidly into advanced medical treatments and procedures. Once a procedure is covered by a health insurance plan, its financing is spread among all participants in the plan. In the case of publicly funded insurance, that includes all taxpayers.

Because many emerging treatments and procedures will have serious ethical ramifications, poli-

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cymakers should enact major reforms that would allow health care in America to function more as a genuine consumer-driven and values-driven market functions. Freedom of conscience is merely an abstraction unless individuals and families can act on it, especially when spending their own money on insurance premiums, medical providers, and medical procedures. In this way, individuals and families could "vote with their feet," freely choosing which health benefit plans, packages, and medical procedures they wish to support.

Emerging Ethical Challenges. Abortion and related issues are flashpoints at the busy intersection of health care policy, medical ethics, and personal morality. Meanwhile, embryonic stem cell research, therapeutic cloning, pre-birth genetic screening to identify "unwanted" children, therapies or treatments for genetic enhancement, and growing social acceptance of physician-assisted suicide will create new ethical challenges. Individuals and families cannot assume that employers, third-party administrators, or government officials will resolve these sensitive issues in a manner consistent with their personal beliefs.

Creating a New Environment for Personal Freedom. Most individuals and families have little control over the terms or conditions of their health insurance contracts or the payment of premiums to doctors and other providers. Most Americans get what they are given and pay what they are told to pay. Personal choice is limited, and this limitation on personal freedom is a central defect of America's health care system. Policymakers can correct this deficiency by returning control to individuals and families in four major ways:

- **Allow all Americans to choose their own health plans.** In addition to conventional and employer-sponsored health plans, Americans should be allowed to choose plans sponsored by professional associations, employee organizations, unions, and faith-based and religious groups. Individuals and families could then secure coverage through health plans that are compatible with their ethical and moral values.
- **Eliminate discrimination in the tax code.** To make personal choice a reality, the federal and state tax codes should treat all types of plans equally. The best way to accomplish this is to give every person a refundable, individual health care tax credit to purchase the plan of his or her choosing, regardless of place of work. This change could foster the development of new kinds of plans, including plans sponsored by religious organizations and church consortia.
- **Open up health insurance markets.** Health insurance is governed by state law and, to a lesser extent, federal law. State officials could open up current markets by replacing the balkanized, highly regulated state health insurance markets with a single statewide market, or insurance exchange. Through the exchange, employers could contribute a defined amount to the health plans designated by their employees, and plans would compete directly with each other for consumers' dollars. Congress could allow Americans to purchase health insurance across state lines, just as they buy many other goods and services, including other types of insurance.
- **Allow values-driven health plans to participate in public programs.** Health plans sponsored by religious and other organizations should be allowed to participate in Medicare, Medicaid, and the State Children's Health Insurance Program, just as they already do in the Federal Employees Health Benefits Program.

Conclusion. Individuals and families should be free to control the flow of dollars in their health care plans and to make the decisions that will affect their medical treatment and health care coverage, including ethical decisions.

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Patients' Freedom of Conscience: The Case for Values-Driven Health Care Plans

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Ethical and moral issues are inseparable from health care. These issues include bitter debates over the taxpayer and insurance funding of controversial procedures such as abortion, contraception, in vitro fertilization, and, more recently, physician-assisted suicide and the protocols governing end-of-life care. While concerns over health care have been deepening—driven by anxieties over costs, access to health care coverage, and quality of care—more and more Americans are becoming concerned about the impact of ongoing biomedical research on embryonic stem cells, human cloning, genetic engineering, and government policy on end-of-life care.

Through the deliberations of their elected representatives, Americans will continue to debate what is and is not permissible in civilized society. They will define and refine the laws on abortion, medical care at the end of life, and many other complex and difficult topics, such as the use of genetic information, embryonic stem cell research, and the disposition of fetal tissue. Public debate on biomedical ethics is necessary and should not be confined to experts. Every American has a stake in these issues.

Primacy of Conscience. Meanwhile, Americans must retain their right to make health care decisions—including how their money is spent on their health care, especially the benefits, medical treatments, and procedures financed through their health insurance—according to the dictates of conscience within the law. This is why, regardless of their differing views on many controversial health issues, all

Talking Points

- Health care policy is inseparable from moral and ethical issues, such as abortion and end-of-life care for the aged.
- Health insurance plans often include ethically controversial medical procedures, but few Americans control their health care dollars, so their premium payments may subsidize medical procedures to which they may have ethical, moral, or religious objections.
- Americans can no longer assume a consensus among doctors on traditional medical ethics. The venerable Hippocratic Oath has sunk quietly into disuse.
- Policymakers can restore patients' freedom of conscience in health care by allowing individuals to choose their health plans, ending tax code discrimination against non–employer-based health plans, opening up health insurance markets geographically, and allowing ethical health plans to compete or participate in Medicare, Medicaid, and S-CHIP.

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Americans should work together to protect patients' freedom of conscience in health care.

The problem is that most Americans, as a practical matter, do not have that kind of control over their own health care. Third-party payers—administrators of government and private health insurance plans—generally set the rules for coverage: which plans are offered, what benefits are included, and how they are funded. Many Americans are rightly concerned that they are progressively losing control over the key decisions that affect their health care.

The focus on freedom of conscience in ethically controversial matters has been almost exclusively confined to health care institutions, third-party payers, and medical providers, not patients.[1] Freedom of conscience—for both provider and patient—should be the rule in health care, one of the most sensitive areas of human life. Moreover, health care is the central arena of new and profoundly serious scientific and ethical debates. Americans should have the option to control their health care dollars and participate in plans that respect their values and deliver medical benefits that are consistent with those values.

Biomedical Advances. Doctors are employing increasingly sophisticated medical technologies. With the advance of biotechnology and applied genetic research, physicians will be able to improve the quality and longevity of human life. The fruits of biomedical research will be incorporated rapidly into advanced medical treatments and procedures. As such treatments and procedures become more widely available, insurance companies will routinely cover them as health benefits. Once a procedure is covered by a health insurance plan, its financing is spread among all participants in the plan. In the case of publicly funded insurance, that includes all taxpayers.

Because the fruits of biomedical research are incorporated into health plans as covered medical treatments and procedures, many of which have serious ethical consequences, policymakers should enact major reforms that would allow health care in America to function more as a genuine consumer-driven market functions. Ideally, every family and individual should be free to choose the health care coverage, physicians, and medical treatments that reflect their ethical values. This is the essence of freedom of conscience.

However, freedom of conscience is just an abstraction unless individuals and families can act on it, especially when spending their own money on insurance premiums, medical providers, and medical procedures. This control of health care dollars would empower individuals and families to "vote with their feet" when choosing which health benefit plans, packages, and medical procedures to subsidize with their insurance premiums.

Unavoidable Ethical Challenges. Abortion and related issues are flashpoints at the busy intersection of health care policy, medical ethics, and personal morality. Meanwhile, embryonic stem cell research, cloning, pre-birth genetic screening to identify "unwanted" children, therapies or treatments for genetic enhancement, and growing social acceptance of physician-assisted suicide will likely create new ethical challenges. Individuals and families cannot assume that employers, third-party payment administrators, or government officials will resolve these sensitive issues in a manner consistent with their personal beliefs.

Creating an Environment for Personal Freedom. Today, health care financing is divided roughly equally between private-sector and government spending. In both cases, the dominant financial arrangement is a third-party payment system. With some notable exceptions, such as federal employees and retirees, most Americans have little practical control when selecting their health care plans. Most individuals and families also have little

1. At the federal level, the Hyde–Weldon "conscience protection amendment" of 2004 specifies that no government agency or program receiving federal funds can discriminate against a health care provider because the provider refuses to provide, pay for, cover, or refer for abortion. At the state level, 47 states have some degree of protection for health care rights of conscience for providers, doctors, and other medical professionals, and largely related to abortion. See Denise M. Burke *et al.*, *Defending Life 2006: A State-by-State Legal Guide to Abortion, Bioethics and the End of Life* (Chicago: Americans United for Life, 2006), pp. 285–289.

control over the terms or conditions of health insurance contracts or the flow of their premium dollars to doctors and other health care providers.

While health plan choice has expanded in large companies, the kinds of benefits financed through health insurance are still determined largely by employers (or employers and union officials in contract negotiations), insurance executives, managed care network officials, or government officials. Most Americans still get what they are given—not what they might have chosen—and pay what they are told to pay. Personal choice is limited.

