

## “Poor” Coverage: The Preferential Option for the Poor and Access to Health Care

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[A]lthough “uninsured” and “poor” are not synonyms – one doesn’t have to be poor to lack health care coverage – there are distinct relationships between being uninsured and poverty.<sup>1</sup>

The current health care system is so inequitable, and the disparities between rich and poor and those with access and those without are so great that it is clearly unjust.<sup>2</sup>

### Introduction

Significant aspects of employer-employee relationship are governed by private ordering. Apart from minimal requirements such as mandating that employers pay employees a minimum wage<sup>3</sup> and prohibiting employers from discriminating against protected groups in terms of salary and benefits,<sup>4</sup> the law permits employers and employees to freely bargain over various elements of compensation.<sup>5</sup> For many kinds of employee benefits, that may makes sense; why not let market forces dictate how much

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<sup>1</sup> U.S. Catholic Health Association, Overview, *available at* <http://www.chausa.org/Pub/MainNav/ourcommitments/tothepoor/>. See also Catholic Campaign for Human Development, News Release, Jan. 2005, available at [usccb.org/comm/archives/2005/05-0006.shtml](http://usccb.org/comm/archives/2005/05-0006.shtml) (“It does not take a great leap of logic to understand that poor and low-income people are heavily represented among the uninsured in our country and the situation with poor children is especially tragic.”).

<sup>2</sup> U.S. Conference of Catholic Bishops, *Framework for Comprehensive Health Care Reform* (1993).

<sup>3</sup> See 29 U.S.C. § 206 (1996). Not all employees are required to pay a minimum wage to all employees; the Fair Labor Standards Act contains a lengthy list of exemptions from the minimum wage requirements. 29 U.S.C. § 213 (1996).

<sup>4</sup> For example, the 1993 Equal Pay Act prohibits wage discrimination on the basis of sex. 29 U.S.C. § 206(d)(1) (1993). The Internal Revenue Code (“the Code”) also prevents discrimination in favor of highly compensated employees with respect to the provision of retirement benefits. I.R.C. §§ 401(a)(4); 410(b)(2) (2004).

<sup>5</sup> There are certain exceptions. The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001-1461 (2000), regulates the pension plans of most private employers, providing minimum design standards in areas such as vesting, benefit accrual and funding that cannot be varied by contract. 29 U.S.C. §§ 1053-1086. Additionally, for union employees, certain aspects of compensation are mandatory subjects of collective bargaining under the National Labor Relations Act. But even that means only that the employer and the union have to bargain over the terms; the law does not mandate what those terms will be.

vacation or other nonessential (albeit enjoyable and potentially valuable) “fringe benefits” an employee may receive?<sup>6</sup> But some of what falls into the category of employee benefits, and is therefore left to the employer’s discretion, is far from “fringe” or nonessential.

One of the more troubling things we leave to voluntary bargaining between employers and employees is access to affordable health care. Nothing in the law forces an employer to provide its employees with health insurance,<sup>7</sup> and based on their own business and competitive needs, many employers opt to not provide any form of medical coverage to their employees. The result is that “[f]or lower income working Americans, lack of health insurance is quickly becoming the new normal.”<sup>8</sup> The consequences, in economic and health terms are unacceptable – families being pushed into worse financial situation than they already are in and deaths and diseases that could have been avoided if access to medical care had been available.<sup>9</sup>

Catholic Social Thought demands that we think differently about providing access to health care to all Americans. Affordable health care is one of the basic needs of the poor – not only those living in abject poverty – but the working poor, whose paychecks

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<sup>6</sup> I don’t mean to suggest that what might be termed “nonessential” or “fringe” benefits are unimportant to the quality of life of employees. Although beyond the scope of this Article, from a Catholic Social Thought perspective one might argue benefits such as vacation benefits are quite important to the work-family balance of employees. But that does not say the law should impose mandatory requirements regarding such benefits.

<sup>7</sup> See *infra* text accompanying notes 34-35. In the early 1990’s the Clinton administration attempted to enact a mandate that employer provide medical coverage to their employees. However, the proposal was killed by political resistance in Congress. See Adam Clymer, Robert Pear and Robin Toner, *The Health Care Debate: What Went Wrong? How the Health Care Campaign Collapsed*, N.Y. TIMES, August 29, 1994, at p.A1; CONG. RECORD, May 11, 2006, p.H3162 (statement of Rep. McDermott) (noting that the Republicans “took pride and bragged in the next election over the fact that they had killed the Clinton health care plan”). Several states have attempted to achieve a form of mandatory coverage; Massachusetts effort is discussed *infra* at text accompanying notes 129-142.

<sup>8</sup> Paul Krugman, *Death by Insurance*, N.Y. TIMES, May 1, 2006, at A19; see *infra* text accompanying notes 13-16.

<sup>9</sup> See *infra* text accompanying notes 23-33.

simply cannot cover the cost of adequate medical care in the absence of health insurance. This Article explores what Catholic social teaching on the preferential option for the poor contributes to our thinking about the provision of health care.<sup>10</sup> Catholic Social Thought generally, and the preferential option for the poor in particular, force us to think of health care as a fundamental human right, not as a voluntarily provided employee benefit. The preferential option for the poor also forces us to think about the provision of such care as a collective responsibility.

However, focusing only on the preferential option for the poor is not sufficient. Doing so risks proposing solutions to improve access to affordable health care that do violence to the principle of subsidiarity, another central theme of Catholic Social Thought. Thus, the Article also explores how subsidiarity contributes to our thinking about how best to meet the collective responsibility of ensuring adequate health care, comparing several approaches to health care reform in terms of their adherences not only to the preferential option for the poor, but to subsidiarity as well.

### **I. Access to Health Care in the United States**

Approximately 46 million people in the United States are without health insurance.<sup>11</sup> Eighty percent of those without such insurance either have jobs themselves or are part of a family unit where someone is employed.<sup>12</sup>

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<sup>10</sup> My focus here is on medical care. The Church's social teachings, however, also invite us to think deeply about other aspects of the employer-employee relationship. A proper concern for the rights of workers have been a consistent theme of Catholic Social Thought from the issuance of *Rerum Novarum* in 1891. POPE LEO XIII, *RERUM NOVARUM* (1891). See *supra* note 6.

<sup>11</sup> See, e.g., Paul Fronstein, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey*, EBRI ISSUE BRIEF NO. 298, Oct. 2006, at p.4 (finding 46.1 million uninsured in 2006); David Leonhardt, *A Health Fix That Is Not A Fantasy*, N.Y. TIMES, Apr. 12, 2006, at C1 (citing recent estimate that 46 million people do not have health insurance, an increase from 31 million in 1987); U.S. Conference of Catholic Bishops, *Health Care for the Insured*, Feb. 2006, at 1 (observing that the 45.8 million figures "is the largest number of Americans reported to be without insurance since the Census Bureau began issuing data on the uninsured in 1987"); Daniel Yi, *More U.S.*

Nor surprisingly, a significant number of those workers who lack insurance coverage are in the category of the “working poor” – persons who work, sometimes two or more jobs, and yet are unable to meet basic needs.<sup>13</sup> According to estimates, more than one-half of those who lack medical insurance “are in low-wage earning families with income below 200% of the federal poverty level.”<sup>14</sup> The Commonwealth Fund recently released survey findings that 41 percent of working-age Americans with incomes between \$20,000 and \$40,000 a year were without health insurance for all or part of

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*Workers Go Uninsured*, L.A. TIMES, Sept. 27, 2006, at C1 (citing Economic Policy Institute study findings that the number of uninsured employees increased to 46.6 million in 2005 from 39.8 million in 2000). The 46 million number does not give the complete picture, because many more individuals are without coverage at any point in a year. See Robert Pear, *New Study Finds 60 Million Uninsured During a Year*, N.Y. TIMES, May 13, 2003, at A22 (citing Congressional Budget Office findings that between 57 and 59 million people lacked health insurance at some point during the year in 1998).

<sup>12</sup> U.S. Conference of Catholic Bishops, *Health Care for the Insured*, Feb. 2006, at p.2 (8 of 10 nonelderly uninsured are from working families; 70% are in families with at least one full-time worker; more than 50% are in low-wage earning families with income below 200% of the federal poverty level). The same report observes that more than 80% of the more than 8 million children who are uninsured “live in households headed by a working adult.” *Id.* See Catherine Hoffman, Diane Rowland & Alicia L. Carbaugh, *Holes in the Health Insurance System – Who Lacks Coverage and Why*, 32 J. L. MED. & ETHICS 390, 394 (2004) (observing that “[t]he large majority of the uninsured come from families with at least one member who is working outside the home”); See Karen Seccombe & Cherly Amey, *Playing by the Rules and Losing: Health Insurance and the Working Poor*, 36 J. HEALTH & SOC. BEHAV. 168, 169 (1995) (citing 1993 statistics that 84% of uninsured are employed or dependents of employed persons).

<sup>13</sup> The U.S. Bureau of Labor Statistics Reports that in 2004, there were 7.8 million “working poor,” i.e., individuals who spent 27 or more weeks of the year in the labor force but still earned income below the poverty line. U.S. Department of Labor, U.S. Bureau of Labor Statistics, Report No. 994, *A Profile of the Working Poor, 2004*, May 2006, at p.1. See also DAVID HOLLENBACH, *THE COMMON GOOD AND CHRISTIAN ETHIC* 181 (2002) (noting that “[t]he poverty of today’s working poor continues to place severe strains on family life and on parents’ ability to care for their children”); BARBARA EHRENREICH, NICKEL AND DIMED (2001); DAVID K. SHIPLER, *THE WORKING POOR: INVISIBLE IN AMERICA* (2005) (discussing challenges of surviving for minimum wage earners). The situation is unlikely to improve. The Ford Foundation recently reported that “1.8 million of the 2/2 million net new jobs were low-wage.” H.J. Cummins, *Intangibles Count When Employers Try to Compensate Low-Wage Workers*, MINNEAPOLIS STAR TRIBUNE, Nov. 2, 2006, at D1, 2 (citing Ford Foundation figures and also noting that “33 percent of those on the bottom tier have no health insurance, compared with less than 1 percent on the top”).

<sup>14</sup> U.S. Conference of Catholic Bishops, *Health Care for the Insured*, Feb. 2006, at p.2. See U.S. Department of Labor Bureau of Labor Statistics, *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2005* (Aug. 2005), at 5-6 (87% of workers earning an average wage of \$15 or higher have access to medical benefits compared with 58% of workers earning less than \$15 per hour; 72% of workers earning an average wage of \$15 or higher participate in medical care plans compared with 39% of workers earning less than \$15 per hour).

2005, a figure that represents a “dramatic and rapid increase” from the 2001 of 28%.<sup>15</sup>

Thus, it is “the poor and near-poor [who] have the greatest risk of being uninsured.”<sup>16</sup>

The number of lower income workers without medical coverage provided by their employer is likely to grow substantially. Concerned about rising employee benefit costs, many employers have “reduced benefits, increased employee contributions for premiums and co-payments, or dropped coverage entirely.”<sup>17</sup> Other employers are moving to hire more and more part-time and other contingent workers, who typically do not receive

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<sup>15</sup> Sara R. Collins, et al., *Gaps in Health Insurance: An All-American Problem*, FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, p. vii (Apr. 2006). See Paul Krugman, *Death by Insurance*, N.Y. TIMES, May 1, 2006, at p.A19. That figure represents an increase from 28% in 2001, a shocking increase over a four year time period.

