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The Complexities of Providing Health Insurance

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Abstract

Private health insurance increasingly entails moral and ethical issues of consequence to both employers and workers. Recent federal health care legislation has exacerbated the situation by implicitly asserting the supremacy of government's moral judgments over those of employers and workers who finance private health plans. The Heritage Foundation's Edmund F. Haislmaier, Senior Research Fellow in Health Policy Studies, examined these issues in a presentation to Catholic bishops attending the National Catholic Bioethics Center's Twenty-Fourth Workshop for Bishops—"Bioethics Through the Eyes of Faith: Serving Christ in the Sick and Vulnerable"—in Dallas, Texas. He concluded that respect for freedom of conscience in addressing the moral dimensions of medical care should lead to a preference for health policy solutions built around the primacy of patients.

This paper, in its entirety, can be found at **http://report.heritage.org/hl1222**

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Key Points

- There is broad consensus today that modern societies have an obligation to ensure that all of their members have access to needed medical care.
- Today, the truly contentious issues in health care financing are those that center on the morality of specific therapies or actions.
- The recent health care legislation shifts the locus of authority over private medical treatment and private financing decisions, including those that entail ethical or moral considerations, from employers and individuals to government.
- It is possible to ensure that all members of society have access to needed medical care, accompanied by just and equitable financing arrangements, without resorting to laws that infringe on freedom of religion and conscience.
- The health care system will function best if it is structured such that patients and consumers—not, governments or employers—are empowered to be the ultimate decision-makers.

Discussions of the ethics of health care financing typically focus on issues of equity and social justice. Yet such discussions are more often about means than ends. Contrary to the impression given by occasionally heated political rhetoric, there, in fact, exists a broad consensus across the political spectrum that modern societies have an obligation to ensure that all of their members have access to needed medical care.

Of course, there are still disagreements over what should be considered necessary or appropriate care, or where to draw the line between personal and collective financial responsibilities, but those are mainly disputes at the margins.

Somewhat more consequential are the debates over how the system should be structured. They involve not only disagreements over the proper roles of the government and the private sector, but also practical considerations with respect to the efficacy of different approaches for organizing the financing and delivery of medical care.

The same can also be found in other social policy areas, such as education. For instance, the existence of broad societal support for the proposition that all children should be educated to a minimum level, does not,

in and of itself, resolve questions over how best to achieve that end, the appropriate level of resources to devote to the effort, how the system should be structured, or the proper roles of the various participants.

Rather, in health care financing, the truly contentious issues today are those that center on the morality of specific therapies or actions. Indeed, recent scientific advances are spawning new ethical issues in medicine—and by extension, in health care financing as well. To the issues that have long been present, such as abortion, euthanasia, and assisted suicide, must now be added others, such as artificial contraception, assisted reproduction, sex-change treatments, genetic therapies, therapeutic cloning, and potential therapies derived from embryonic stem cells.

While these issues typically attract attention in the context of debates over the use of public funds, such as the issue of paying for abortion in public programs, they also exist, though less visibly, in private health care financing. That is particularly the case in the United States, where half of all medical care is still privately financed, mainly through employer-provided health insurance.

Private, employer-sponsored health insurance has been the dominant form of medical coverage in the United States for over half a century. Even though the share of the population covered by employer health plans has declined from its peak in the 1970s, 58.4 percent of the non-elderly U.S. population is still covered by employment-based health insurance.[1] This arrangement is the product of social policies since the 1940s that have favored it, mainly by treating employer-provided health benefits as tax-free income to workers. In the intervening years, government also imposed regulations on these arrangements, but until now those regulations were almost exclusively limited to addressing the contractual and financial aspects of private coverage.

However, this coverage arrangement presents its own set of ethical considerations, and while the latest federal health care legislation has pushed those issues to the forefront, they have long been present in the system in latent form.

Employer-sponsored health insurance is a form of compensation paid by an employer to its workers. As such, the ethics of how those funds are spent is of consequence to both the employer and the workers. Moral obligations attach not only to the employer's decisions with respect to selecting or designing the plan, but also to the employee's participation in the plan, since such plans are collective arrangements funded with monies that would otherwise be part of the worker's cash wages.