This limitation on personal freedom is a central defect of the American health care system. Policymakers can correct this deficiency by changing tax and insurance laws and returning control over health care to individuals and families in four major ways:

- **Allow all Americans to choose their own health plans.** In addition to conventional employer-sponsored health plans, Americans should be allowed to choose plans sponsored by professional associations, employee organizations, unions, and faith-based and religious groups. Currently, much of the congressional debate about association health plans centers on business association plans, but discussion of expanding this option is often confined to employment-based associations. A richer and more diverse concept of association health plans would include, as President George W. Bush recommends, health insurance offered through individual membership associations such as professional and faith-based organizations. Individuals and families could then secure coverage through plans that are compatible with their ethical or moral values.
- **Eliminate discrimination in the tax code.** To make this choice a reality, the federal and state tax codes should treat all types of plans equally and stop giving preference to employer-based health plans. The best way to accomplish this is to give every person a refundable, individual health care tax credit to purchase the plan of his or her choosing, regardless of place of work. This change could foster the development of new kinds of plans, including plans sponsored by religious organizations and church consortia.
- **Open up health insurance markets.** Most health insurance is governed by state law and, to a lesser extent, federal law. State rules define and limit the kind of health insurance that is available to individuals and families. Regrettably, existing insurance rules often prevent individuals and families from getting the specific kind of coverage that they want at an affordable price. Policymakers can pursue two alternatives.

  First, state officials could open up the current markets by replacing the balkanized, highly regulated health insurance markets with a statewide single market, or health insurance exchange. Through such an exchange, employers could contribute a specified amount (known as "defined contributions") to the health plans designated by their employees, and plans would compete with each other directly for consumers' dollars.

  Second, Congress could allow Americans to purchase health insurance across state lines, taking advantage of interstate commerce, just as they buy many other goods and services including other types of insurance.
- **Allow values-driven health plans to participate in public programs.** Health plans sponsored by religious and other types of organizations should be among the plans made available through Medicare, Medicaid, and the State Children's Health Insurance Program (S-CHIP), just as they already do in the Federal Employees Health Benefits Program (FEHBP).

Individuals and families can no longer afford—financially or ethically—to be passive recipients of third-party decisions. They should be free to control the flow of dollars in their health plans and to make the decisions that will affect their medical treatment and health care coverage.

The Biomedical Revolution and the Clash of Values

A revolutionary age in biotechnology and biomedical research is dawning. Physicians will have vast new arsenals of advanced weapons to combat

disease and new ways to extend and improve the quality of human life. These advances will also enable medical professionals to deliver highly personalized health care to their patients.[2]

This progress, however, is not without complications and moral dilemmas. Medicine is already deeply entangled in debates over complex issues surrounding the beginning and end of life. Today's ethical divisions will be compounded by tomorrow's growing demands on the health care system. For example, Dr. Peter Singer of Princeton University, already notable for his view that infanticide can be morally justified,[3] recently predicted: "During the next 35 years, the traditional view of the sanctity of human life will collapse under pressure from scientific, technological, and demographic developments."[4]

The Beginning of Life. A number of ethical issues surround the beginning of human life, but none has been as controversial as abortion. However, a whole new set of beginning-of-life ethical questions is emerging, related to the pursuit and application of human embryonic stem cell research, the cloning of human embryos for research and reproductive purposes, and the harvesting and use of fetal tissue in medical research.[5]

Of course, all of this depends on the initial fertilization of a human egg and the creation of a human embryo.[6] The President's Council on Bioethics—a philosophically diverse panel—notes this interrelatedness of beginning-of-life issues and advises beginning the bioethics discussion with in vitro fertilization,[7] a relatively common practice that many Americans seldom question:

> [A]ssisted reproduction is, in practice, the necessary gateway to all the newer technologies—present and projected—that affect human reproduction. Preimplantation genetic diagnosis (including sex selection), germ-line genetic modification, human embryo research, and similar techniques all presuppose in vitro fertilization and the existence of developing human life in vitro.[8]

Embryonic Stem Cell Research. The term "stem cells" is used to describe a diverse group of multi-potent cells. These cells, which begin as undifferentiated and unspecialized cells, can become the highly specialized cells of all parts of the body, from skin cells to brain cells. Every specialized cell originally arises from a stem cell, and ultimately from a small group of embryonic stem cells that develop during the first several days of the embryo's life.[9] Stem cells, which first occur during embryonic development, continue to exist in many systems of the human body throughout life, including in a newborn's umbilical cord and an adult's bone marrow.[10]

2. On this point, see Christina Sochacki and Robert E. Moffit, Ph.D., "The Promise of Personalized Health Care: Why and How to Encourage Diversity and Choice," Heritage Foundation *WebMemo* No. 801, July 20, 2005, at *www.heritage.org/Research/HealthCare/wm801.cfm*.
3. Peter Singer, "Taking Life: Humans," at *www.utilitarian.net/singer/by/1993——.htm* (December 6, 2005), excerpted from *Practical Ethics*, 2nd ed. (Cambridge, U.K.: Cambridge University Press, 1993), pp. 175–217.
4. Peter Singer, "The Sanctity of Life: Here Today, Gone Tomorrow," *Foreign Policy*, September/October 2005, at *www.foreignpolicy.com/story/cms.php?story_id=3159* (April 10, 2006).
5. The use of fetal tissue from spontaneous or induced abortion is already governed by federal regulations. See 42 U.S. Code 289g-1.
6. See Kelly Hollowell, J.D., Ph.D., Philip H. Coelho, David Weldon, M.D., and Robert E. Moffit, Ph.D., "Federal Stem Cell Research: What Taxpayers Should Know," Heritage Foundation *Lecture* No. 888, June 24, 2005, at *www.heritage.org/Research/HealthCare/hl888.cfm*.
7. In vitro fertilization is a fertility treatment technique in which the egg is fertilized by sperm outside the woman's body. "In vitro" literally means "in glass" in Latin, generally referring to a test tube.
8. President's Council on Bioethics, *Reproduction & Responsibility: The Regulation of New Biotechnologies*, March 2004, p. xlii, at *www.bioethics.gov/reports/reproductionandresponsibility/_pcbe_final_reproduction_and_responsibility.pdf* (April 10, 2006).
9. President's Council on Bioethics, *Monitoring Stem Cell Research*, January 2004, p. 2, at *www.bioethics.gov/reports/stemcell/fulldoc.html* (April 10, 2006).

Stem cells hold scientific and medical interest precisely because of their inherent capacity to differentiate into specialized cells, potentially becoming any type of cell in the human body. Researchers hope to study these cells and learn more about the molecular processes through which they become specialized, forming different tissues and organs. Scientists hope eventually to learn how to manipulate these cells to become specific types of cells that could be used to treat and cure disease. Doctors could then use them as a unique source of transplantable cells that could repair or regenerate damaged tissue or organs inside a patient's body.

Embryonic stem cell research seems to hold great promise for treating and curing diseases; however, it is not at all clear that it will be able to deliver on that promise. Moreover, the problem is that the process of extracting embryonic stem cells destroys the human embryo.

Americans who advocate the protection of human life from its earliest stages are unwilling to pursue medical research at the expense of a human embryo, which is biologically understood to be a nascent human life. Instead of crossing that line, many argue in favor of alternative stem cell research that does not require embryo destruction—such as using placental cord blood, a robust and renewable resource of stem cells, or adult stem cells.[11] Such research is preferable, they argue, not only because it avoids the thorny ethical controversies surrounding embryonic stem cell research, but also because cord blood and adult stem cells have already proven highly successful in treating diseases. Unlike embryonic stem cells, which have never yielded a medical treatment, adult and cord blood stem cells have already been used to treat over 58 diseases successfully.[12]

Cloning. Cloning is a form of reproduction in which the offspring is the result of deliberate replication of another individual's genetic makeup.[13] Human cloning could be accomplished by introducing nuclear material from a human somatic cell (such as a skin cell) into an unfertilized egg, which has had its nucleus removed. The result is a human embryo with a genetic constitution that is virtually identical to the donor of the somatic cell.

The President's Council on Bioethics makes a categorical distinction between "[c]loning-to-produce-children" and "[c]loning-for-biomedical-research." The Council defines the latter as "production of a cloned human embryo, formed for the (proximate) purpose of using it in research or for extracting its stem cells, with the (ultimate) goals of gaining scientific knowledge of normal and abnormal development and of developing cures for human diseases."[14] Logically, the same ethical concerns that apply when the cloned human embryo is used for research purposes that result in its destruction also apply when any other human embryo is destroyed.