These figures only speak to lack of coverage by employed persons. They do not include those without jobs who lack any means of purchasing affordable health insurance.

<sup>16</sup> See Hoffman et al., *supra* note 12, at 394. Not only are “[l]ow-wage workers...less likely to be offered coverage by their employers[, but] even when they are offered coverage, it is more difficult for them to afford the cost of premiums.” Kaiser Family Found., *Women and Health Care: A National Profile*, at 16 (2005), available at <http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf>.

As in so many economic areas, women are particularly hard-hit, especially minorities. A 2005 Kaiser Family Foundation report found that “37% of poor women (family incomes below the poverty level) and 27% of near-poor women (100% to 199% of the poverty level) are uninsured. 16% of women with incomes of 200-299% of the poverty level have no insurance. Medicaid covers only one-third of poor women. 38% of Latinas have no health insurance, compared to 13% of white women. Only 39% of them have employer-sponsored health insurance, versus 70% of white women.” Lorraine Schmall, *Birth Control as a Labor Law Issue*, 13 DUKE J. GENDER L. & POL’Y 139, 168 (2006) (citing Kaiser findings); see Kaiser Family Found., *supra*.

<sup>17</sup> Maria O’Brien Hylton, *Insecure Retirement Income, Wrongful Plan Administration and Other Employee Benefits Woes – Evaluating ERISA at Age Thirty*, 53 BUFF. L. REV. 1193, 1205 (2005). See Paul Fronstein, *The Impact of Hours of Work on Employment-Based Health Benefits*, EBRI NOTES, May 2006, at 2, 5 (noting that 62.4 percent of the nonelderly population was covered in 2004, compared to 66.8% in 2000, and noting as part of the cause the rising cost of health benefits); Paul Fronstein, *Uninsured Unchanged in 2004, But Employment-Based Coverage Declined*, EBRI NOTES, Oct. 2005, at 2 (noting that 59.8% of U.S. persons were covered by employment-based health benefits during 2004, compared to 63.6% in 2000). Because the law does not vest medical benefits the way pension benefits are vested, employers are free to offer benefits and then decide to not offer such benefits; David Koepfel, *When ‘Job’ Means Part Time, Life Becomes Very Different*, N.Y. TIMES, Oct. 10, 2004, at §10, p. 1 (citing Kaiser Family Foundation survey finding that there are now 5 million fewer jobs providing health coverage than there were in 2000). “The number of full-time workers without any insurance increased to 17.7% in 2005 from 16.8% in 2002.” Mary Agnes Carey & Rebecca Adams, *Middle Class Lack Health Coverage*, CQ Weekly, Sept. 4, 2006, at p.2276 (citing expert belief that the coverage problem is likely to worsen). For example, Ford Motor Co. recently announced a 30% increase in required health insurance contributions by employees, in response to the fact that it paid about \$3.5 billion for health insurance for its employees in 2005. See *Ford Cuts Health Benefits, Merit Pay*, available at <http://news.findlaw.com>, Nov. 2, 2006.

benefits, to perform tasks previously performed by full-time workers.<sup>18</sup> The Employee Benefit Research Institute recently concluded that given rising health care costs and structural changes in the work force, “there is every reason to believe that the decline in the percentage of workers with employment-based health benefits will continue.”<sup>19</sup>

Those without employer-provided medical coverage do not have it easy: The purchase of individual health insurance in the United States is prohibitively expensive for all but the wealthy,<sup>20</sup> even assuming one can qualify for individual insurance, which many people without employer-provided coverage cannot.<sup>21</sup> Although there is some government sponsored health care for the very poor, the Medicaid system is inadequate

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<sup>18</sup> See Paul Fronstein, *The Impact of Hours of Work on Employment-Based Health Benefits*, EBRI NOTES, May 2006, at p.2, 4-5 (discussing implications for health benefits of movement of employees from full-time to part-time status); Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J. L. MED. & ETHICS 404, 406 (2004) (“a third of workers ineligible for their employer’s coverage did not work enough hours or weeks to qualify and more than half (51 percent) were ineligible because they were contract or temporary workers and their employers restricted coverage to certain classes of employees that did not include those categories of workers”); David Koepfel, *When ‘Job’ Means Part Time, Life Becomes Very Different*, N.Y. TIMES, Oct. 10, 2004, at §10, p.1 (noting that of the 1.2 million jobs added in 2004, 1 million were part time jobs and explaining the upward trend of part-time employment by a 59 percent increase in job-based insurance premiums since 2000).

<sup>19</sup> Paul Fronstein, *The Impact of Hours of Work on Employment-Based Health Benefits*, EBRI NOTES, May 2006, at p.5. Health insurance costs “have increased by double-digit percentages” in four of the last five years, with the result that “[h]ealth insurance costs are on pace to become the largest share of employers’ total benefit spending.” Olympia J. Snowe, *Small Business Health Plans: A Critical Step in Solving the Small Business Health Care Crisis*, 43 HARV. J. ON LEGIS. 231, 231 (2006). This is not necessarily a criticism of employers, who are behaving in a rational fashion from an economic standpoint. As one commentator observed, “we have a huge problem for American business because it is pretty hard to compete in a global economy when the price of your health care is put on the cost of goods, while in other countries, it is shared amongst society.” The Brookings Institute, *Employment-Based Health Insurance: A Prominent Past, but Does it Have a Future?*, p.9, June 16, 2006 (quoting remarks of SEIU President, Andrew Stern). Mr. Stern goes on to point out that “[b]y 2008, according to McKenzie, employers will spend more on health care than they will make in profit.... This is just an unsustainable economic situation.” *Id.* at 13. See also U.S. Government Accounting Office, *Employee Compensation: Employer Spending on Benefits Has Grown Faster than Wages, Due Largely to Rising Costs for Health Insurance and Retirement Benefits*, GAO-06-285, Feb. 2006, at p.26 (discussing fact that employer-sponsored system of benefits may be unsustainable, “largely because productivity growth is unlikely to support rising benefit costs”).

<sup>20</sup> David Leonhardt, *A Health Fix That Is Not A Fantasy*, N.Y. TIMES, Apr. 12, 2006, at C6 (discussing fact that the “only affordable ways to get [medical] coverage are from your employer or through a government program such as Medicare”).

<sup>21</sup> Collins, et al., *supra* note 15, at 1 (observing that “[d]ue to the underwriting practices in some states, many individuals, particularly those who are older or have chronic health problems, are left on the sidelines – unable even to qualify for coverage”).

and getting worse, serving only the very poorest of the poor and failing to provide adequate benefits.<sup>22</sup>

At the same time that medical coverage for working Americans is becoming a scarcer commodity, rising health care costs make it more and more difficult for those without insurance to pay for necessary care. Those without health insurance are forced to forego necessary medical care<sup>23</sup> or to forego other basic necessities in order to pay for the medical care they need.<sup>24</sup> Uninsured adults “cut[]corners on medical care to save money – failing to fill prescriptions, skipping medication, going without preventive care.”<sup>25</sup> They skip medications for chronic conditions such as asthma or diabetes and do not get preventive care.<sup>26</sup> A recent Commonwealth Fund survey finds that the uninsured have difficulty paying medical bills and that nearly half “used up all their savings to pay their bills.”<sup>27</sup> The same survey found that 20% of the uninsured have difficulty paying for basic necessities such as food, heat or rent because of their medical bills.<sup>28</sup>

Those with already shaky financial situations are often pushed over the brink by an inability to obtain affordable health care. A study done by Harvard University found

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<sup>22</sup> See, e.g., U.S. Conference of Catholic Bishops, *Health Care for the Insured*, Feb. 2006, at p.1 (observing that “[w]hile uninsured families may qualify for coverage under Medicaid or the State Children’s Health Insurance Program (SCHIP), between 2002 and 2006 43 states restricted eligibility and 39 states reduced benefits”). See *infra* text accompanying notes 42-49.

<sup>23</sup> See U.S. Conference of Catholic Bishops, *Health Care for the Insured*, Feb. 2006, at p.2 (discussing consequences of being uninsured or underinsured and quoting estimate of Institute of Medicine that “18,000 Americans die unnecessarily each year due to the lack of health insurance coverage).

<sup>24</sup> Jeff Teiman, *Poverty and Health: Connections that Can Spark a Dialogue*, HEALTH PROGRESS, May-June 2005, at 6, 7 (reporting survey findings that “more than one-quarter of those struggling with medical bills said that they had been unable to afford such basic necessities as good, heat, or rent”).

<sup>25</sup> Paul Krugman, *Death by Insurance*, N.Y. TIMES, May 1, 2006, at p.A19 (reporting findings of Commonwealth Fund survey). See Seccombe & Amey, *supra* note 12, at 168 (reporting that individuals without insurance “are likely to postpone or forgo visits to health care practitioners for all but the most urgent conditions”).

<sup>26</sup> Collins, et al., *supra* note 15, at *ixi*; see Seccombe & Amey, *supra* note 12, at 168 (reporting that individuals without insurance “are likely to postpone or forgo visits to health care practitioners for all but the most urgent conditions”).

<sup>27</sup> Collins, et al., *supra* note 15, at *viii*.

<sup>28</sup> *Id.*

that “[a]s many as 2.2 million Americans who filed for personal bankruptcy in 2001 cited medical causes for their financial trouble.”<sup>29</sup> That translates into more than one million people “who saw their financial and personal stability collapse because they could not afford health care.”<sup>30</sup>

The results in terms of public health<sup>31</sup> are scandalous. The United States has an infant mortality rate closer to that of developing countries than to other developed nations.<sup>32</sup> And a study by the Institute of Medicine estimated that 18,000 unnecessary deaths in the United States are caused each year by lack of health insurance.<sup>33</sup>

## II. How the U.S. Legal System Treats Health Care

The most apt description of the health insurance system in the United States – at least as it affects most nonelderly Americans – is that it is an employment-based,

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<sup>29</sup> *Id.* at 6, 7. See Michele Melden, *Guarding Against the High Risk of High Deductible Health Plans: A Proposal for Regulatory Protections*, 18 LOY. CONSUMER L. REV. 403, 411 (2006) (“analysts are discovering that medical debt is the leading cause of consumer bankruptcies”).

<sup>30</sup> *Id.*

<sup>31</sup> Although my concern in this Article is with the direct effect on the working poor of lack of coverage, from an economic perspective, large numbers of employees without medical coverage also causes employees with coverage to feel locked into their jobs, which results in less than optimal job matches in the labor force. See Inas Rashad & Eric Sarpong, *Employer-Provided Health Insurance and the Incidence of “Job-Lock: Is There a Consensus?”*, Andrew Young School of Policy Studies Research Paper Series, Working Paper 06-53 (May 2006), available at <http://aysps.gsu.edu/publications/2006/index.htm>. (suggesting that declining health care coverage contributes to job lock problem).