Yet, most workers probably do not know if their employer's health plan uses their money to pay for items or services that they consider immoral. They might be surprised to learn, for example, that a 2003 health care coverage survey found that 46 percent of workers with employer-sponsored health insurance were covered by plans that paid for abortion services.[2] Indeed, there have been instances in which even conscientious employers, including some Catholic institutions, discovered that they had been, unintentionally, providing their workers with health plans that include coverage for morally objectionable items or procedures.

UNLESS AN EMPLOYER IS DILIGENT IN EXCLUDING MORALLY OBJECTIONABLE SERVICES FROM ITS HEALTH PLAN COVERAGE, ONE OR MORE OF THOSE SERVICES ARE INCREASINGLY LIKELY TO BE IN THE PLAN BY DEFAULT.

These situations occur because changing social norms and developments in medical science have steadily altered what is considered "standard" or "typical" in employer health plan coverage. Unless an employer is diligent in excluding morally objectionable services from its health plan coverage, one or more of those services are increasingly likely to be in the plan by default.

To this equation has now been added another dimension by the most recent federal health care legislation, the Patient Protection and Affordable Care Act (PPACA) of 2010.[3] While that legislation does expand existing public programs somewhat, its more consequential feature is that it takes the novel approach of attempting to achieve social policy objectives by compelling individuals to engage in government-specified transactions with other private parties. In effect, rather than increasing taxation to the level necessary to achieve its objectives through public programs, Congress instead decided to commandeer existing private resources to achieve

1. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey," Employee Benefit Research Institute, *Issue Brief* No. 376, September, 2012, http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2012_No376_Sources1.pdf (accessed February 15, 2013).
2. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2003 Annual Survey," p. 109, Exhibit 8.2, www.kff.org/insurance/upload/Kaiser-Family-Foundation-2003-Employer-Health-Benefits-Survey-Full-Report.pdf (accessed February 15, 2013).

those objectives through closely regulated private arrangements.

That this approach is novel in terms of secular law can be seen from the challenges to the constitutionality of the law's requirement that individuals purchase health insurance. However, it is also novel with respect to the ethics of health care financing, in that it shifts the locus of authority over private medical treatment and private financing decisions, including those that entail ethical or moral considerations, from employers and individuals to government.

The legislation expands federal government regulation of private health care coverage in a number of significant ways, three of which embody this significant shift in authority:

First, it grants the U.S. Department of Health and Human Services (HHS) sweeping new powers to impose a wide range of benefit requirements on policies sold by health insurers and, in some cases, on employer-sponsored health plans as well.

Second, for the first time, it requires employers with 50 or more workers to provide their employees with health insurance coverage that the federal government deems to be adequate and affordable, or pay annual fines for failing to comply.

Third, and also for the first time, it requires individuals to obtain the minimum health insurance coverage specified by the government, or pay annual fines for failing to comply.

Underlying these measures is a corresponding shift in the rationale for government regulation that has profound implications for the ethics of private health care financing.

In October 2010, a major medical journal published a paper by a leading supporter of the legislation arguing for the constitutionality of its requirement on individuals to obtain health insurance. Setting aside the merits of the legal reasoning, it is the author's exposition of the law's underlying philosophical rationale that is most clarifying for our purposes. The principal justification offered for the requirement on individuals to obtain health insurance is that it is part of "a broader regulatory scheme" embodied in the new law:

> First, and perhaps most fundamentally, in a remarkable shift whose precedent lies in the watershed Civil Rights Act of 1964, the [PPACA] transforms health insurance into a public accommodation.... This basic reconceptualization of health insurance as a good whose availability is a matter of national public interest essentially frames health insurance the way the Civil Rights Act framed other business interests.[4]

It is under this "public accommodation" rationale that the government now asserts the power to: (1) require employers to fund and manage health plans for their workers; (2) compel individuals to purchase health coverage; and (3) determine the scope and benefits of the coverage that must be provided and purchased. Because some of those decisions will involve ethical or moral considerations, the government is also implicitly asserting the supremacy of its own moral judgments over those of the employers and workers whose resources pay for the medical care in question.

The first conflict to arise out of the government's exercise of these new powers centers on the requirement that employers and individuals pay for and facilitate contraception, sterilization, and abortion-inducing drugs. However, it is not hard to envision more such conflicts arising in the future, should this new arrogation of power by the government be permitted to stand. That is because the legislation's two separate benefit-setting provisions are drafted as broad grants of discretionary authority to the executive branch.