The idea of cloning for biomedical research raises another issue: the practice of permitting cloned embryos to develop into human fetuses to be harvested for organs. As morbidly bizarre as it might sound, the notion of "fetal farming" is not simply a figment of the imagination. As Professor Robert George of Princeton University, a member of the President's Council on Bioethics, recently observed:

> [B]ased on the literature I have read and the evasive answers given by spokesmen for the biotechnology industry at meetings of the President's Council on Bioethics, I fear that

10. *Ibid.*, p. 3.
11. For more on alternative sources of stem cells, see President's Council on Bioethics, *Alternative Sources of Human Pluripotent Stem Cells*, May 2005, at *www.bioethics.gov/reports/white_paper/alternative_sources_white_paper.pdf* (May 3, 2006).
12. For examples, see Representative Virginia Foxx (R–NC), "Stem Cell Research: Embryonic Versus Adult," *Congressional Record*, May 18, 2005, pp. H3551–H3552, and Senator Sam Brownback (R–KS), "Stem Cell Therapeutic and Research Act," *Congressional Record*, December 17, 2005, pp. S13960–S13962.
13. President's Council on Bioethics, *Human Cloning and Human Dignity: An Ethical Inquiry*, July 2002, p. xxiv, at *www.bioethics.gov/reports/cloningreport/pcbe_cloning_report.pdf*.
14. *Ibid.*

> the long-term goal is indeed to create an industry in harvesting late embryonic and fetal body parts for use in regenerative medicine and organ transplantation.[15]

The ethical issues surrounding human cloning for the purpose of producing children are even more pronounced. The President's Council observed:

> Human cloning, were it to succeed, would enable parents for the first time to determine the entire genetic makeup of their children. Bypassing sexual reproduction, it would move procreation increasingly under artful human control and in the direction of manufacture. Seen as a forerunner of possible future genetic engineering, it raises for many people concerns also about eugenics, the project to "improve" the human race. A world that practiced human cloning, we sense, could be a very different world, perhaps radically different, from the one we know.[16]

Genetic Engineering. Today medical researchers have the scientific capability to test human life genetically at its early embryonic stages. This raises the question: Should doctors use these technologies not only to screen for and prevent disease, but also to produce "better" children?[17] The biomedical capacity to genetically engineer "better" children and deter the conception and birth of "lesser" children is naturally accompanied by a whole range of ethical issues reminiscent of those raised by eugenics movements of the past.[18]

A related issue is the medical treatment of premature infants, including those who are severely disabled. Using advanced medical technology to keep these infants alive is now a routine feature of medical treatment, but it may not remain so. Such decisions often incur public as well as private expense, inviting the intervention of legislators, attorneys, and other public officials. In government-run health care systems, officials can simply determine that premature infants are not worth the expense. In Britain, the Royal College of Pediatrics and Child Health has been debating whether it is "unethical" to provide intensive care in the financially strapped National Health Service to premature babies, born under 25 weeks. Care would be denied primarily because of economic considerations.[19]

Medical decision-making will undoubtedly become more complex, especially as technology advances and medical options expand. The question is whether individuals and families should have the freedom to make these decisions, including life-and-death decisions, within the law.

Advocates for a government-run health care system of "collective choice" often argue that ordinary Americans are largely incapable of making these decisions and that such decisions should be left to professional experts. These experts would be appointed, paid, or otherwise supervised by government officials who in turn would control public health care spending.[20] Some proponents of government-run health care even go so far as to argue that this restriction on personal decision-making,

15. Robert P. George, "Fetal Attraction," *The Weekly Standard*, October 3, 2005, at *www.weeklystandard.com/Content/Protected/Articles/000/000/006/119xobmg.asp* (April 10, 2006).
16. President's Council on Bioethics, *Human Cloning, and Human Dignity*, p. xviii.
17. The President's Council on Bioethics raises this question in President's Council on Bioethics, *Beyond Therapy: Biotechnology and the Pursuit of Happiness*, October 2003, p. 4, at w*ww.bioethics.gov/reports/beyondtherapy/beyond_therapy_final_webcorrected.pdf* (April 10, 2006).
18. On a related note, the availability of prenatal testing for a number of debilitating diseases seems to have led to an increase in abortions among women whose pregnancies test positive for diseases such as Down syndrome, spina bifida, and cystic fibrosis. For more discussion of this subject, see Patricia E. Bauer, "The Abortion Debate No One Wants to Have," *The Washington Post*, October 18, 2005, p. A25, at *www.washingtonpost.com/wp-dyn/content/article/2005/10/17/AR2005101701311.html* (April 10, 2006).
19. Sarah-Kate Templeton, "Doctors Call Premature Babies 'Bed Blockers,'" *The Sunday Times*, March 26, 2006, at *www.timesonline.couk/article/0,,2087-2104205,00.html*.

in view of emerging medical complexity, should apply to life-and-death situations.[21]

Third-party decision-making by public or private insurers—such as rationing care to the sick, disabled, or elderly—could include protocols that many Americans might find morally objectionable. In that case, many people would presumably wish to withhold their premiums from health plans that finance medical procedures or protocols to which they object. Today, however, that is not a feasible option for most Americans.

The End of Life. End-of-life issues have the potential to divide Americans even more than those surrounding the beginning of life. The technological ability to sustain life is emerging in an environment befogged by a lack of moral consensus and characterized by rapidly rising health care costs. The fastest growing cohort in the American population is people 85 and older. With the coming retirement of the baby-boom generation, America will enter a new demographic era—an emerging "mass geriatric society."[22] The kind and level of medical technology that will be available to this new retiree population of 77 million people will preoccupy government officials and insurance plan executives, many of whom hope that such innovations will not only improve and extend life, but also control health care costs.

Within the next few years, the first major test will fall on Medicare, the $336 billion government health program that covers senior and disabled citizens. Subject to congressional authority, the Centers for Medicare and Medicaid Services (CMS)[23] and the contractors who administer the Medicare program in the states are charged with determining whether certain medical treatments or procedures are "reasonable and necessary" and to be reimbursed under the program. The CMS routinely delegates about 90 percent of these coverage decisions to Medicare contractors.[24] Medicare officials aim to adopt the fruits of biomedical research and new medical technologies through "national coverage" determinations. While recent research indicates that adopting some of these new technologies may indeed improve and extend the lives of Medicare beneficiaries, it would also increase already high Medicare spending.[25]

20. Most proponents of national health insurance, while they would prohibit or restrict a person's right to choose private health insurance, nonetheless affirm the right of individuals to choose their physicians. However, not all single-payer advocates exhibit confidence in the ability of ordinary Americans to choose physicians or follow their recommendations. For example, Terri Combs-Orme, an assistant professor at the Johns Hopkins University School of Hygiene and Public Health, observes: "Americans are relatively sophisticated about automobiles; apparently they can judge the reliability record of a Honda and choose it over many American models. But can they select the better physician, or exercise discretion regarding whether or not to undergo a test or procedure recommended by a physician?... I don't think so. Competition can only govern supply and demand when the consumer has discretion; most Americans cannot exercise such discretion with regard to health care, and with regard to either selecting a provider or undergoing specific procedures." See Robert E. Moffit, Ph.D., and Terri Combs-Orme, Ph.D., "Should the Federal Government Finance Health Care for All Americans?" in Howard J. Karger and James Midgley, eds., *Controversial Issues in Social Policy* (Boston: Allyn and Bacon, 1994), p. 47.
21. Economist Paul Krugman writes: "For decades we've been lectured on the evils of big government and the glories of the private sector. Yet health reform is a job for the public sector which already pays most of the bills directly or indirectly and sooner or later will have to make key decisions about medical treatment." Krugman elaborates on the increasing complexity of medical decisions: "Moreover, it's neither fair nor realistic to expect ordinary citizens to have enough medical expertise to make life or death decisions about their own medical treatment." Paul Krugman, "Medicine: Who Decides?" *The New York Times*, December 26, 2005, p. A31. In many states, physicians are required by law to explain to patients the risks and benefits of medical procedures, and patients routinely sign statements of consent before beginning a procedure or course of medical treatments that carries risk, including life-and-death decisions.
22. President's Council on Bioethics, *Taking Care: Ethical Care-Giving in Our Aging Society*, September 2005, p. ix, at *www.bioethics.gov/reports/taking_care/taking_care.pdf* (April 10, 2006).
23. The CMS is the agency that runs the Medicare program and oversees Medicare contractors.
24. Barry Straube, "How Changes in the Medicare Coverage Process Have Facilitated the Spread of New Technologies," *Health Affairs Web Exclusive*, June 23, 2005, p. W5-314.

Today, the diseases most closely associated with aging—such as Alzheimer's disease, congestive heart failure, dementia, and stroke—account for roughly 40 percent of all deaths.[26] For example, Alzheimer's affects nearly 4.7 million Americans, and that number is projected to increase fourfold by 2050 absent a major medical breakthrough.[27] These diseases are often accompanied by a prolonged decline, which can take a high emotional toll on the patient's family and incurs substantial financial costs.