<sup>32</sup> Nicholas D. Kristof, *Health Care? Ask Cuba*, N.Y. TIMES, Jan. 12, 2005, at p.A21 (observing that “if the U.S. had an infant mortality rate *as good as Cuba’s*, we would save an additional 2,212 American babies a year”) (emphasis in original).

<sup>33</sup> Paul Krugman, *Death by Insurance*, N.Y. TIMES, May 1, 2006, at p.A19 (citing estimates of the National Academy of Sciences’ Institute of Medicine). The press release of the Institute of Medicine’s 2002 reports that “Americans without health insurance are more likely to have poorer health and die prematurely than those with insurance” and that “[u]ninsured patients with colon or breast cancer face up to a 50 percent greater chance of dying than patients with private coverage. Uninsured victims of trauma also are more likely to die from their injuries. Being uninsured for even a year appears to diminish a person’s general health.” The National Academies News Release, *Uninsured Adults More Likely to Die Prematurely*, May 21, 2002, available at <http://www4.nas.edu/news.nsf/6a3520dc2dbfc2ad85256ca8005c1381/77c7c949ea9ddd3585256ca70072dca0?OpenDocument>.

voluntary system.<sup>34</sup> By that I mean two things. First, most nonelderly Americans who have health insurance have employer-provided insurance.<sup>35</sup> Second, employers are free to decide whether or not to provide health insurance to their employees, based on their own assessment of their competitive business needs; nothing in the law forces an employer to provide such benefits to their employees.

Even for those employers who voluntarily choose to provide their employees with health insurance coverage, the regulation of employer-provided medical benefits is surprisingly limited. The Employee Retirement Income Security Act of 1974 (“ERISA”),<sup>36</sup> the primary federal statute regulating employee benefit plans of private employers, does not require the vesting of health care benefits, meaning that an employer who provides such benefits is free to modify, reduce or even eliminate such benefits at any time and for any reason. Nor does ERISA do very much to substantively regulate the content of such benefits: It requires that employees who lose coverage due to certain events provide continuation coverage for a specified period of time<sup>37</sup> and subjects health plans to its fiduciary and reporting and disclosure provisions,<sup>38</sup> but does little more.<sup>39</sup>

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<sup>34</sup> This same description applies to the American pension system, the problems with which I explore in Susan J. Stabile, *Is it Time to Admit the Failure of an Employment-Based Pension System*, 11 LEWIS AND CLARK L. REV. \_\_\_ (2007).

<sup>35</sup> See Paul Fronstein, *The Tax Treatment of Health Insurance and Employment-Based Health Benefits*, EBRI ISSUE BRIEF NO. 294, June 2006, at 4 (noting that “[e]mployment-based health benefits are the most common source of health insurance among persons under age 65 in the United States”); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 782 (2006) (citing 2003 findings that “77% of the nonelderly population that had health insurance were covered by employment-based insurance). I discuss the factors contributing to this in Susan J. Stabile, *State Health Care Initiatives*, ST. THOMAS L. REV. (forthcoming 2006). See also Katherine V.W. Stone, *A Fatal Mismatch: Employer-Centric Benefits in a Boundaryless World*, 11 LEWIS & CLARK L. REV. \_\_\_ (2007) (discussing origins of the employer-centric benefit system).

<sup>36</sup> 29 U.S.C. § 1001-1461 (2000).

<sup>37</sup> 29 U.S.C. § 1161 et. seq.

<sup>38</sup> 29 U.S.C. §§ 1021, 1104.

<sup>39</sup> ERISA has been amended on occasion to add requirements that some specific benefits be provided. 20 U.S.C. §§ 1181-1183. However, those scattershot amendments represent responses to specific political pressures rather than any effort to think comprehensively about how health benefits should be regulated. See Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential*

Despite its failure to provide for any comprehensive regulation of health plans, ERISA preempts state laws relating to employee benefit plans, thus limiting the ability of states to regulate employer-provided health plans.<sup>40</sup> The statutory preemption provision, however, does contain an exception for state insurance regulation, allowing some indirect regulation of such plans by virtue of the state's ability to regulate insurance.<sup>41</sup>

Exceptions to the employment-based voluntary system are limited. Medicaid provides medical care for the very poor,<sup>42</sup> but funding cuts and stringent eligibility requirements mean that most of the working poor will be unable to secure coverage through Medicaid.<sup>43</sup> Additionally, the State Children's Health Insurance Program ("SCHIP") provides federal funds to state programs providing low-income and homeless children with access to healthcare.<sup>44</sup> Although SCHIP plans have been approved in all 50 states and the District of Columbia,<sup>45</sup> such plans would still only represent a partial solution to the problem of lack of access, even if they did cover all eligible children who

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*for Employer-Sponsored Health Insurance Under ERISA*, 31 Loy. U. Chi. L.J. 29 (1999) (characterizing the amendments as "consumer-driven attempts to resolve problems by attracting media attention" rather than comprehensive, meaningful reform).

<sup>40</sup> 29 U.S.C. § 1144 (1998). See Laura Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 Hous. J. Health L. & Pol'y 1, 30 (2005) (noting that ERISA "largely removes most regulation states could propose regarding health insurance plans offered through employment, without offering any substantial federal remedies to replace them").

The effect of ERISA's preemption provision is to limit severely the effort of states to try to deal with the health care crisis in this country. I explore state efforts to address health care more extensively in Susan J. Stabile, *State Law Health Care Initiatives*, ST. THOMAS L. REV. (forthcoming 2006).

<sup>41</sup> 29 U.S.C. § 1144(b)(2)(A). The insurance exception only saves the application of state insurance laws to insured employer plans. Because of the operation of the so-called "deemer clause," 29 U.S.C. § 1144(b)(2)(B), state insurance laws cannot be applied to regulate self-funded plans, creating the anomalous result that such plans are effectively regulated by neither state nor federal law.

<sup>42</sup> See Department of Health and Human Services, *Medicaid At-a-Glance 2005* (2005) (describing basic provisions of Medicaid program, including eligibility provisions).

<sup>43</sup> See John Jacobi, *Dangerous Times for Medicaid*, 33 J.L. Med. & Ethics 834 (2005) (citing surveys that funding cuts have already left thousands without coverage and discussing initiatives proposed by Congress and the current administrations which aim to reduce Medicaid expenditures).

<sup>44</sup> 42 U.S.C. §§ 1397aa-1397jj (2000).

<sup>45</sup> National Conference of State Legislatures, *State Children's Health Insurance Program*, available at <http://www.ncsl.org/programs/health/chiphome.htm>.

otherwise lack medical care coverage.<sup>46</sup> Medicare provides medical benefits to the elderly,<sup>47</sup> although it has its own problems. Recent changes purport to help the elderly, but arguably will make prescription drugs less affordable<sup>48</sup> and have been widely criticized as overly complicated and difficult to understand by the elderly the statute is intended to serve.<sup>49</sup>

As the foregoing discussion makes clear, we cannot provide adequate health care to those without the financial resources to purchase individual coverage within the current structure of primarily employer provided care, supplemented by limited government coverage for very poor and very old.

### **III. The Contribution of Catholic Social Thought and the Preferential Option for the Poor to our Thinking About Access to Health Care**

When Jesus explained to his disciples who would inherit the Kingdom, he said it would be those to whom he could say, “I was hungry and you gave me food, I was thirsty and you gave me drink...naked and you clothed me, ill and you cared for

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<sup>46</sup> According to the Kaiser Family Foundation, there are 8.4 million uninsured children in the United States, of which 70% are eligible for public health coverage and have simply not signed up. Kaiser Family Foundation, *Opening Doorways to Health Care for Children*, available at <http://www.kff.org/medicaid/upload/7506.pdf>. Also, SCHIP and Medicaid programs are not available to legal immigrants until they have lived in the United States for five years and are not available to undocumented immigrants at all. Kaiser Family Foundation, *Medicaid and SCHIP Eligibility for Immigrants Fact Sheet*, available at <http://www.kff.org/medicaid/upload/7492.pdf>

<sup>47</sup> Almost two-thirds of the cost of providing health care to the elderly is paid for by Medicare. James Lubitz et. al, *Longevity and Medicare Expenditures*, 332 NEW ENG. J. MED. 999 (1995).

<sup>48</sup> See Alex Berenson, *Drug Plan's Side Effect is Severe*, N.Y. TIMES, Apr. 8, 2006, at C1 (explaining that many cancer patients whose treatments require costly drugs which were received for free under Medicare will now be forced to make co-payments of up to \$3,600 to receive the drugs. Many cancer drug manufacturers have required recipients to enroll in Medicare part D). See also *Retirees Said to Need \$200,000 for Healthcare*, L.A. TIMES, Mar. 7, 2006, at p.5 (citing a Fidelity Investments study finding that retirees at age 65 will need \$200,000 for Medicare Part B and D cost-sharing devices such as premiums and copayments); Diana L. Hayes, *Our Individualism Should Shame Us*, NATIONAL CATHOLIC REPORTER, June 18, 2004 (suggesting that the new Medicare law, “while purporting to help the elderly purchase their prescription medicine, will actually make them less affordable for many because of the huge deductible and the veto of Medi-gap programs”).

<sup>49</sup> See Fred Griesbach, *Proposal Would Ease Confusion on Medicare*, PHILADELPHIA INQUIRER, May 11, 2006, at B2.

me....[W]hatever you did for the least brothers of mine, you did for me.”<sup>50</sup> What could better demonstrate the primacy of Catholic concern for the poor than this – that the ultimate criterion by which we will be judged by God is not any explicitly religious activity, but how well we have treated those in need.<sup>51</sup>

This section explores how the principle of preferential option for the poor, informed by other principles of Catholic Social Thought, leads to a conclusion that health care ought to be viewed both as a right and as a communal obligation and helps provide a framework for evaluating social and political means of achieving that right.

### **A. Preferential Option for the Poor and Health Care**

Catholic social thought has always recognized that “the poor and helpless have a claim to special consideration.”<sup>52</sup> Pope John Paul II explained the preferential option for the poor as “a call to special solidarity with the humble and the weak, with those who are suffering and weeping, who are humiliated and left on the fringes of life and society, in order to have them realize more fully their own dignity as human persons and children of God.”<sup>53</sup> He made clear that although “the precept to love all men and women admits no

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<sup>50</sup> Matthew 25:35-36, 40.

<sup>51</sup> MICHAEL J. HIMES, *THE MYSTERY OF FAITH: AN INTRODUCTION TO CATHOLICISM* 8-9 (2004) (calling Jesus’ words in this passage from Matthew “[o]ne of the most extraordinary statements” of our call to love “in the whole Christian tradition”). See also EDWARD P. DEBERRI & JAMES E. HUG, *CATHOLIC SOCIAL TEACHING: OUR BEST KEPT SECRET* 29 (4<sup>th</sup> ed. 2003) (noting that a concern for those in poverty has always been “at the heart of the Judeo-Christian social vision”); World Synod of Catholic Bishops, *Justice in the World* ¶ 6 (1971) (observing that “[a]ction on behalf of justice and participation in the transformation of the world fully appear to us as a constitutive dimension of the preaching of the Gospel, or in other words, of the Church’s mission for the redemption of the human race and its liberation from every oppressive situation”).