First, Congress empowered HHS to define and "periodically update," a package of "essential health benefits" within at least 10 broad categories.[5] Starting in 2014, insurers will be required to include the essential health benefits in all individual and small-group policies.[6]

Second, the law requires both insurers and employers, including those that "self-insure," to cover specified

3. The Patient Protection and Affordable Care Act of 2010 (PPACA), Public Law 111-148.
4. Sara Rosenbaum, "A 'Broader Regulatory Scheme'—The Constitutionality of Health Care Reform," *The New England Journal of Medicine*, October 27, 2010, http://www.nejm.org/doi/full/10.1056/NEJMp1010850 (accessed February 15, 2013).
5. PPACA, Public Law 111-148, § 1302. The statue stipulates that the essential health benefits, "shall include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management, and; pediatric services, including oral and vision care."
6. New § 2707 of the Public Health Service Act (42 U.S. Code § 300gg-6), as added by PL 111–148 § 1201(4).

"preventive services" with no enrollee cost-sharing.[7] The requirement that employers and insurers provide coverage for contraception (including abortion-inducing drugs) and sterilization, is a subset of this second set of benefit mandates.

With these provisions now in federal law, there will likely be interest group pressure to expand the list of mandated benefits, and some of those proposed additions are likely to also be morally objectionable.[8] Indeed, that has been the experience with benefit mandates imposed by state governments on insurers, though employers can avoid state government mandates by not purchasing coverage from an insurance company and instead designing and funding their own "self-insured" plans. However, that solution will not work for the subset of new federal benefit mandates that are imposed not only on insurers but also directly on employers.

Thus, both employers and individuals attempting to act in accordance with Catholic moral teaching are placed in an unsatisfactory position.

One option for a Catholic or other conscientious employer, would be to simply discontinue the employee health plan and convert plan contributions back into cash wages paid to the workers. However, under the new law, if the employer has 50 or more workers, it would then be fined $2,000 each year, per worker, for not providing the required coverage. Furthermore, its workers would also be fined if they did not, then, obtain the required coverage on their own. Yet, all of the alternative plans available to them in either the individual insurance market, or through the employer of another worker in the family, would be required to include the morally objectionable items or services. Thus, this option is not a satisfactory solution for either the employer or the employees.

Another option would be for employers who are conscientious objectors to redesign their employee health benefit plans in ways that:

1. exclude coverage of morally objectionable items and services, and thus do not violate their consciences;

2. avoid exposing their organizations to the ruinous fines imposed on non-compliant plans, yet; and

3. still enable them to offer their workers employer-sponsored health benefits on a pre-tax basis.

I have been working with others who also have expertise in this area to develop a template for such benefit plan redesigns that Catholic and other objecting employers could use. However, under this approach, the employer would still be fined the same as if he provided no coverage, and his employees would also be fined if they did not otherwise obtain the required coverage. Thus, while creatively redesigning employer plans could significantly reduce the risks and costs associated with non-compliance—relieving some of the pressure on employers as they await the eventual disposition of their legal challenges—this option also does not resolve the underlying conflict.

Of course, pursuing court challenges to the infringement on rights of conscience posed by morally objectionable government benefit mandates is important, but it, too, will not produce a definitive resolution. Even if the plaintiffs challenging the imposition of the contraceptive coverage mandate eventually prevail in court, the government would still retain the power to later impose one or more other morally objectionable coverage requirements. Each future infringement would have to be litigated all over again.[9]

A more definitive solution would be to add a "conscience exemption" to the law.[10] Yet, to be truly satisfactory, a conscience exemption would need to meet at least the following four tests:

1. It would need to be explicit and unambiguous.

7. New § 2713 of the Public Health Service Act (42 U.S. Code § 300gg-13) as added by PL 111–148 § 1001(5).

8. See, for example, Kellan Baker and Andrew Cray, "Ensuring Benefits Parity and Gender Identity Nondiscrimination in Essential Health Benefits," Center for American Progress, November 15, 2012, http://www.americanprogress.org/wp-content/uploads/2012/11/BakerHealthBenefits-2.pdf (accessed February 15, 2013).

9. For a discussion of the limits of judicial remedies in this case, and the more general problems with creating exemptions to unjust laws, particularly when such exemptions are the product of court decisions rather than legislative amendments, see Vincent Phillip Muñoz, "The Religious Liberty Case Against Religious Liberty Litigation: Non-Universal Exemptions and Judicial Overreach," The Witherspoon Institute, October 11, 2012, http://www.thepublicdiscourse.com/2012/10/6562/ (accessed February 15, 2013), and Muñoz, "The Religious Liberty Case Against Religious Liberty Litigation: Renewed Focus on Reasonable, Not Sectarian, Arguments," The Witherspoon Institute, October 12, 2013, http://www.thepublicdiscourse.com/2012/10/6565/ (accessed February 15, 2013).