Not surprisingly, Medicare's rising costs—projected to reach a stunning $792 billion by 2015—will be driven disproportionately by end-of-life care. Dr. Henry Aaron, a senior fellow at the Brookings Institution, warns that rapidly rising health care costs will force policymakers to make hard decisions, including explicitly rationing care.[28]

In Britain, explicit rationing of medical services for debilitated senior citizens is an emerging issue. In fact, according to *The Telegraph*, "Recent British Medical Association Guidelines say doctors should be allowed to authorize withdrawal of nutrition and hydration by tube for stroke victims and the confused elderly, even when the patient is *not* terminally ill."[29]

Social and economic pressures will intensify the debates about the quality of life among the aged. Many Americans understandably welcome advance directives, intended to bring greater clarity and personal choice to end-of-life decisions. Wary critics, however, charge that do-not-resuscitate orders, living will documents, and physician-assisted suicide laws are "signposts of our own culture of death," in which "more of us will die prematurely; some of us will even be persuaded that we want to."[30]

Physician-Assisted Suicide. Physician-assisted suicide involves a physician, at the request of a terminally ill patient, prescribing a lethal dosage of medication to the patient, who administers it to himself. In this respect, physician-assisted suicide is different from euthanasia, the cessation of medical treatment or a lethal injection administered by a doctor. Euthanasia is illegal in every state in the U.S., but it is legal in some European countries.

In America, Oregon is the only state that has legalized physician-assisted suicide. A recent survey there showed that "[t]he most common reason for wanting to hasten death was not pain, but anxiety over a loss of autonomy."[31] In 2004, the most recent year for which data are available, 37 Oregonians ingested a prescribed lethal drug, although 60 prescriptions were written.[32] Currently, Oregon taxpayers fund physician-assisted suicide through their state Medicaid programs. Private health plans are also permitted to cover physician-assisted suicide under Oregon law.

Despite the medical profession's formal opposition, physician-assisted suicide is likely to become

25. Dana P. Goldman, Baoping Shang, Jayanta Bhattacharya, Alan M. Garber, Michael Hurd, Geoffrey F. Joyce, Darius N. Lacdawalla, Constantjin Panis, and Paul G. Shekelle, "Consequences of Health Trends and Medical Innovation for the Future Elderly," *Health Affairs Web Exclusive*, September 26, 2005, p. W5-R5.
26. President's Council on Bioethics, *Taking Care*, p. 13.
27. *Ibid.*, p. 36.
28. Henry J. Aaron, William B. Schwartz, and Melissa Cox, *Can We Say No? The Challenge of Rationing Health Care* (Washington, D.C.: Brookings Institution Press, 2006), pp. 146–148.
29. Sandra Laville and Celia Hall, "Elderly Patients 'Left Starving to Death in NHS,'" *The Telegraph*, December 6, 1999, at *www.telegraph.co.uk/htmlContent.jhtml?html=/archive/1999/12/06/neld06.html* (May 3, 2006). Emphasis added.
30. Paul McHugh, "Annihilating Terri Schiavo," *Commentary*, June 2005, p. 32.
31. "The Art of Dying," *The Economist*, October 13, 2005, p. 59, at *www.economist.com/printedition/displayStory.cfm?story_id=5026337&fsrc=RSS* (April 10, 2006).
32. Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, *Seventh Annual Report on Oregon's Death with Dignity Act*, March 10, 2005, p. 4, at *www.oregon.gov/DHS/ph/pas/docs/year7.pdf* (April 10, 2006).

The Hippocratic Oath

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.[1]

1. Ludwig Edelstein, trans., "The Hippocratic Oath," in Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (Baltimore, Md.: Johns Hopkins Press, 1943), at *www.pbs.org/wgbh/nova/doctors/oath_classical.html* (April 13, 2006).

more common. Measures to legalize the practice have surfaced in California, Vermont, Connecticut, Hawaii, Maine, Michigan, and Washington. In *Gonzales v. State of Oregon*, the U.S. Supreme Court recently heard a challenge to Oregon's Death with Dignity law and upheld the 9th Circuit Court's decision in favor of the Oregon law.[33]

Once again, American public opinion is deeply divided over whether physician-assisted suicide should be legalized: 46 percent of Americans approve of such laws, while 45 percent oppose them.[34] Detailed survey results indicate that Americans' views on the morality of different end-of-life issues vary substantially, depending on circumstances. Interestingly, fewer people would personally request that their doctor withhold treatment if they themselves were diagnosed with a terminal or debilitating illness than would sup-

33. See *Gonzales, Attorney General, et al. v. Oregon et al.*, 546 U.S. __ (2006), Slip Opinion, Decided January 17, 2006, at *http://a257.g.akamaitech.net/7/257/2422/17jan20061050/www.supremecourtus.gov/opinions/05pdf/04-623.pdf#search='gonzales%2C%20attorney%20general%20v.%20state%20of%20oregon'* (May 8, 2006).

34. Pew Research Center for the People and the Press, "Strong Public Support for Right to Die: More Americans Discussing—and Planning—End-of-Life Treatment," January 5, 2006, p. 5, at *people-press.org/reports/pdf/266.pdf* (April 10, 2006).

port the general idea of cutting off medical treatment in similar circumstances.[35]

Patients and Doctors. Trust is crucial in the doctor–patient relationship, and it is clearly enhanced when physicians and patients share basic ideas about care. Preliminary studies show that the compatibility between patients' and doctors' beliefs about medical care itself is a key determinant of patient trust and satisfaction.[36] Patients are more likely to trust their physicians if their beliefs are congruent or comparable.[37]

The public consensus on ethical questions about beginning-of-life and end-of-life issues has broken down. This is evidenced by survey research on the abortion issue,[38] public opinion on the tragic Terri Schiavo case, and polling about embryonic stem cell research. Given the lack of moral consensus on ethical issues, the doctor–patient relationship becomes even more crucial. However, this gives rise to another problem: A reliance on the personal judgment of physicians on these matters may prove to be of small comfort to millions of Americans simply because physicians do not necessarily share their perspectives on these ethical questions. It is a profound mistake to assume either that the medical profession is united under a common set of strict ethical and moral standards or that one's doctor has sworn to uphold the Hippocratic Oath.[39]

The Hippocratic Oath and its traditional variants have quietly sunk into obscurity. By 1977, only 6 percent of American medical schools used the literal translation of the Oath of Hippocrates from the original Greek, and 42 percent used a modified version.[40] Some medical schools administered no oath at all. In others, the medical students vote for the oath they prefer.[41]

By 1993, an analysis of the oaths administered in medical schools showed a continuing decline of the traditional Hippocratic Oath, with schools simply discontinuing it, eliminating or watering down its ethical content, adopting other physician oaths, or requiring no oaths at all.[42] As health care economists John Goodman and Gerald Musgrave observe, "[A]lthough many physicians still honor the tradition and general sentiments of the Hippocratic Oath, as a practical matter, the oath is largely ignored in modern medicine."[43]

The dismissal of the Hippocratic Oath and its relevance has direct clinical consequences. Inequality of treatment for cancer, heart disease, and strokes and the rationing of health care among senior citizens in Britain—even the denial of water and nutrition to debilitated patients—is reflective of it. As Sir

35. *Ibid.*, p. 6.
36. Edward Krupat, Ph.D., John Hsu, M.D., Julie Irish, Ph.D., Julie A. Schmittdiel, and Joe Selby, M.D., "Matching Patients and Practitioners Based on Beliefs About Care: Results of a Randomized Controlled Trial," *The American Journal of Managed Care*, Vol. 10, No. 11 (November 2004), pp. 814–822.
37. Edward Krupat, Ph.D., Robert A. Bell, Ph.D., Richard L. Kravitz, M.D., David Thom, M.D., Ph.D., and Rahman Azari, Ph.D., "When Physicians and Patients Think Alike: Patient-Centered Beliefs and Their Impact on Satisfaction and Trust," *The Journal of Family Practice*, Vol. 50, No. 12 (December 2001), p. 1057.
38. Polling data on public opinion about abortion are plentiful and generally indicate that Americans are divided on when (if ever) abortion should be legal and whether or not abortion constitutes murder. For a comprehensive collection of public opinion data, see Karlyn H. Bowman, Bryan O'Keefe, and Adam Herschthal, "Attitudes About Abortion," American Enterprise Institute *Studies in Public Opinion*, July 2005, at *www.aei.org/publications/pubID.22864/pub_detail.asp* (April 10, 2006).
39. For example, the Hippocratic Oath explicitly forbids abortion, euthanasia, the seduction of patients, and the betrayal of patient confidentiality. See Jane M. Orient, M.D., *Your Doctor Is Not In* (New York: Crown Publishers, 1994), pp. 255–256.
40. Orient, *Your Doctor Is Not In*, p. 66.
41. *Ibid.*
42. Robert D. Orr, M.D., and Norman Pang, M.D., "Content Analysis of Oaths Administered in Medical Schools," presentation at Loma Linda University, 1993.
43. John C. Goodman and Gerald L. Musgrave, *Patient Power* (Washington, D.C.: Cato Institute, 1992).