<sup>52</sup> POPE LEO XIII, *RERUM NOVARUM* ¶ 29 (1891). *Rerum Novarum* observes that, unlike those who are better off, who “have many ways of protecting themselves,...those who are badly off have no resources of their own to fall back upon.” *Id.*

<sup>53</sup> POPE JOHN PAUL II, *Address to the Bishops of Brazil* (1980), quoted in Rev. Gerald S. Twomey, *Pope John Paul II and the “Preferential Option for the Poor”*, \_\_ ST. JOHN’S J. CATH. LEG. STUD. \_\_ (2006).

exclusion,...it does admit a privileged engagement in favor of the poorest”<sup>54</sup> and on any number of occasions, he affirmed the Church’s solidarity with the poor everywhere.<sup>55</sup>

The Final Report of the 1985 Synod of Bishops devoted a separate section to the preferential option for the poor, expressing the Church’s awareness of its mission to serve the poor and its need to “in prophetic fashion denounce every form of poverty and oppression and defend and support everywhere the fundamental and inalienable rights of the human person.”<sup>56</sup>

The preferential option for the poor, thus, has meaning as a *moral concern*, reminding us of God’s special concern for the weak, vulnerable and poor and the need to provide for the needs of the disadvantaged.<sup>57</sup> Moreover, the Compendium of the Social

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<sup>54</sup> POPE JOHN PAUL II, *The Paraguayan Bishops on their Ad Limina Visit to Rome*, (1984), quoted in Twomey, *supra* note 53.

<sup>55</sup> An extensive collection of Pope John Paul II’s statements on solidarity with the poor are collected in Rev. Gerald S. Twomey, *Pope John Paul II and the “Preferential Option for the Poor”*, \_\_ ST. JOHN’S J. CATH. LEG. STUD. \_\_ (2006). The Pope made clear that although the option has often been discussed in the context of Latin America, it is relevant for the Church and the world as a whole. JP II, *Address to the Communitari S. Egirdio*, in *Osservatore Romano* (Dec. 14, 1986).

<sup>56</sup> Appendix II: The Final Report in Xavier Rynne, JP II/s Extraordinary Synod: A Collegial Achievement (1986).

The *Compendium of the Social Doctrine of the Church* presents the preferential option for the poor as a subset of the requirement of the universal destination of goods. PONTIFICAL COUNCIL FOR JUSTICE AND PEACE, *COMPENDIUM OF THE SOCIAL DOCTRINE OF THE CHURCH*, ¶ 182, at p.102 (2004) [hereinafter *Compendium*]. Prior to the publication of the *Compendium*, most listings of the basic principles of Catholic Social Thought considered the option for the poor as a separate principle. The failure of the *Compendium* to do so has been criticized. Kenneth Himes suggests that placing the option for the poor as subset of the universal destiny of goods rather than as separate principle in its own right misses the “crucial point” that the option for the poor “runs throughout the tradition of social teaching as a distinctive motif that influences how Catholics understand the meaning of the other basic principles.” Kenneth R. Himes, *To Inspire and Inform*, AMERICA, June 6-13, 2005, at p.9-10. Himes argues that rather than being a subcategory of another norm, the option for the poor should be treated as the focus “from which to begin ethical reflection.” *Id.* at 10. Similarly, Thomas Massaro laments that the failure to give sufficient prominence in its own right to the option for the poor carries over in the discussion of Economic Life later in the *Compendium*, which “overemphasize[s] the praise that the church has extended to capitalism over recent decades” while failing to sufficiently “remind[] entrepreneurs and investors that the proper end of economic activity is the progress of the entire community, especially the poorest members.” Thomas Massaro, S.J., *On Work and Markets*, AMERICA, June 6-13, 2005, at 11, 13. Although it is important to heed to concerns expressed by Himes and Massaro that the principle not become subordinated to other interests, it is less clear that the preferential option is any less persuasive as an element or outgrowth of the universal destiny of common goods than as a stand-alone principle.

<sup>57</sup> KENNETH HIMES, *RESPONSES TO 101 QUESTIONS ON CATHOLIC SOCIAL TEACHING* 39 (2001).

Doctrine of the Church makes clear that the option for the poor is not only applicable to individual Christians,<sup>58</sup> “but it applies equally to our *social responsibilities* and hence to our manner of living, and to the logical decisions to be made concerning the ownership and use of goods.”<sup>59</sup>

The preferential option for the poor also has meaning as a *vision*, as an encouragement to choose to see how things look to a poor person.<sup>60</sup> In their 1986 pastoral letter, *Economic Justice for All*, the American Catholic Bishops describe the preferential option as an “obligation to evaluate social and economic activity from the viewpoint of the poor and the powerless.”<sup>61</sup>

One cannot speak of the preferential option for the poor without talking about health care. “The biblical mandate to care for the poor...prompts us to work to ensure that our country’s health care delivery system provides adequate health care for the poor.”<sup>62</sup> The Compendium observes further that among those the preferential option for the poor “cannot but embrace” are “those without health care.”<sup>63</sup>

These statements should not be surprising. From a Catholic perspective, health care is a basic human right, grounded in the principle of the dignity of the human person.<sup>64</sup> In his encyclical *Pacem in Terris*, Pope John XXIII identified health care as

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<sup>58</sup> The preferential option for the poor “affects the life of each Christian inasmuch as he or she seeks to imitate the life of Christ.” *Compendium*, *supra* note 56, at ¶182, p.102.

<sup>59</sup> *Compendium*, *supra* note 56, at ¶182, p.102.

<sup>60</sup> HIMES, *supra* note 57, at 39.

<sup>61</sup> United States Bishops, *Economic Justice for All: Catholic Social Teaching and the U.S. Economy*, ¶ 87 (1986).

<sup>62</sup> NATIONAL CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES, introduction to Part 1 (4th ed. June 15, 2001), available at <http://www.usccb.org/bishops/directives.htm>.

<sup>63</sup> *Compendium*, *supra* note 56, at p. 102.

<sup>64</sup> HIMES, *supra* note 57, at 67 (“People have a legitimate claim based on their dignity to those essential material goods that meet basic needs for food, clothing, shelter, health, education, security and rest.”); Jeff Teiman, *Poverty and Health: Connections that Can Spark a Dialogue*, HEALTH PROGRESS, May-June 2005, at 6, 8 (observing that lack of access to health care offends human dignity). See also CATECHISM OF THE

among the basic rights that flow from the dignity of the human person.<sup>65</sup> In his address to the 34<sup>th</sup> General Assembly of the United Nations, Pope John Paul II also included as among the human rights endorsed by the Catholic Church “the right to food, clothing, housing [and] sufficient health care.”<sup>66</sup> The American bishops have also been vocal on this matter, speaking on numerous occasions of access to adequate health care as a basic right “necessary for the development and maintenance of life and for the ability of human beings to realize the fullness of their dignity.”<sup>67</sup>

Thus, in Catholic social teaching, access to health care “is a human right – not just another commodity.”<sup>68</sup> Seen in that light, one cannot talk about addressing the needs of the poor without addressing access by the poor to a basic necessity for their ability to fully realize their human dignity. That means that, from a Catholic standpoint, one cannot talk about health care as though it were a fringe benefit that may or may not be provided to someone depending on the whim of an employer or market concerns.

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CATHOLIC CHURCH ¶ 2288 (“concern for the health of its citizens requires society help in the attainment of living conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment”).

<sup>65</sup> Pope John XXIII, *Pacem in Terris*, ¶ 11 (Apr. 11, 1963).

<sup>66</sup> Pope John Paul II, *Address to the 34<sup>th</sup> General Assembly of the United Nations* ¶ 13 (1979). The list also includes the rights to “rest, and leisure; the right to freedom of expression, education and culture; the right to freedom of thought, conscience and religion; the right to manifest one’s religion either individually or in community, in public or in private; the right to choose a state of life, to found a family and to enjoy all conditions necessary for family life; the right to property and work, to adequate working conditions and a just wage; the right of assembly and association; the right to freedom of movement, to internal and external migration; the right to nationality and residence; the right to political participation and the right to participate in the free choice of the political system of the people to which one belongs.” *Id.*

Pope John Paul II also discussed the need for health care in *Laborem Exercens*. Pope John Paul II, *Laborem Exercens*, ¶ 19 (Sept. 14, 1981).

<sup>67</sup> Catholic Conference of Kentucky, *Health Care is a Moral Right, a Safeguard of Human Life* (Dec. 2005). See also United States Conference of Catholic Bishops, *Framework for Comprehensive Health Care Reform* (1993) (all people have a right to health care); United States Catholic Conference, *Health and Health Care*, Nov. 19, 1981, at p.3 (observing that the “ability to live a fully human life and to reflect the unique dignity that belongs to each person is greatly affected by health” and that health care is “a basic human right which flows from the sanctity of human life”).

<sup>68</sup> U.S. Conference of Catholic Bishops, *A Fair and Just Workplace: Principles and Practices for Catholic Health Care*, Dec. 5, 2005, at p.3

Nor is this a principle as to which Catholics stand alone. It is noteworthy that language used by the papacy and by American bishops to talk about health care is not at all dissimilar from that contained in Universal Declaration on Human Rights which recognizes an individual right to health as a fundamental human right founded on the right to life.<sup>69</sup> The Universal Declaration speaks of everyone having “the right to a standard of living adequate for the health and well-being of himself and his family, including...medical care and necessary social services.”<sup>70</sup> More recently, the Citizen’s Health Care Working Group, created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003,<sup>71</sup> expressed in its Values and Principles that “[h]ealth and health care are fundamental to the well-being and security of the American people,” that “[i]t should be public policy, established in law, that all Americans have affordable health care coverage,” and that “[a]ssuring health care is a shared social responsibility.”<sup>72</sup>

In light of how Catholic Social Thought talks about health care, it is easy to come to the conclusion that common good requires that all individuals have access to affordable health care, that access to affordable health care is a right no person should be without. The more difficult question is how that right can and should be realized.

Catholic Social Thought does not address this point directly. Although papal encyclicals speak of a right to affordable health care, language in those documents also

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<sup>69</sup> Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR, 3d Sess., art. 3, U.N. Doc. 1/810 (1948).

<sup>70</sup> *Id.* at art. 25(1).

<sup>71</sup> 42 U.S.C. § 299 (2003).

<sup>72</sup> Citizen’s Health Care Working Group, *Health Care that Works for All Americans: Interim Recommendations of the Citizens’ Health Care Working Group*, p.6 (June 1, 2006).

Some have argued more broadly for the importance of recognizing a collective, rather than an individual right to health. See Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing A Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101 (2005).

seems to suggest acceptance of an employment-based system of providing health care.<sup>73</sup> They also, while speaking of affordable health care being an aspect of a just wage, recognize that an employer's obligation is affected by market and competitive conditions.<sup>74</sup>

The Catholic Health Association takes the reasonable position that “[t]he promotion, maintenance, and enhancement of health is a social good with societal responsibility shared by individuals, families, health care providers, voluntary agencies, employers, and governments.”<sup>75</sup> However, acceptance of the proposition that the provision of affordable health care is a social, shared responsibility, still does not answer the challenging question how health care access should be afforded to those who cannot attain it through normal market channels. And deciding how the right to access to affordable health care should be realized is impossible without also thinking about the principle of subsidiarity.