10. See, for example, the Respect for Rights of Conscience Act of 2011, H.R. 1179 and S. 1467, 112th Congress, http://www.gpo.gov/fdsys/pkg/BILLS-112hr1179ih/pdf/BILLS-112hr1179ih.pdf (accessed February 15, 2013).

2. It would need to broadly protect conscience rights with respect to decisions not only involving existing items, services, and treatments, but future ones as well.

3. It would need to be available, on equal terms and as a matter of right, to any individual or entity, and could not be otherwise conditional or dependent on government deciding the validity of conscience claims.

4. It would need to be functionally meaningful by also permitting health insurers to offer plans that exclude from coverage specific items or services if their customers have moral objections to funding or facilitating those items or services.

Yet, the very need for such an amendment indicates that the basic structure of the underlying law is seriously flawed. A law crafted such that it can be applied justly only if significant exceptions are permitted, is inherently defective in either its basic premise or its basic design, or both. In such circumstances, it is best for lawmakers to simply repeal the defective law. Assuming that the original objectives are legitimate, lawmakers may then adopt other, less problematic, means to achieving the same ends.

It is possible to ensure that all members of society have access to needed medical care, accompanied by just and equitable financing arrangements, without resorting to laws that infringe on freedom of religion and conscience.

While designing such an alternative approach involves practical considerations that are outside the scope of the Church's moral and teaching authority, it is possible, and indeed helpful, for the Church to offer additional guidance derived from other principles beyond those of equity and social justice.

To return to the earlier analogy, if there are multiple ways to structure a system of universal primary education, then, in order to assess the relative merits of those competing approaches, one must look for guidance to some other principle beyond that of social justice. In the case of education, that principle should be the Church's teaching that parents are the ones who have the primary responsibility and authority in educating their children. Judged in light of that principle, an educational system that operates with more deference to the rights and authority of parents would be preferable to one that gives less deference.

In the same fashion, the Church's teaching on the inherent dignity and worth of every human life should be the guiding principle for assessing the relative merits of differing approaches to constructing a comprehensive and equitable system for financing and delivering medical care.

The system will function best and most effectively if it is structured such that patients and consumers—not governments or employers—are empowered to be the ultimate decision-makers. It is possible to construct a comprehensive, just, and equitable health care system without subordinating the needs and authority of patients to those of government, employers, insurers, or medical providers. My colleagues and I have spent years working on the details of how that can, in fact, be accomplished.[11]

We also argued several years ago that greater patient and consumer control over health care financing was also the best way to ultimately, and more satisfactorily, address the growing number of issues in biomedical ethics.[12]

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While the Church rightly does not pronounce on prudential matters that do not have direct moral implications, it does point to the relevant, basic principles that should guide our assessments of the total effects of social structures and public policies.

To adapt a formulation sometimes used in other contexts, I submit that, just as the totality of Catholic teaching should lead us in education policy to a preferential option for solutions built around the primacy of parents, so, too, it should lead us in health care policy to a preferential option for solutions built around the primacy of

11. For further elaboration of the patient- and consumer-oriented approach to systematic health reform, see Robert E. Moffit, "Expanding Choice through Defined Contributions: Overcoming a Non-Participatory Health Care Economy," *Journal of Law, Medicine & Ethics*, Vol. 40, No. 3 (Fall 2012), pp. 558–573, and Edmund F. Haislmaier, "Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market," Heritage Foundation *Backgrounder* No. 2128, April 23, 2008, http://www.heritage.org/research/reports/2008/04/health-care-reform-design-principles-for-a-patient-centered-consumer-based-market.

12. Robert E. Moffit, Jennifer A. Marshall, and Grace V. Smith, "Patients' Freedom of Conscience: The Case for Values-Driven Health Plans," Heritage Foundation *Backgrounder* No. 1933, May 12, 2006, http://www.heritage.org/research/reports/2006/05/patients-freedom-of-conscience-the-case-for-values-driven-health-plans.

patients. That primacy is not just a primacy of their needs, or even a primacy of their authority. It is also a primacy of their consciences.

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