John Grimley Evans, professor of clinical gerontology at Oxford University, observes:

> If this is a decision which is being made by private trusts about the way we treat the elderly and by doctors who have taken a Hippocratic oath, then I cannot square that. It needs to be out in the open. If as a society this is what we want to happen and that is acceptable, then so be it. But let's not have it going on behind closed doors.[44]

Millions of Americans can no longer assume that their physicians uphold traditional medical ethics concerning some of the most contentious issues in medical care. In the absence of a moral consensus, most Americans would probably agree that these are precisely the cases in which medical decisions ought to reflect the affected individual's beliefs.

Individuals need to be free to choose health plans and physicians that are in accord with these beliefs or that, at the very least, will respect them. New values-driven health plans could allow just that. Such plans could include only those physicians and specialists who are dedicated to upholding a specific set of ethical standards.

How Health Care Financing Frustrates Personal Freedom

The third-party payment arrangement—individuals pay premiums to insurers, who in turn pay doctors and hospitals—dominates health care financing today through insurance. Economically, this arrangement is inherently flawed. Professor Vernon Smith, a 2002 Nobel Laureate in Economics at George Mason University, explains that "there is no automatic balance between willingness to pay by the consumer and willingness to accept by the producer that constrains and limits the choices of each."[45]

In the private sector, third-party payment is employer-based, with employers contracting with private plans on behalf of employees and their families. In the public sector, large government health care programs, notably Medicare and Medicaid, pay doctors and hospitals for specified benefits under certain specified and highly regulated conditions on the basis of government fee schedules. In both cases, the status quo frustrates consumer choice by heavily insulating a huge and growing portion (one-sixth or $1.9 trillion) of the American economy from the personal preferences of individual consumers.[46]

Restricted Choice. For most Americans, a choice of employer-based health plans often means a conventional health plan such as a health maintenance organization (HMO) or preferred provider organization (PPO). The range of personal choice varies sharply with employer size. According to a recent Kaiser Family Foundation report, 65 percent of large firms (5,000 or more employees) offer a choice of three or more plans, but only 5 percent of small firms (less than 200 workers) offer the same range of choice. Among all firms, 80 percent offer only one plan.[47]

While the raw data suggest that most Americans have a choice of health plans through employers, in reality, that choice is tightly constrained because employer health plans are usually offered through the same insurance carrier, often with the same networks of physicians and delivery systems. Alain Enthoven, professor at the Graduate School of Business at Stanford University, estimates that only

44. Laville and Hall, "Elderly Patients 'Left Starving to Death in NHS.'"

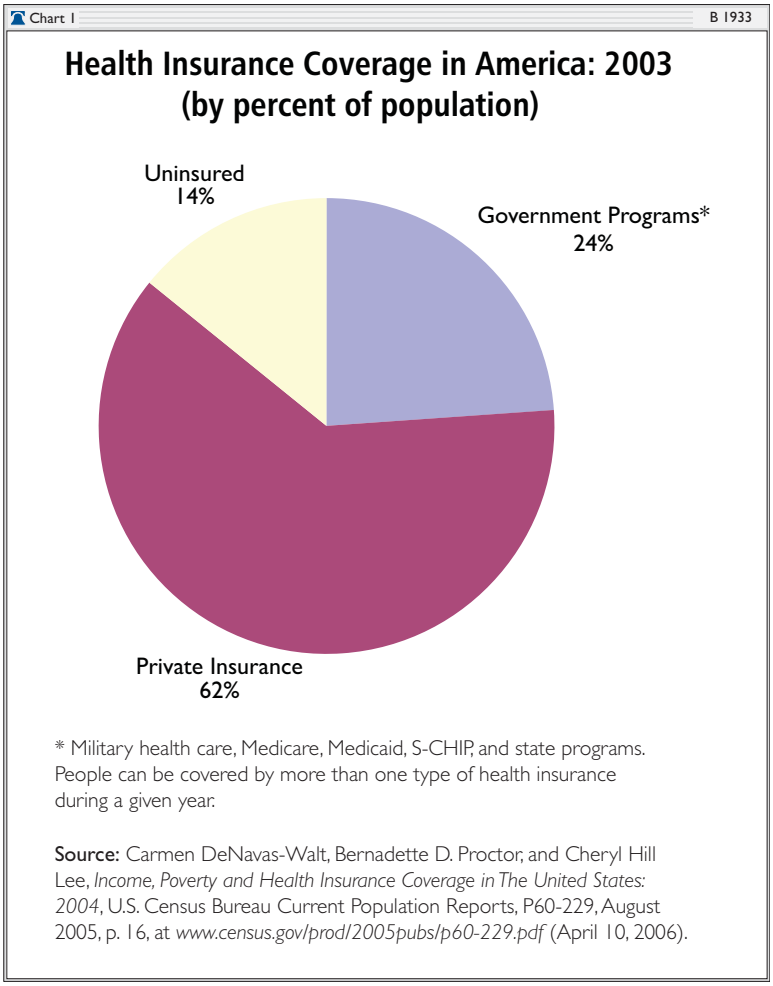
45. Vernon L. Smith, "Trust the Customer," *The Wall Street Journal*, March 8, 2006, p. A20.

46. National health expenditures are projected to exceed $4 trillion in 2015. As a share of GDP, health spending is projected to reach 20 percent by 2015, up from 16.5 percent in 2006. Direct out-of-pocket spending for health care accounts for only 15.1 percent of personal health care spending and is expected to decline to 12.6 percent in 2015. While health savings accounts, from which direct medical payments are made to doctors and other medical professionals, are rapidly growing, they still accounted for only 1 percent of all employees with insurance coverage in 2005. Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal, and M. Kent Clemens, "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs Web Exclusive*, February 22, 2006, pp. W61–W63.

47. Henry J. Kaiser Family Foundation, "Employer Health Benefits 2005 Annual Survey," at *www.kff.org/insurance/7315/sections/ehbs05-design-print.cfm* (April 10, 2006).

23 percent of insured workers were offered a choice of carrier.[48]

Nearly 85 percent of the American population is covered by health insurance programs. More specifically, 27.2 percent of Americans are covered under government programs, such as Medicare, Medicaid, and the State Children's Health Insurance Program, and 68.1 percent are covered by private insurance. (See Chart 1.)



The largest share of private coverage is employment-based coverage, which accounts for almost 60 percent of health insurance coverage in America.[49] A Kaiser Family Foundation survey of employer-sponsored group health insurance found that the average annual premium for single coverage is $4,024 and that the average annual premium for family coverage is $10,880.[50] The much smaller individual health insurance market is generally less expensive, but its cost varies sharply from state to state and with demographic and geographic characteristics of the insured population.

A Politicized Process. Health insurance is governed by federal and state tax policy, state regulation and insurance rules (including benefit mandates), and certain federal regulations. It is one of the most highly regulated sectors of the American economy. Together, these government policies largely determine the kind and quality of health insurance that is available to individuals and families.

The evolving set of complex relationships among health plans, doctors, hospitals, and other medical institutions is routinely played out in an arcane legislative and regulatory arena where powerful special interests attempt to push the levers of government power to micromanage their competitive position in the health care system. Therefore, health care financing and delivery is largely politicized and driven by narrow but intense special interests, not by the free market or the personal preferences of individuals and families.

Federal Tax Policy. America's health insurance markets are characterized by large and growing federal and state tax breaks for health insurance

48. Alain Enthoven, "Employment-Based Health Insurance Is Failing: Now What?" *Health Affairs Web Exclusive*, May 28, 2003, p. W3-240.
49. Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, *Income, Poverty and Health Insurance Coverage in the United States: 2004*, U.S. Census Bureau *Current Population Reports*, P60–229, August 2005, p. 16, at *www.census.gov/prod/2005pubs/p60-229.pdf* (April 10, 2006).
50. Henry J. Kaiser Family Foundation, "Employer Health Benefit: 2005 Summary of Findings," September 14, 2005, p. 2, at *kff.org/insurance/7315/sections/upload/7316.pdf* (April 10, 2006).

that total more than $210 billion in 2004 dollars. Under the federal tax code, an individual can get unlimited tax relief only if he purchases health insurance through his employer.

For all practical purposes, this creates a monopoly of one type of health care coverage: employer-based health insurance. If an individual or a family wanted to buy a plan other than the one offered through an employer, their only choice would be to buy the health plan with their after-tax dollars, which would greatly increase the effective cost of the health insurance package. Without the special tax treatment, a health plan provided by an employer to a typical middle-class family on a pre-tax basis would cost twice as much as it would with after-tax dollars.[51] Coupled with the higher administrative, marketing, and regulatory costs of individual insurance coverage, this often makes health plans outside of employment prohibitively expensive for middle-class families.

There are other serious problems with the existing federal and state tax treatment of health insurance.

First, because individuals and families often receive health insurance through employers, they enjoy no portability or continuity of coverage. If they leave or lose their job, they lose their health plans because they do not own the insurance policies; their employers own them. A contributing factor in the growing number of uninsured is that millions of Americans lose their coverage or are in and out of coverage.