## **B. Subsidiarity**

Subsidiarity has long been one of the central themes of Catholic social teaching. In *Quadragesimo Anno*, Pope Pius XI expressed it as a “fundamental” and “fixed and unchangeable principle of social philosophy” that

one should not withdraw from individuals and commit to the community what they can accomplish by their own enterprise and industry. So, too, it is an injustice and at the same time a grave evil and a disturbance of right order to transfer to the larger and higher collectivity functions which can be performed and provided for by lesser and subordinate bodies. Inasmuch as every social activity

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<sup>73</sup> For example, *Laborem Exercens* speaks of the direct employer according workers various social benefits, including health care. Pope John Paul II, *Laborem Exercens*, ¶ 19 (Sept. 14, 1981).

<sup>74</sup> This is implicit in the consistent acceptance of capitalism in papal documents.

<sup>75</sup> Catholic Health Ass'n, *Guidelines for Medical Reform for the 108<sup>th</sup> Congress*. See also Catholic Conference of Kentucky, *Health Care is a Moral Right, a Safeguard of Human Life*, p.3 (Dec. 2005) (observing that health care “is the responsibility of each individual, every family, employers, communities, health care providers, health care facilities, and state and federal governments share in the responsibility to ensure health care for all and to safeguard human life”).

should, by its very nature, prove a help to members of the body social, it should never destroy or absorb them.<sup>76</sup>

As I have discussed elsewhere,<sup>77</sup> subsidiarity reflects more than the belief that those closest to a problem are most effectively able to understand and solve it. An important part of what underlies the principle of subsidiarity is the need to facilitate individual development and achievement of aspirations. “Human development and achievement of aspirations require initiative. Social organizations are the means of assisting participants in the association to help themselves, or to permit them initiatives of commitment and action.”<sup>78</sup> This point was emphasized by Pope John XXIII in his encyclical *Mater et Magistra*,<sup>79</sup> when he warned that government action should never interfere with the full development of human personality, but rather should aim to augment individual freedom and development, encouraging individuals to take an active part in ordering their lives.<sup>80</sup> This empowering of individuals is important not only for the individual but for the health of society as a whole.<sup>81</sup>

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<sup>76</sup> Pope Pius XI, *Quadragesimo Anno* (After Forty Years) ¶ 79 (May 15, 1931). See *Compendium*, *supra* note 56, at ¶ 1884; Catechism of the Catholic Church ¶ 1883 (1994) (“A community of a higher order should not interfere in the internal life of a community of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to coordinate its activity with the activities of the rest of society, always with the view to the common good”) (quoting *Centesimus Annus*).

<sup>77</sup> Susan J. Stabile, Subsidiarity and the Use of Faith-Based Organizations in the Fight Against Poverty, 2 VILLANOVA JOURNAL OF CATHOLIC SOCIAL THOUGHT 313 (2005).

<sup>78</sup> Dinah Shelton, *Subsidiarity, Democracy and Human Rights*, in BROADENING THE FRONTIERS OF HUMAN RIGHTS (Ed. Donna Gomien) 43, 47 (Scandinavian Univ. Press 1993).

<sup>79</sup> Pope John XXIII, *Mater et Magistra* (On Christianity and Social Progress), May 15, 1961.

<sup>80</sup> *Id.* at ¶ 45, 55.

<sup>81</sup> See Robert K. Vischer, *Subsidiarity as a Principle of Governance: Beyond Devolution*, 35 IND. L. REV. 103, 109 (2001) (suggesting that subsidiarity embodies the notion “that a society’s health is a function, in great part, of the vibrancy and empowerment of individuals acting together through social groupings and associations”).

A significant aim, then, of subsidiarity is the furthering of human development.

As explained by the Congregation of the Doctrine of the Faith in its *Instruction on Christian Freedom and Liberation*,<sup>82</sup> the principle of subsidiarity means that

Neither the State nor any society must ever substitute itself for the initiative and responsibility of individuals and of intermediate communities at the level on which they can function, nor must they take away the room necessary for their freedom. Hence the Church's social doctrine is opposed to all forms of collectivism.<sup>83</sup>

Although the State may not displace other smaller communities,<sup>84</sup> subsidiarity does not rule out any role or obligation for the government. That is, while it violates subsidiarity to “transfer to the larger and higher collectivity functions which can be performed and provided for by lesser and subordinate bodies,”<sup>85</sup> the state must step in when the lower orders can not provide for basic needs. The government may be required to achieve “an appropriate structuring of the human community;”<sup>86</sup> it has the right to and must intervene where leaving things to the market is inimical to the common good.<sup>87</sup>

This understanding is reinforced by the principle of solidarity,<sup>88</sup> which emphasizes interdependence and relationship as basic elements of human existence.

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<sup>82</sup> Congregation for the Doctrine of the Faith, *Instruction on Christian Freedom and Liberation*, Mar. 22, 1986.

<sup>83</sup> *Id.* at ¶ 73.

<sup>84</sup> Pope John Paul II, *Centesimus Annus* ¶ 48 (1991) (suggesting that, where necessary, communities of a higher order should support smaller communities, rather than to take over their functions).

<sup>85</sup> Pope Pius XI, *Quadragesimo Anno* ¶ 79 (1931).

<sup>86</sup> *Mater et Magistra* ¶ 67.

<sup>87</sup> See Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* ¶ 188 (2004); Robert A. Sirico, *Subsidiarity, Society, and Entitlements: Understanding and Application*, 11 NOTRE DAME J. L. ETHICS & PUB. POL'Y 549, 567 (1997) (observing that subsidiarity does not mean all solutions have to be private, it means private efforts should not be crowded out by government efforts”), U.S. CATHOLIC CONF., CATECHISM OF THE CATHOLIC CHURCH ¶ 1833 (1994) (“A community of a higher order should not interfere in the internal life of a community of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to coordinate its activity with the activities of the rest of society, always with a view to the common good.”).

<sup>88</sup> David Hollenbach has suggested that “a revival of commitment to the common good and a deeper sense of solidarity are preconditions for significant improvement of the lives of the poor.” DAVID HOLLENBACH, *THE COMMON GOOD AND CHRISTIAN ETHICS* 173 (2002).

Remembering solidarity ensures that subsidiarity does not become “a conservative mantra used to justify the devolution of government power with little concern for the common good.”<sup>89</sup>

Subsidiarity thus embodies a preference for addressing social needs at the lowest possible organizational level that can be effective<sup>90</sup> and thus demands that governmental functions be performed at the lowest possible level to perform the function effectively.<sup>91</sup> It also demands that governmental solutions are not appropriate unless problems can not be addressed by nongovernmental community entities.

#### IV. Moving from Broad Statements to Prescriptions

The principle of the preferential option for the poor, informed by the principle of human dignity demands that we think about access to health care as a basic human right, rather than as a voluntarily provided employee benefit. Informed by the principle of solidarity, it also means that providing all citizens with access to health care should be

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<sup>89</sup> Robert K. Vischer, *Solidarity, Subsidiarity and the Consumerist Impetus of American Law*, in SELF-EVIDENT TRUTHS: CATHOLIC PERSPECTIVES ON AMERICAN LAW (M. SCAPERLANDA & T. COLLETT EDs.) (forthcoming) (discussing the importance of connecting the doctrines of subsidiarity and solidarity). See also Stabile, *supra* note 77, at 316 (noting importance of assuring that subsidiarity is not “used as an excuse to merely devolve responsibility downward without assurance of effectiveness, that it not be used as an excuse for the federal government to not abdicate responsibility to provide for the social welfare of its citizens”).

<sup>90</sup> Stabile, *supra* note 77, at 327.

<sup>91</sup> Sirico, *supra* note 87, at 549 (“To empower higher authorities as anything but second-best solutions or even last resorts endangers the rights and liberties of those who are most affected.”); See David A. Bosnich, *The Principle of Subsidiarity*, 6 RELIGION AND LIBERTY (July-Aug. 1996), available at <http://www.acton.org/public/randl/article.php?id=200> (arguing that subsidiarity addresses the respective roles of the state and federal governments and that “[w]hen the federal government usurps the rights and responsibilities of state and local governments, a flagrant violation of the principle of subsidiarity has occurred”).

As Michael Moreland observed in his commentary to my presentation at the Villanova conference, there is an issue as to how well various papal comments on subsidiarity map onto the U.S. system, that is, how one translates language discussing the proper assignment of roles and of civil authority onto the American system of government. I confess that I tend to equate the papal use of the term “State” with “federal government,” which admittedly is not precise. But even if the mapping is not precise, I think subsidiarity has something useful to contribute to our thinking about solutions in a federalist system.

viewed as a collective responsibility.<sup>92</sup> At the same time the principle of subsidiarity adds caution about making decisions as to the appropriate role of the government in providing access to health care.

The difficult question is always how to move from broad statements about what Catholic Social Teaching contributes to our thinking about an issue of public policy to offering specific prescriptions for social change. One way to approach the question in the context of access to health care is to examine alternative means of improving access to health care from the perspective of Catholic social thought. This section addresses three alternatives that represent very different philosophical approaches to the addressing the problem of access. It starts with two that I believe are problematic from a Catholic social thought perspective – the first, because it embodies the preferential option for the poor in a way that may not give sufficient respect to the principle of subsidiarity, and the second, because it does not take seriously the obligation to treat medical care as a right fundamental to human dignity. Finally, the section considers a third alternative that, while not without its own difficulties, may suggest a more promising path to increasing access to affordable health care to the working poor.

### **A. A National Health System**

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<sup>92</sup> Prof. Lois Shepherd argues that we have not taken the notion of responsibility (vs. rights) seriously in the health care context. She argues:

It seems that especially in the legal realm – whether we are assessing what courts or legislatures or administrative agencies should do – we have yet to develop a robust explanation for who is responsible for what, and why. Understanding the interpersonal nature of health care and health care’s relation to the prevention and alleviation of suffering makes clear that questions of responsibility lie in the shadows of nearly every important decision that must be made regarding health law, from questions of access to quality to patient choice. But as it now stands, our understanding of responsibility, although often appealed to, is fuzzy and vague, and ultimately ineffectual as an analytical tool for solving problems.

Lois Shepherd, *Rethinking Health Law: Assuming Responsibility*, 41 WAKE FOREST L. REV.445 (2006).

“To a lot of thoughtful people, the only way to fix the health insurance crisis is to get the federal government to cover everyone. Britain, Canada, Japan and a number of other rich countries to so, and they each spend less money on health care than this country does.”<sup>93</sup> Adoption by the federal government of a national health system has been advocated by many, including the United States Conference of Catholic Bishops in its 1981 Pastoral Letter on Health and Health Care.<sup>94</sup>

In a national health system of the kind used by many European countries, hospitals and service providers are reimbursed directly by the government, in a similar fashion to how Medicare operates today using funds from payroll taxes to pay for care for the elderly and disabled.<sup>95</sup> In order to control the costs of such a system, various measures are typically employed. Some form of cost sharing with the consumer is often used, both to cut costs and to ensure that free care is not used irresponsibly or excessively. In addition, some countries, such as the United Kingdom regulate the costs of health care through regulation of the profits of pharmaceutical companies and setting fee schedules for physicians.<sup>96</sup> Costs are also controlled by the budget set by the

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<sup>93</sup> David Leonhardt, *A Health Fix That is Not a Fantasy*, NY TIMES, Apr. 12, 2006, at C1.