Second, because these individuals and families do not own the policies, they have no final determination over the content of the health plan—what is and is not covered. For all practical purposes, health insurance for most Americans is a take-it-or-leave it proposition. This is also the flashpoint where health care financing often collides with ethical issues. Catholic Medical Association officials note that, while more than 45 million Americans are uninsured, "the number of Americans…who cannot obtain coverage that matches the varying needs of the life cycle, or more important, who cannot obtain coverage that accords with their fundamental moral beliefs—is far larger."[52]

State Regulation and Mandates. State governments impose regulations and benefit requirements on insurance companies and health plans. Nationwide, state legislators have imposed an estimated 1,824 benefit and provider mandates, covering a broad range of medical services, treatments, procedures, and providers.[53] From an ethical standpoint, some are controversial. For example, 29 states require coverage for contraceptives, and 15 states mandate in vitro fertilization coverage—an expensive benefit.[54]

Many Americans do not realize that their insurance premiums are financing medical procedures that violate their moral convictions. These could include abortion, in vitro fertilization, sterilization, and contraception, all of which are practices and procedures that many Americans, in varying numbers, consider unethical or incompatible with their religious convictions.[55]

For example, a 2003 Kaiser Family Foundation report found that 46 percent of workers in employer-sponsored insurance were covered by health plans that included abortion services.[56] Likewise, the number of private health plans that cover contraceptives has increased rapidly in recent years, from only 28 percent of the employer-spon-

51. See National Center for Policy Analysis, "Making Health Insurance Portable," at *www.ncpa.org/pub/special/20060130-sp.html* (April 10, 2006).

52. Catholic Medical Association, *Health Care in America: A Catholic Proposal for Renewal*, September 2004, p. 1.

53. Merrill Matthews, Director, Council for Affordable Health Insurance, testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, June 28, 2005, p. 4, at *www.cahi.org/cahi_contents/issues/MMChoiceTestimony.pdf* (April 10, 2006).

54. Victoria Craig Bunce and J. P. Wieske, "Health Insurance Mandates in the States," Council for Affordable Health Insurance, January 2005, at *www.cahi.org/cahi_contents/resources/pdf/MandatePubDec2004.pdf* (April 10, 2006).

55. No state currently mandates coverage for abortion, and only Vermont mandates coverage for sterilization procedures; however, many health plans choose to include these procedures for political or other reasons.

sored health plans in 1993 to 86 percent in 2002.[57] While those who are enrolled in health plans that cover contraceptives may forgo such benefits, they are nevertheless forced to contribute financially to something that offends their consciences.

Beyond ethical conflicts in private health care arrangements, individuals and families are taxed to support medical procedures that they might find ethically or morally objectionable. For example, each year, S-CHIP gives states billions of dollars in federal grants to provide health insurance to the children of working parents. States administer this program, and most states include coverage for artificial contraception through S-CHIP. Many state officials are not required to seek parental consent or even to inform parents when their minor children receive these prescriptions or procedures. In fact, many states have laws, ostensibly written to protect adolescents' privacy, that effectively prohibit parents from making informed decisions about their children's health care and treatment.[58] Likewise, while Congress routinely restricts Medicaid funding for abortion, states administer the program, and some states use state Medicaid funds to reimburse for abortion expenses.[59]

With time, ethical issues in health care will have broader practical and political consequences. The fruits of ongoing research in genetics, embryonic stem cell research, and human cloning are likely to become embodied in medical treatments and procedures that in turn will be absorbed into health insurance coverage. Individuals' freedom of conscience, often focused on the ethical responsibilities of doctors, nurses, pharmacists, and other medical providers, will inevitably become a major issue for patients. The old system of health care financing, particularly the third-party payment system that dominates public and private insurance, is not prepared to cope with those concerns.

Why Values-Driven Health Care Plans Make Sense

In America, the financing of health care through insurance is routinely separated from its delivery through various institutions and providers.[60] A new consumer-driven system that included values-driven health plans would have great potential to bridge this gap.

This consumer-driven system could enable single organizations with comprehensive philosophies of care to include doctors and insurers of like mind. In such an organization, the insurer would act as the patient's direct agent, while doctors and medical professionals would serve the patient's health care needs. Under the employment-based insurance model, employers contract with doctors and hospitals for reasons of efficiency and cost-effectiveness, but almost never on the basis of shared ethical or religious values.

Controlling the Dollars. The current system of health care financing contrasts sharply with how millions of Americans finance their pensions and make other financial investments. Many Americans are keenly aware that their financial investments may be used for purposes that contradict their beliefs or advance objectives with which they disagree. As a result, there has been a growing phenomenon of "socially responsible investing" or "ethical investing," which integrates personal, social, or ethical concerns

56. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *2003 Employee Health Benefits Survey*, p. 109, Exhibit 8.2, at *www.kff.org/insurance/upload/Kaiser-Family-Foundation-2003-Employer-Health-Benefits-Survey-Full-Report.pdf* (October 21, 2005).
57. Adam Sonfield, Rachel Benson Gold, Jennifer J. Frost, and Jacqueline E. Darroch, "U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002," *Perspectives on Sexual and Reproductive Health*, Vol. 36, No. 2 (March/April 2004), pp. 72–79, at *www.guttmacher.org/pubs/journals/3607204.pdf* (April 10, 2006).
58. See Laura Landro, "Parents Barred from Teen Health Files," *The Wall Street Journal*, August 24, 2005, p. D1.
59. National Abortion Federation, "Public Funding for Abortion: Medicaid and the Hyde Amendment," at *www.prochoice.org/about_abortion/facts/public_funding.html* (March 14, 2006).
60. A clear exception to this conventional approach is the Kaiser Permanente insurance program of managed care, which tightly integrates health insurance, care delivery, and case management. Basically, the Kaiser system is an insurance company with its own doctors and hospitals.

with financial objectives. Today, millions of Americans control their investment portfolios, including more than $2.1 trillion invested in firms that practice some form of self-described ethical investing.

Nonetheless, millions of Americans pay hundreds of billions of dollars in premiums to health care plans over which they have no such control. The financial investment world, where ethical investing is well-established, could serve as a model of how personal control of health care spending could work.

A Religious Base. Religious institutions and faith-based organizations have been and continue to be very active in performing social services and delivering health care to millions of Americans. As a result, many would be ideally suited to sponsor or endorse values-driven health plans of their own.

Hospitals, clinics, and hospice centers run by religious groups represent a significant national force in health care delivery. For example:

- The Adventist Health System, one of the largest not-for-profit health care organizations in the United States, employs 44,000 people, administers 38 hospitals in 10 states, runs 23 nursing homes, and serves over 4 million patients annually.[61]
- Baptist Health System, Inc., is Alabama's largest health care system with eight hospitals, approximately 1,700 physicians, and nine senior housing facilities.[62]
- Similarly, there are Baptist hospitals or health care facilities in many other states, including Arkansas, Florida, North Carolina, Tennessee, Texas, and Virginia.
- The Jewish Hospital HealthCare Services is a regional network of more than 50 health care facilities in Kentucky and southern Indiana,[63] and many other religiously affiliated hospitals and service providers can be found throughout the country.
- There are also a large number of health care services provided by institutions affiliated with the Roman Catholic Church. The 615 Catholic hospitals in the United States account for roughly 12.5 percent of all community hospitals and 20 percent of all hospital admissions in 20 states across the country.[64] In addition, Catholic ministries run social service centers, day and extended day services, continuing care ministry facilities, and hospice care.

Churches and faith-based groups also tend to be active at the community level in other aspects of health care, such as preventive care, meals for the sick, care for the poor and uninsured, retirement or assisted living for the elderly, and hospice care for the dying. Hospice care especially lends itself to religious participation because it occurs once a patient's disease is medically incurable and usually terminal. Its goal is to ease the patient's suffering, never betraying the patient to death by depriving him of food, water, and cleanliness but sometimes helping the patient to accept the inevitability of a terminal illness and forgo heroic, but ultimately ineffective, medical procedures.[65]

A Tradition of Service. During the 19th and early 20th centuries, numerous fraternal societies, including faith-based groups, sponsored insurance policies for their members that covered old age, disability, dismemberment, and sickness. For example, in 1887, the Polish Roman Catholic Union of America had a program for life and survivor benefits; in 1902, the Aid Association for Luth-

61. Adventist Health System, "Adventist Health System Fast Facts," at *www.adventisthealthsystem.com/about.asp* (September 6, 2005).

62. Baptist Health System, "About BHS," at *www.baptistmedical.org/aboutUs/index.asp* (September 2, 2005).

63. Jewish Hospital and St. Mary's HealthCare, "About Jewish Hospital," updated November 30, 2005, at *www.jewishhospital.com/about/index.asp* (September 2, 2005).

64. Catholic Health Association of the United States, "Catholic Health Care in the United States," January 2006, at *www.chausa.org/NR/rdonlyres/68B7C0E5-F9AA-4106-B182-7DF0FC30A1CA/0/FACTSHEET.pdf* (April 28, 2006), and "Fast Facts," *www.chausa.org/Pub/MainNav/whoweare/Our+Present/FastFacts.htm* (April 10, 2006).

65. McHugh, "Annihilating Terri Schiavo," pp. 30–31.

erans provided sickness and disability benefits for its members; and in 1925, the Independent Order of Brith Shalom offered insurance for life and old age benefits to its Jewish membership.[66]

Future Possibilities. With the right legal and regulatory changes, policymakers could create a consumer-based environment for the resurrection of fraternal, social, and religious institutions to play a direct role in the financing and delivery of health care.[67]

The Federal Employees Health Benefits Program, the largest group insurance system in America, is a national consumer-driven market for federal employees and retirees. Governed by a single set of simple rules, it provides a level playing field for all kinds of health plans. It is open to federal employees, retirees, and their families, who can choose a plan from a large pool of health care options.[68] In 2005, 249 plans competed nationally for enrollees' business, with families around the country able to choose from between one and two dozen different plans. In 2006, 278 plans participate in the FEHBP.

One of these federal employee plans is the Order of Saint Francis Healthcare System, run by an order of Catholic nuns in Illinois.[69] The Sisters of the Third Order of St. Francis are very clear about their governing values in health care: Every person is created in the image and likeness of God, is dependent on God, and is endowed with God-given rights. Every person has moral obligations toward God, fellow human beings, and himself.[70]

While the American people are highly religious, Americans have access to very few health plans that are governed by religious values, outside of isolated pockets where church groups provide religiously based insurance arrangements. However, there are alternative arrangements.

For example, the Christian Care Ministry's Medi-Share program is a faith-based health care alternative in the form of a religiously based cooperative.[71] With over 50,000 participants, Medi-Share, which is sponsored by the American Evangelistic Association, brings Christian families together to share medical expenses. Contributors pay what they can, but Medi-Share participants' contributions are in the form of after-tax dollars. This contrasts sharply with employer-based health insurance, in which persons pay for insurance with pre-tax dollars.

Removing Barriers to Values-Driven Health Care Options

Ideally, American families should be free to choose from a wide variety of health insurance options, including plans sponsored by unions,

66. There were many other religiously affiliated groups that provided similar services, including the Bohemian Roman Catholic Union of Texas, the Catholic Aid Association of Minnesota, the German Baptists Life Association, the Independent Order Free Sons of Israel, the Lutheran Brotherhood, the Roman Catholic Mutual Protective Society of Iowa, and the Slavonic Evangelical Union of America. *The Fraternal Insurance Compend of 1926*, cited in Phyllis Berry Myers, Richard Swenson, M.D., Michael O'Dea, and Robert E. Moffit, Ph.D., "Why It's Time for Faith-Based Health Plans," Heritage Foundation *Lecture* No. 850, August 24, 2004, at *www.heritage.org/Research/HealthCare/hl850.cfm*.

67. For a broad discussion of the rationale and potential role of church and religious organizations in sponsoring health insurance plans, see Myers *et al.*, "Why It's Time for Faith-Based Health Plans."

68. Robert E. Moffit, Ph.D., "What Federal Workers Are Doing Today That You Can't," Heritage Foundation *WebMemo* No. 604, November 8, 2004, at *www.heritage.org/Research/HealthCare/wm604.cfm*.

69. For more information about the Order of Saint Francis Healthcare System, see OSF Healthcare System, Web site, at *www.osfhealthcare.org/index.html* (April 26, 2006).

70. The Order of St. Francis Healthcare System consists of six acute care facilities, one long-term care facility, two colleges of nursing, and a primary care physician network of 120 physicians and 50 mid-level providers. OSF Healthcare, "Mission," at *www.osfhealthcare.org/missionvision.html* (April 10, 2006), and "Who We Are," *www.osfhealthcare.org/whoweare.html* (April 10, 2006).

71. For a discussion of the efforts of Christian Care Medi-Share and similar programs, see Sandra G. Boodman, "Seeking Divine Protection," *The Washington Post*, October 25, 2005, p. HE01, at *www.washingtonpost.com/wp-dyn/content/article/2005/10/22/AR2005102200046.html* (April 13, 2006).

trade associations, affinity groups, ethnic and fraternal organizations, and religious and faith-based institutions. With a diversity of health care options competing on a level playing field unhampered by outdated tax and regulatory penalties, individuals and families could enroll in health plans that best meet their health care needs and reaffirm (or at least respect) their ethical, moral, and religious values. For all practical purposes, American families are barred from making such choices today.

The main obstacles to integrating faith-based and other values-driven organizations into the health care system are outdated statutory and regulatory policies at the state and federal levels. Congress and the Bush Administration have taken several small steps toward changing both the tax treatment of health insurance and the structure of the health insurance market. The most significant change has been the creation of tax-free, high-deductible health savings accounts (HSAs). Yet HSA plans by themselves will not broadly transform the health insurance markets.

To make serious changes in the insurance markets and to create a level playing field for a variety of health plans, including values-driven plans, Congress should take several crucial steps:

Step # 1: End tax code discrimination against personal choice by providing individual health care tax credits.

Every person and every family should have the right to enroll in the health care plan of their choice, including a values-driven health plan. The only way to do this is to allow individuals and families to own their health insurance policies. This, in turn, can be done only by providing direct individual tax relief for the purchase of health insurance policies. Without this key policy change, personal control over health insurance is unattainable.[72]

Congress can accomplish this goal in a variety of ways. A comprehensive option would be to replace the existing tax regime for health insurance, including the tax exclusion of the value of employer-based health benefits, with a universal national tax credit system, as proposed by The Heritage Foundation[73] and the American Enterprise Institute.[74] Broadly, under the original Heritage Foundation proposal, health care tax credits would be generous, refundable, universally available, and vary according to a person's income and health care needs, with families that have lower incomes and higher health care costs receiving more assistance.

A more limited option would target a refundable health care tax credit system to the uninsured, employees of small firms,[75] and employees who do not or cannot get health insurance through their places of work. President Bush and several Members of Congress have made broadly similar proposals over the past several years.[76] This more limited approach would create a more robust parallel system of private coverage, along with the existing system of employer-based health insurance, while expanding coverage to the millions of Americans who are currently uninsured.

72. For a more detailed discussion of this point, see Robert E. Moffit, Ph.D., "The Economic and Ethical Dimensions of Health Policy," *The Journal of Contemporary Health Law and Policy*, Vol. 18, No. 3 (Fall 2002), pp. 663–672.
73. For the most recent version of The Heritage Foundation's proposal for universal coverage, see Stuart M. Butler, "Reforming the Tax Treatment of Health Care to Achieve Universal Coverage," in Economic and Social Research Institute, *Covering America: Real Remedies for the Uninsured*, Vol. I, June 2001, pp. 21–42, at *www.esresearch.org/RWJ11PDF/butler.pdf* (April 13, 2006).
74. For an account of the comprehensive American Enterprise Institute (AEI) plan, see Mark V. Pauly, Patricia M. Danzon, Paul Feldstein, and John S. Hoff, *Responsible National Health Insurance* (Washington, D.C.: AEI Press, 1992). For a more recent AEI discussion, see Mark V. Pauly and John S. Hoff, *Responsible Tax Credits for Health Insurance* (Washington, D.C.: AEI Press, 2002), at *www.cnehealth.org/pubs/health_care_debate_in_usa.pdf* (April 13, 2006).
75. See Stuart M. Butler, "Reducing Uninsurance by Reforming Health Insurance in the Small-Business Sector," Heritage Foundation *Backgrounder* No. 1769, June 17, 2004, at *www.heritage.org/research/healthcare/bg1769.cfm*.
76. For an account of the Bush proposal, see Robert E. Moffit and Nina Owcharenko, "An Examination of the Bush Health Care Agenda," Heritage Foundation *Backgrounder* No 1804, October 12, 2004, at *www.heritage.org/research/healthcare/bg1804.cfm*.

In either case, the individual health care tax credit would enable families to buy the health plans that they want with direct assistance from the government, just as others receive tax relief for insurance premiums paid through employer-based health benefit programs. For individuals and families purchasing health insurance in the individual market, even a modest tax break could result in significant savings to family budgets, depending on market conditions in their states.

Premiums in the individual market are not as high as many Americans might imagine and are generally less than premiums in employer-based health insurance. According to a major survey of individual health plans by America's Health Insurance Plans (AHIP), the nation's largest trade association for health insurers, nationwide premiums for these plans average $2,268 for single coverage and $4,424 for family coverage.[77]

Indeed, the most affordable health insurance products for individuals and families are the rapidly growing HSA plans, which now have more than 3 million enrollees. As an insurance product, HSAs are generally less costly than conventional insurance.[78] Beyond the limited HSAs, individual health care tax credits would make health care more affordable and flexible for all and address the problem of the uninsured.