<sup>94</sup> United States Catholic Conference, *Health and Health care: A Pastoral Letter of the American Catholic Bishops*, Nov. 19, 1981, at p.18-19 (“It is the responsibility of the federal government to establish a comprehensive health care system that will ensure a basic level of health care for all Americans. The federal government should also ensure adequate funding for this basic level of care through a national health insurance program”).

The public is also in favor of such an approach. See 151 CONG. RECORD 113162-02 (May 11, 2005) (statement of Rep. Kucinich) (citing Kaiser Foundation poll findings that 64% of American favor expanding Medicare to cover everyone). See also George Raine, *Union Leader Declares Health Care is Priority*, SAN FRANCISCO CHRONICLE, Nov. 4, 2006, available at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2006/11/04/BUG07M5SC21.DTL&type=health>.

<sup>95</sup> See Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, at 557 (2006).

<sup>96</sup> *Id.*, at 591.

government for health care in given period of time; the amount of money budgeted for health care is the amount of money spent on health care.<sup>97</sup>

One argument advanced in favor of a single-payer system is that it would reduce administrative costs. It is estimated that under our current system of private health insurance, “less than 80 cents of each dollar in health insurance premiums [is spent] on actually providing medical care,” with the other 20 cents being spent on marketing and administrative expenses.<sup>98</sup> In contrast, Medicare – which is essentially a single-payer system for providing health care for the elderly – spends almost 90 cents of each dollar on medical care.<sup>99</sup> A single-payer system would also save doctors from the expenses incurred in dealing with the filing and other requirements of different health insurance providers.<sup>100</sup>

In the United States, a national health system could be implemented by expanding Medicare to cover all citizens. A bill that would do precisely that was proposed in 2005.<sup>101</sup> The proposal was described as a “universal, single payer, not-for-profit health care system [which would make] it possible for people to be covered for all medically necessary procedures: for vision care, for dental care, for mental health care, for long-term care, and a prescription drug benefit.”<sup>102</sup> The bill aims at ensuring “that all individuals have access, guaranteed by law, to the highest quality and most cost effective healthcare services regardless of their employment, income, or healthcare status.”<sup>103</sup>

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<sup>97</sup> *Id.*, at 592 (noting that in such countries, the health care budget must compete with the budgets for defense, education and so on).

<sup>98</sup> Paul Krugman, *Death By Insurance*, N.Y. TIMES, May 1, 2006, at p.A19.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> See H.R. 767, 109<sup>th</sup> Cong. 1<sup>st</sup> Sess. (2005) (introduced Feb. 8, 2005 as the United States National Health Insurance Act).

<sup>102</sup> 151 CONG. RECORD H3897 (May 25, 2005) (statement of Rep. Kucinich).

<sup>103</sup> 151 CONG. RECORD E707 (May 3, 2006) (statement of Rep. Lee).

Although additional sponsors have signed on to the bill in the last year or so, no real action has yet been taken on it, and it is unlikely the proposal will ever garner enough support to have a realistic chance of being enacted.<sup>104</sup>

From a secular standpoint, there may be reasons to question the viability of a national health system, even apart from the fact that such a system is not likely to be adopted any time soon. Critics have expressed concerns about the workability of such a system as well as objection to the idea of the government making choices about what benefits would be provided.<sup>105</sup> Concern has also been expressed that a governmental system would lack the flexibility that “allows employers to rapidly adapt their coverage arrangements...[varying] benefit design based on health care market, economic and workplace factors, usually without having to go through a cumbersome and public administrative process to make needed benefit adjustments.”<sup>106</sup> In addition, the experience of some European countries with single-payer systems has been that of numerous reforms prompted by fiscal crises and inefficient service.<sup>107</sup> Having said that, there are models of national health insurance, for example, Germany, as to which these criticisms seem less applicable.<sup>108</sup>

More importantly for purposes of this Article, is how such a proposal would be viewed from the perspective of Catholic social thought. If the sole goal from a Catholic

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<sup>104</sup> See David Leonhardt, *A Health Fix That is Not a Fantasy*, NY TIMES, Apr. 12, 2006, at C1 (discussing reasons Congress would not enact a universal coverage system).

<sup>105</sup> See Jost, *supra* note 95, at 579 (noting that “public programs are necessarily controlled by bureaucracies, and can thus be afflicted by the inefficiencies and corruption that plague bureaucracies.” As an example, consider the notorious delays for routine medical procedures and visits in some European countries).

<sup>106</sup> Glied & Borzi, *supra* note 18, at 407.

<sup>107</sup> See Miriam Laugesen, *Why Some Market Reforms Lack Legitimacy in Health Care*, 30 J. Health Pol. Pol'y & L. 1065 (2005).

<sup>108</sup> See generally Reinhard Busse & Annette Riesberg, *Health Care Systems in Transition: Germany* (2004), available at <http://www.who.dk/Document/E85472.pdf>.

perspective were to provide affordable access to care, there would be precious little reason to object to a national health system, presuming the workability of such a system. Indeed, if our only consideration is providing access to benefits, a large enough federal government conceivably could be the direct provider of all of its citizens needs, solving all of our social ills.

However, Catholic thought cautions against assuming that all problems should be met by having the State directly provide benefits. In a related context, Pope John Paul II spoke harshly about the “Welfare State” in *Centesimus Annus*. Although he recognized addressing poverty as an important goal, he expressed concern that the expansion of the Welfare State did not give proper regard for the principle of subsidiarity and for the appropriate role of the State.<sup>109</sup> He criticized the notion of an entitlement to government-provided welfare as “assuming that failure is a constant pattern of the lower orders, and robbing them of the opportunity to provide better care for those who need. Indeed, with an ‘entitlement,’ the competence or incompetence of the lower orders in accomplishing the task of charity is not even an issue.”<sup>110</sup> Subsidiarity demands that we ensure ourselves that provision of adequate health care to all cannot be managed by lower order entities before we hand the task to the federal government.

As discussed earlier, underlying subsidiarity is a belief in the importance of facilitating individual development, as well as a belief that subsidiary entities may do a better job than the State. Having the federal government step in to become the direct

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<sup>109</sup> Pope John Paul II, *Centesimus Annus* ¶ 48 (May 1, 1991). He observes that “[b]y intervening directly and depriving society of its responsibility, the Social Assistance State leads to a loss of human energies and an inordinate increase of public agencies, which are dominated more by bureaucratic ways of thinking than by concern for serving their clients, and which are accompanied by an enormous increase in spending. In fact, it would appear that needs are best understood and satisfied by people who are closest to them and who act as neighbors to those in need. It should be added that certain kinds of demands often call for a response which is simply not material but which is capable of perceiving the deeper human need.” *Id.*

<sup>110</sup> *Centesimus Annus* ¶48.

provider of health care benefits to all citizens substitutes the decisionmaking of a central government for that of entities closer to the people being served and, indeed, removes any participation from the people being served themselves. It thus cuts against subsidiarity's concern for permitting individual initiatives and its emphasis on augmenting individual freedom and development. Under a national health system, individuals are given no ability to take an active part in ordering this aspect of their lives. For this reason, absent conviction that it is impossible through other means to provide affordable access to health care to all Americans, a national health care system cannot be justified from the perspective of Catholic social thought.<sup>111</sup>

## **B. Consumer Choice (Health Savings Account) Plans**

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<sup>111</sup> The obvious implication is that if the state governments or other lower intermediaries are unable (or intractably unwilling) to effectively provide affordable, adequate health care for all Americans, the federal government should step in to do so. As the discussion in Section IV.C., *infra*, suggests, however, it would be better from the standpoint of subsidiarity if access to affordable, quality care could be provided through a system in which the federal government acts in the role of facilitator of more local efforts rather than as a direct provider of benefits.

There is another risk that cannot be ignored from the standpoint of Catholic thought. To the extent that the federal government is put in the role of deciding what constitutes a core benefit package that must be made available to all citizens, that package will likely include procedures that are morally objectionable from a Catholic standpoint. This is a concern that was raised by the U.S. Conference of Catholic Bishops in their statement of reaction to the recommendations of the Citizens' Health Care Working Group. See Office of Social Development & World Peace, USCCB, *Letter to Chair, Citizen's Health Care Working Group*, Aug. 23, 2006, available at <http://www.usccb.org/sdwp/national/hcrecommendations.htm>. This may also be a risk with state approaches where the state determines what constitutes quality insurance coverage, see *infra* note 134 and accompanying text, but presumably creates a less global problem as state approaches will vary.

There is also the risk that the greater the government's involvement in the direct provision of care, the stronger will be arguments that the government is justified in forcing Catholic health care providers to act in ways inconsistent with their religious beliefs. To be sure, we have already seen some such pressure on Catholic organizations, but direct federal funding of the health care needs of all citizens may make the situation worse. As one example of current pressure, I discuss the issue of forcing Catholic employer's to provide prescription contraception coverage (and the slippery slope toward forcing Catholic entities to fund or provide abortions) in Susan J. Stabile, *State Attempts to Define Religion: The Ramifications of Applying Mandatory Prescription Contraceptive Coverage Statutes to Religious Employers*, 28 HARV. J. LAW & PUB. POL'Y 741 (2005).

The approach to improving access to health care that has consistently been promoted by the Bush Administration is the health savings account (“HSA”).<sup>112</sup> Briefly, the idea of the HSA is to allow individuals and families to make tax-deductible contributions into savings accounts to be used for the payment of qualified medical expenses. In order to be eligible to contribute to an HSA, the individual must be covered by a high-deductible health plan, i.e. a plan with an annual deductible of at least \$1,000 for individual coverage and \$2,000 for family coverage, and must not be eligible for Medicare. Annual tax-deductible HSA contributions are generally limited to 100% of the health plan deductible, up to a maximum contribution of \$2,600 for an individual and \$5,150 for a family. Any contributions in excess of the deductible amounts are subject to a 6% excise tax. Not only do earnings on contributions accumulate tax free, but no taxes need to be paid on distributions from an HSA that are used to pay qualified medical expenses.<sup>113</sup>

A number of employers have expressed interest in the HSA approach. “One study found that 73 percent of small business owners were interested in the HSA concept. Another study found that 61 percent of employers they surveyed were likely to offer HSAs in the near future. A third study found that 19 percent of surveyed employers were

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<sup>112</sup> Glied & Borzi, *supra* note 18, at 404 (2004) (citing Conservatives argument that current system should be replaced with individually purchased insurance, such as tax-favored spending accounts). The creation of HSAs was authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

<sup>113</sup> LANGBEIN, STABILE AND WOLK, PENSIONS AND EMPLOYEE BENEFITS LAW 55-56 (4<sup>th</sup> ed. 2006). For further discussion of the operation of health savings accounts, see, e.g., J.M. Razor, *Health Savings Accounts: Increasing Health Care Access in America?*, 17 LOY. CONSUMER L. REV. 419, 420-27 (2005)

very likely to offer HSAs by 2006, and another 54 percent were somewhat likely to offer them.”<sup>114</sup>

The theory is that HSAs will encourage participants “to become more astute health care consumers.”<sup>115</sup> In praising the plans, President Bush remarked that “one of the greatest elements about health savings accounts is that all of a sudden the consumer starts being more in charge of the decision making process....And when consumers make choices, it then encourages them to start making healthy choices, particularly when you get to save money, when it’s like your money on the line.”<sup>116</sup>

As a vehicle for providing additional tax-favored savings for the wealthy, HSA’s are wonderful. They “appeal primarily to lawyers, doctors and partners in small businesses who may welcome tax-free savings accounts for themselves.”<sup>117</sup>

However, whether or not HSA’s will lower health care costs is more debatable. Some have argued that while this approach may affect spending on medical care that is relatively price elastic, it will not reduce the demand for nondiscretionary medical

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<sup>114</sup> Paul Fronstin, Health Savings Accounts and Other Account-Based Health Plans, EBRI Issue Brief 273, Sept. 2004, at 1. Small business owners have particular difficulty securing cost-effective insurance coverage for their employees. See Snowe, *supra* note 19, at 232.