Regardless of how individual health care tax credits are designed—and there are numerous design options[79]—the central policy objective that unifies the advocates of tax reform is that the federal tax code should not discriminate against individuals or groups who purchase health insurance outside the workplace. This single policy change would remove a major barrier to enrollment in values-driven health plans by both individuals and families.

Step #2: Create a level playing field for different kinds of health plans.

Today, federal and state laws and regulations favor employer-based health insurance.[80] While Congress is considering legislation to expand health insurance options to association health plans (AHPs), this expansion is limited and does not adequately expand access for individuals and families outside of the conventional employer-based insurance model. Legislation passed by the House of Representatives in 2005 would have broadened employer pooling by allowing small businesses to pool their resources to achieve the same economies of scale and lower administrative and regulatory costs that large corporations enjoy.

While this approach would make it easier for small-business owners to purchase insurance, it does not create a consumer-based system. President Bush's proposal to broaden the insurance market for all kinds of association health plans, especially individual membership plans, is a better proposal. According to the White House:

> Expanded AHPs address the needs of vulnerable Americans by allowing bona fide civic, community and religious groups to purchase health coverage for their members, giving individuals and their families the ability to pool together to buy health insurance outside of the workplace. Giving people more choices to buy insurance at group rates from organizations they already know and trust will help many Americans

77. Thomas F. Wildsmith, Teresa Chovan, and Hannah Yoo, "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," America's Health Insurance Plans, Center for Policy and Research, August 2005, p. 1, at *www.heartland.org/pdf/17693.pdf* (April 13, 2006).

78. Derek Hunter, "Health Savings Accounts: The News Keeps Getting Better," Heritage Foundation *WebMemo* No. 833, September 6, 2005, at *www.heritage.org/Research/HealthCare/wm833.cfm*.

79. Nina Owcharenko, "Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage," Heritage Foundation *Backgrounder* No. 1895, November 8, 2005, at *www.heritage.org/research/healthcare/bg1895.cfm*.

80. Federal regulation of self-insured plans is authorized under the Employees Retirement Income Security Act of 1974 (ERISA). This law governs large, corporate-based health insurance arrangements. Under ERISA, these corporate plans are exempt from state-based regulation, including state benefit mandates, and state premium taxes.

purchase quality, affordable, and portable health insurance.[81]

Similarly, state legislators could set up a health insurance market for their state, such as a statewide health insurance exchange where individuals and families could purchase coverage. Employers could make tax-free defined contributions to the health plans that employees choose, and state governments could help low-income families with subsidies to offset the cost of the coverage. These state-level changes would also allow health care plans run by associations and values-driven health plans to compete in a more robust health care marketplace.

At the very least, state legislators could change state insurance law, eliminate or reduce benefit mandates, promote greater flexibility in benefit design, and remove state tax and regulatory penalties that frustrate the growth of different kinds of health plans, including association and values-driven health plans based on individual membership.

Step #3: Eliminate barriers to Americans purchasing health insurance across state lines.

Health care markets are geographically concentrated in state and local jurisdictions, where they are largely governed and restricted by state law and regulation. Professor Regina Herzlinger of Harvard University has noted that current arrangements fragment the delivery of health care, frustrate consumer choice, and are characterized by a greater variability in the quality of care and reduced economic efficiency.[82]

As Michael Porter of Harvard University and Elizabeth Olmstead Teisberg of the University of Virginia also argue, "Such competition insulates mediocre providers from market pressures and inhibits the spread of best practices and innovations."[83] They note that health care costs vary widely across the United States and that this variation is not correlated with medical performance or outcomes. Furthermore, local health plans are insulated from broader market competition, which would reduce costs and enable growth of regional and national markets.[84] Today's confined health care markets are outdated in an age of expanded information technology and increasingly national access to goods and services in every other sector of the economy.

As in local health provider markets, health insurance premiums vary widely from state to state. A recent eHealthInsurance survey of the individual insurance market found that monthly premiums for self-only, individual policies in the top 50 U.S. cities range from a low of $54 in Long Beach, California, to $334 in New York City.[85] These variations reflect underlying health care costs and medical practice patterns as well as the different state health insurance regulations and policies. In both cases, current insurance markets restrict individual and family access to different types of health insurance, hindering the potential for the growth of values-driven health plans on a nationwide basis.

To broaden access to affordable insurance, Representative John Shaddeg (R–AZ) and Senator Jim DeMint (R–SC) have sponsored the Health Care Choice Act (H.R. 2355 and S. 1015), which would allow individuals and families to purchase health insurance plans across state lines while retaining the states' primary authority to regulate health insurance products.[86] Evidence suggests that the public understands the limitations of current insurance markets. A recent Zogby International poll conducted for the Council for Affordable Health

81. The White House, "Reforming Health Care for the 21st Century," February 15, 2006, p. 11, at *www.whitehouse.gov/stateoftheunion/2006/healthcare/healthcare_booklet.pdf* (April 13, 2006).

82. Regina E. Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (New York: Perseus Books, 1997).

83. Michael E. Porter and Elizabeth Olmstead Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 2004, p. 69.

84. *Ibid.*

85. eHealthInsurance, "The Most Affordable Cities for Individuals to Buy Health Insurance," June 28, 2005, p. 7, at *www.ehealthinsurance.com/content/ReportNew/06.28.05MostAffordSinglesReportFinal.pdf* (April 13, 2006).

Insurance found that 72 percent of Americans favor allowing persons in one state to purchase health insurance in another state on the condition that the insurance is state-regulated.[87]

The emergence of a national, consumer-driven market for health insurance would:

- Allow increased diversity of competing health insurance options, including values-driven health plans.
- Allow the creation of large national health insurance pools, particularly among faith-based organizations. Increased competition and larger pools would apply downward pressure on administrative costs, and enrollment of younger and healthier persons armed with tax credits would reduce average claims costs.
- Revolutionize consumer relations by giving insurance carriers strong incentives to retain the business of individuals and families and write long-term insurance contracts for them. This in turn would contribute to price stability and reduce churning in the health insurance market.

Step #4: Allow values-driven health plans to compete in public programs.

In 2005, the plan run by the Sisters of the Third Order of Saint Francis entered the Federal Employees Health Benefits Program. As noted, the Order of Saint Francis Healthcare System is a values-driven plan, governed by a Catholic perspective on health care.

Logically, there is no reason why similar plans could not compete for the allegiance of senior citizens in the Medicare Advantage program, the large new system of private health plans in Medicare that started competing for seniors' enrollment under the Medicare Modernization Act of 2003. Senior citizens may be especially interested in signing up for health plans that explicitly state their philosophies concerning end-of-life care and contract with doctors and medical professionals who respect these values.

Likewise, state officials could allow values-driven health plans to participate in S-CHIP and Medicaid, the federal–state health care program for the poor and indigent. This could introduce into Medicaid the dynamics of personal freedom and responsibility while providing better health care. Moreover, religious and other organizations could rate health plans in terms of their respect for ethical or religious values in the delivery and financing of medical care.

Conclusion

Today's health care system is a conglomeration of large public and private financing arrangements, dominated by third-party decision-makers. Aggravated by political intervention on behalf of powerful special interests, the current third-party payment system frustrates the freedom of individuals and families to choose the health care that they believe is best for them. The status quo also leaves many Americans powerless to choose an affordable health care policy on their own terms. They have little control over health care decisions except those that their employer or a government official might cede to them, including decisions involving serious ethical issues, such as their insurance premiums paying for abortions or other current and future medical procedures that they might find morally offensive.

Policymakers should reform the health insurance markets and large government programs to make them responsive to consumer preferences, including their ethical and moral values. This can be done by liberalizing the tax treatment of health insurance through individual health care tax credits; allowing families to choose health plans, including values-driven health plans, regardless of where they live; and allowing participants in public health programs to choose values-driven health

86. For a discussion of this legislation, see Edmund F. Haislmaier, Robert E. Moffit, Ph.D., and Nina Owcharenko, "A Good Start: The House Health Care Reform Bills," Heritage Foundation *WebMemo* No. 803, July 22, 2005, at *www.heritage.org/Research/HealthCare/wm803.cfm*.

87. Press release, "72 percent of Americans Want Health Insurance Choice," Council for Affordable Health Insurance, September 30, 2004, at *www.cahi.org/article.asp?id=425* (April 13, 2006).

plans, just as they could choose to spend their Medicare or Medicaid funds at religious hospitals, clinics, and nursing homes.

A key objective should be to give individuals and families the freedom to choose health plans and physician networks that respect and support their ethical, moral, and religious values. Personal freedom and human dignity must be the paramount values in health care policy.

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