<sup>115</sup> *Id.* Those supporting this approach believe that for the most part, “difficulties with employment based insurance stem from the fact that someone other than the ultimate consumer of health care is making most of the decisions about what coverage to purchase and how much to pay.” David A. Hyman & Mark Hall, *Two Cheers for Employment Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 26-27 (2001). See also Michael F. Cannon, *Health Savings Accounts: Do the Critics Have A Point?*, Cato Institute Policy Analysis No. 569, May 20, 2006, at p.1, available at [http://www.cato.org/pub\\_display.php?pub\\_id=6395](http://www.cato.org/pub_display.php?pub_id=6395) (suggesting that HAS’s “reduce government influence over consumers’ medical decisions by reducing the price distortions created by the federal tax code”).

<sup>116</sup> President George W. Bush, Remarks by the President in a Conversation on Health Access (March 16, 2004), available at <http://whitehouse.gov/news/releases/2004/03/40020316-5.html>. See also *IRS Releases model HSA Trustee Forms; Snow Touts Benefits for Small Businesses*, 9 BNA Health Care Daily Report (Jun3 28, 2004) (quoting Former Treasury Secretary John Snow that HSA’s give consumers “greater control over their health purchasing decisions and the opportunity to budget for health expenses over many years through rollovers of account balances from year to year”).

<sup>117</sup> Milt Freudenheim, *Bush Health Savings Accounts Slow to Gain Acceptance*, N.Y. TIMES, Oct. 13, 2004, at p.C1, C15. See Melden, *supra* note 29 at 410 (observing the irony that the “federal legislation promoting HSAs provides its greatest value to those in the highest tax brackets even though they have the least amount of problems affording health insurance”).

services, which tend to be the “big ticket” items in terms of cost.<sup>118</sup> If, in fact, HSAs fail to reduce costs, “they exacerbate an already worsening situation in terms of access to employment-based coverage.”<sup>119</sup> Additionally, there is reason to question how well HSA holders will make the all of the decisions required of them under these plans. The Department of Labor Working Group on Consumer-Directed Health Care warns that “[t]he difficulty of the decision tasks required of consumers and the skills needed to manage within these plans may be beyond the level of effort many consumers are willing to expend, and may be beyond the ability of others.”<sup>120</sup>

Most importantly, however, for the working poor the problem is that “no matter how much you dress up these plans in the rhetoric of ‘consumer empowerment,’ cost shifting – in the form of higher deductibles, co-insurance, office visit fees, and benefit exclusions – is inherent to their design.”<sup>121</sup> Indeed, the EBRI found that “[d]espite similar rates of health care use, individuals with [HSAs] are more likely to spend a larger share of their income on out-of-pocket health care expenses than those in comprehensive health plans.”<sup>122</sup> These plans thus place a greater burden on the working poor, in the

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<sup>118</sup> Monahan, *supra* note 35, at 836-37 (concluding that HSAs are unlikely to result in a significant cost decrease). See also Stone, *supra* note 35, at \_\_\_ (expressing skepticism about whether costs will be reduced).

<sup>119</sup> Razor, *supra* note 113, at 443.

<sup>120</sup> Advisory Council on Employee Welfare & Pension Benefit Plans, *Final Report of the Working Group on Health Care Security Consumer-Directed Health Care Arrangements 7* (2003), available at [http://www.dol.gov/ebsa/publications/AC\\_1107a03\\_report.html](http://www.dol.gov/ebsa/publications/AC_1107a03_report.html). See also Simona Botti & Sheena S. Iyengar, *The Dark Side of Choice: When Choice Impairs Social Welfare*, 2006 AMER. MKTG. ASS'N J. OF PUB. POL'Y & MARKETING 24 (Spr. 2006 (discussing factors that contribute to the complexity of medical decisionmaking and suggesting that greater autonomy in this area does not promote social welfare)); Stone, *supra* note 35, at \_\_\_ (discussing difficulty of making medical choices under HSA plans).

<sup>121</sup> EBRI, Retirement Income Security: A Look at Social Security, Employment-Based Retirement Plans, and Health Savings Accounts, Aug. 2005, at 7. See Fred Brock, *Weighing the Risks in a Health Savings Account*, N.Y. TIMES, Sept. 21, 2004, at p.G3 (observing that HSAs “achieve savings by shifting more health expenses to consumers”). See Melden, *supra* note 29, at 404 (observing that the reality is more about consumer risk than about consumer choice and that “as much as the rhetoric focuses on expanding consumer choices, the appearance of HDHPs on the market actually narrows and obscures not only consumer choices but also the ability to pursue sound policy in this area”).

<sup>122</sup> Employee Benefit Research Institute, *Survey of Consumer-Driven Health Plans Raises Key Issues*, EBRI NOTES, Feb. 2006, at p.3.

guise of choice. Additionally, many lower income employees will lack the money to make significant contributions to an HSA.<sup>123</sup>

The consequence is that HSAs may encourage lower income consumers to avoid seeking necessary medical care in order to save money.<sup>124</sup> The EBRI found that those covered by HSAs “were significantly more likely to avoid, skip, or delay health care because of costs than were those with comprehensive insurance, with this behavior particularly pronounced among those with health problems or incomes under \$50,000.”<sup>125</sup> While the theory is that HSAs will cause individuals to be more astute consumers of health care services, the reality is that they “will delay or forego care without making great distinctions and choices between medically necessary and unnecessary care.”<sup>126</sup>

Finally, HSAs continue to operate under the rubric of employment-based plans. That means they do nothing to affect access to health to those without jobs. Even for the working poor not currently covered, it is unclear whether employers who currently do not provide any medical coverage will begin offering HSAs, or whether HSAs simply allow employers who already provide health insurance to do so with less expense to themselves. One survey found that the theory that “HSAs would expand access to

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<sup>123</sup> See Melden, *supra* note 29, at 418 (citing findings supporting conclusion that many lower-income employees simply lack the discretionary income to put into an HSA); Stone, *supra* note 35, at \_\_\_ (observing that “[e]ven workers who are employed often lack the extra income at the end of each week to set aside some for something as hypothetical as health insurance. Rather, most individuals on tight budgets, if forced to choose paying for a child’s wedding or putting money into a health savings account for an uncertain gain at an uncertain date, will almost certainly forego the health insurance.”).

<sup>124</sup> See Jennifer L. Spiegel, *Employee Driven Health Care: Health Savings Accounts, More Harm than Good*, 8 U. PA. J. LAB. & EMP. L. 219, 231 (2005) (discussing Rand Corporation study suggesting that “individuals with HSAs may choose to ‘save’ money in a manner that could lead to significantly higher medical costs in the future”).

<sup>125</sup> Employee Benefit Research Institute, *Survey of Consumer-Driven Health Plans Raises Key Issues*, EBRI NOTES, Feb. 2006, at p.3. See also Razor, *supra* note 113, at 444 (suggesting that HSAs may disproportionately affect low-income individuals, who may forgo necessary treatment). See Melden, *supra* note 29, at 413 (noting that about 1/3 of individuals with high deductible plans delay or avoid care due to considerations of cost).

<sup>126</sup> Melden, *supra* note 29, at 415.

coverage by providing a less-expensive option for small employers who might not otherwise offer coverage....hasn't panned out," citing the fact that the use of such plans by small employers "reached only 2% in 2005, while the percentage offering any form of health plan dropped from 66% to 63%."<sup>127</sup>

I mentioned earlier that the danger of subsidiarity divorced from solidarity is that it becomes an argument for government adopting a hands-off attitude that leaves all to the individual. The rhetoric of consumer choice represents a form of this danger and it is a rhetoric that has resulted in the defined contribution approach that has become so prevalent in the retirement plan context being championed as the solution to health care problems.<sup>128</sup> However, the rhetoric of individual choice and the promise of reduced medical costs do not hide the fact that HSAs do not solve the problem of lack of access to medical care by the working poor.

Thus, HSAs – whatever their merits may otherwise be – do little or nothing to address the problem of providing access to adequate health care to the working poor. Analyzed through the lens of the preferential option for the poor, the proposal is an absolute failure.

### **C. The Massachusetts Model**

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<sup>127</sup> Christ L. Peterson, *Data on Enrollment, Premiums, and Cost-Sharing in HSA-Qualified Health Plans*, CRS REPORT FOR CONGRESS, (RS22417), May 13, 2006, at p.4 (quoting Mercer Human Resource Consulting survey).

<sup>128</sup> The rhetoric of individual choice has been part of the driving force in the expansion of defined contribution type pension plans, which provide much less security and assurance of an adequate standard of living in retirement than traditional defined benefit pension plans. See Susan J. Stabile, *Is it Time to Admit the Failure of Employer-Based Pensions?*, LEWIS AND CLARK L. REV. (forthcoming 2006); see also Dana M. Muir, *The U.S. Culture of Employee Ownership and 401(k) Plans*, 14 ELDER L.J. 1, 4 (citing Professor Roels' suggestion that "the United States's high score levels of individualism helped to explain its 401(k) plans, which provide individual employees with significant individual decision-making power"). What proponents of greater individual choice in the retirement and medical areas fail to consider is that "the benefits associated with the provision of choice may be limited to issues in which decision complexity is manageable; as decision complexity rises, the very provision of choice, which is seemingly desirable and beneficial, can become paralyzing and debilitating, resulting in suboptimal decision making." Botti & Iyengar, *supra* note 120.

Massachusetts recently enacted a health care reform law with the aim of reducing the cost of health insurance to individuals and to provide health insurance to those who would not otherwise be able to afford it. The centerpiece of the statute is a requirement that all residents must have medical insurance by July 2007.<sup>129</sup> The law places responsibility for obtaining health insurance is on the individual, assessing penalties for non-compliance with the statutory mandate.<sup>130</sup>

The statute does several things to ensure that individuals have the ability to purchase the required insurance. First, it subsidizes the cost of such insurance. All individuals and families earning less than 100% of the federal poverty line receive a complete subsidy for premiums and are not subject to any deductible costs.<sup>131</sup> The premium costs of those earning between 100% and 300% of the federal poverty line are subsidized on a sliding scale basis and such individuals also are not subject to any deductible costs.<sup>132</sup>

Second, the statute created The Commonwealth Health Insurance Connector (the “Connector”), to provide assistance to individuals and small businesses by connecting them with appropriate health insurance products.<sup>133</sup> To be offered through the Connector,

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<sup>129</sup> Section 12 of the Act provides that residents must “obtain and maintain creditable coverage so long as it is deemed affordable under the schedule set by the board of the connector.” MASS. GEN. LAWS ANN. ch. 111M (2006). The law applies to any person who has filed a tax return with the state, lists a Massachusetts home as their principle residence or is registered to vote in the Commonwealth. MASS. GEN. LAWS ANN. ch. 111M §1. Exempted form coverage are those for whom there is no affordable health insurance and those whose “sincerely held religious beliefs” prevent them from obtaining coverage. MASS. GEN. LAWS ANN. ch. 111M §3.

<sup>130</sup> Residents will be required to indicate on their tax returns that they had creditable coverage in force for the entire year (or July through the end of the year for 2007). Failure to note the possession of adequate health insurance on the individual’s 2007 tax return will result in the forfeiture of the tax payer’s personal exemption for 2007. For 2008 and beyond, an individual without adequate health insurance will be fined one half of the amount health insurance would have cost, as determined by the board of the Connector for each month spent without insurance. MASS. GEN. LAWS ANN. ch. 111M §2b.

<sup>131</sup> MASS. GEN. LAWS ANN. ch. 111M § 2.

<sup>132</sup> MASS. GEN. LAWS ANN. ch. 111M § 5.

<sup>133</sup> MASS. GEN. LAWS ANN. ch. 176Q.

a health insurance policy must be certified as being of “high value and good quality,” and must meet regulations on deductibles and co-pays.<sup>134</sup> The Connector then makes these products available to be purchased by the individual (or non-group consumer) with pre-tax dollars.

The Connector also provides portability of insurance accounts provided through an employee for individuals moving between jobs and for seasonal workers and also allows aggregation of insurance benefits for people working multiple jobs.<sup>135</sup> Insurance may be purchased through the Connector by all residents, regardless of income level.

In order to ease the administrative burden placed on small businesses trying to select and provide health insurance for its employees, the Connector also provides assistance to small business wishing to provide pre-tax insurance benefits to its employees, by allowing them to participate in the Connector and offering a selection of quality health insurance products.

Third, the statute also provides for several insurance reforms aimed at reducing the cost of insurance for individual consumers. Foremost among these measures is a merging of the non-group (i.e., private individual) and small-group markets in July of 2007, a move expected to reduce premiums for individual consumers by 24%.<sup>136</sup>

The most controversial provisions of the new statute impose duties on employers. The so-called Fair Share Contribution requires employers of more than 11 employees who do not provide for, or make a fair and reasonable contribution for health insurance to

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<sup>134</sup> MASS. GEN. LAWS ANN. ch. 176Q § 5, 10.

<sup>135</sup> See Health Care Access and Affordability Conference Committee Report, Apr. 3, 2006. available at <http://www.mass.gov/legis/summary.pdf>

<sup>136</sup> MASS. GEN. LAWS ANN. ch. 176J § 2.

pay each employee an estimated \$295 per year.<sup>137</sup> Recognizing that a portion of the amount employers contribute to health insurance actually goes to free care, the Fair Share Contribution is meant to “level the playing field.”<sup>138</sup> In addition, the statute imposes a free rider surcharge on employers who do not provide health insurance, and whose employees use free care.<sup>139</sup> The surcharge kicks in after a single employee uses free care three times in one year, or after five instances of free care use by employees of the company.<sup>140</sup> The surcharge will be a portion of the cost of employees’ use, with the initial \$50,000 exempted.<sup>141</sup> In addition, the act prohibits a company from punishing any employee who uses free care.<sup>142</sup>

Several questions are raised by the Massachusetts approach. The first is the cost to the state. Massachusetts intends to finance the cost of insurance subsidies with the money that will be saved by the reduced use of free care.<sup>143</sup> The money raised by the Free Rider surcharge will go into a Health Safety Net Trust, which will be used to provide for free care.<sup>144</sup>

The second is whether individuals will, in fact, be able to afford coverage. The problem is not for those earning less than the poverty line; their coverage will be cost free. The concern is with those earning above the poverty line – many of whom are the working poor who now do not have coverage. The Connector has not yet determined the amount of subsidies for those people who earn between 100% and 300% FPL. The

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<sup>137</sup> MASS. GEN. LAWS ANN. ch. 149 § 188.

<sup>138</sup> See Health Care Access and Affordability Conference Committee Report, Apr. 3, 2006. available at <http://www.mass.gov/legis/summary.pdf>.

<sup>139</sup> MASS. GEN. LAWS ANN. ch. 118G § 18B.

<sup>140</sup> MASS. GEN. LAWS ANN. ch. 118G § 18B (c).

<sup>141</sup> MASS. GEN. LAWS ANN. ch. 118G § 18B (b).

<sup>142</sup> MASS. GEN. LAWS ANN. ch. 149 § 6D ½.

<sup>143</sup> See Health Care Access and Affordability Conference Committee Report, Apr. 3, 2006. available at <http://www.mass.gov/legis/summary.pdf>

<sup>144</sup> *Id.*

Executive Office of Health and Human Services has released an estimated expense and subsidy chart, although the final determination will be made by the board of the Connector.<sup>145</sup> The study estimates that insurance will cost \$300 per month for an individual, and \$600 per month for a family of four.<sup>146</sup> At 300% FPL, the administration estimates that the subsidies will pay for between 50 and 55 percent of the premium costs, which translates into a subsidy of \$160 and a payment of \$140 per month for an individual making 300% FPL, or \$29,400, and a subsidy of \$315 and a payment due of \$285 for a family of four earning \$60,012.<sup>147</sup>

There is not yet a consensus as to the impact that new insurance expenses will have on state residents, and specifically on the poor. The state hopes that the merging of non-group and small-group will reduce the cost of premiums to the individual by 24%, and that the influx of healthy, previously uninsured individuals will stabilize the market and lower the average premiums.<sup>148</sup> But it may be that more attention needs to be focused on efforts to contain costs.

Third, there is a question whether ERISA preempts the provisions applying to employers. ERISA broadly preempts state laws that relate to employee benefit plans.<sup>149</sup> As a result, efforts by states to force employers to provide health benefits to their employees, other than indirectly via state insurance regulation (which is saved from preemption),<sup>150</sup> will be met by challenges that the state law is preempted.

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<sup>145</sup> See Liz Kowalczyk, *Health Premiums for Poor Will Vary*, BOSTON GLOBE, June 4, 2006, at A1.

<sup>146</sup> *Id.*

<sup>147</sup> *Id.*

<sup>148</sup> See Health Care Access and Affordability Conference Committee Report, Apr. 3, 2006. available at <http://www.mass.gov/legis/summary.pdf>

<sup>149</sup> See 29 U.S.C. § 1144.

<sup>150</sup> See 29 U.S.C. § 1144(b)(2)(A).

A federal district court addressed a challenge to Maryland's Fair Share Health Care Fund Act, which requires employers of more than 10,000 people in the state to pay at least 8% of its payroll on worker health care, or pay the difference into a state fund designed to expand health care access.<sup>151</sup> In *Retail Industry Leaders Association v. Fielder*,<sup>152</sup> the court held the statute to be preempted by ERISA. The court found that the statute had an impermissible "connection with" an ERISA plan because the statute interfered with ERISA's objective of permitting "the nationally uniform administration of employee benefit plans"<sup>153</sup> and because it had the effect of mandating that the employer provide a certain level of benefits.<sup>154</sup> In the view of the court, the act would require an employer "to increase its health care benefits for Maryland employees and to administer its plan in such a fashion as to ensure that the statutory spending required by the Act is met,"<sup>155</sup> rejecting the argument that the statute does not contain such a mandate because employers are free to pay to the state an amount equal to the difference between its employee health expenditures and the statutorily required amount. This, the court said, amounted to a "Hobson's choice," because employers would never choose to pay the State rather than to increase employee benefits.<sup>156</sup>

Whether a court would apply similar analysis to preempt the approach taken by Massachusetts is an open question. The district court in *Retail Industry* seemed to suggest one might come to a different conclusion about the Massachusetts statute,

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<sup>151</sup> MD. CODE ANN. LAB. & EMPL. §§ 8.5-101 to 8.5-107 (2005).

<sup>152</sup> 435 F. Supp. 2d 481 (D.Md. 2006).

<sup>153</sup> *Id.* at 494 (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995)). The court observed that "[t]he Fair Share Act creates health care spending requirements that are not applicable in most other jurisdictions. Moreover, its requirements directly conflict with the requirements of at least two other jurisdictions." *Id.*

<sup>154</sup> 435 F. Supp. 2d. at 495.

<sup>155</sup> *Id.* at 496.

<sup>156</sup> *Id.* at 497.

characterizing it as “address[ing] health care issues comprehensively and in a manner that arguably has only incidental effect upon ERISA plans.”<sup>157</sup>

More importantly, from the perspective of Catholic Social Thought the Massachusetts approach is one that deserves serious consideration in that it may offer a means of meeting the obligations imposed by the preferential option for the poor while at the same time heeding the commands of subsidiarity.<sup>158</sup> It attempts to offer a comprehensive approach aimed at both reducing medical costs and providing access, and does so while putting the government in the role of facilitator of lower-order entities rather than in the role of direct provider of benefits. Other states have been stepping up as well, experimenting with different approaches to improving the ability of lower-income residents to secure adequate and affordable health coverage.<sup>159</sup> The programs vary, but they suggest that states may be capable of doing exactly what we want states to do in a federal system – to be laboratories for experimentation in controlling costs and providing access to care.<sup>160</sup>

I don’t mean to suggest that there does not remain an important role for the federal government in assuring all U.S. citizens access to quality health care. One can envision various aspects to that role. Many states assuredly will need financial assistance

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<sup>157</sup> *Id.* at 496 n.15.

<sup>158</sup> This approach is also consistent with the traditional role of states as laboratories for innovative public policy. See Timothy Zick, *Are the States Sovereign?* 83 WASH. U. L.Q. 229, 310 (2005) (discussing state “laboratory” function and observing that the “shared understanding or agreement that states should be allowed the breathing space to address novel issues substantially affects the legislative terrain”). States have been quite innovative of late in seeking means to provide access to health care to their citizens. I discuss some of these state approaches more extensively in Stabile, *supra* note 35.

<sup>159</sup> I discuss some of these efforts in Stabile, *supra* note 35.

<sup>160</sup> The value of state experimentation helps to answer the question of why we should tolerate the delay inherent in a state-by-state approach. That is, once health care is established as a basic, fundamental right, the question arises as to what justifies leaving the provision of something so important to a state-by-state approach. One response is that a problem of this complexity benefits from the consideration of varying approaches rather than imposition of a single system at a time when it is difficult to ascertain what the best system is. Having said that, if it becomes clear that state approaches can not be relied on, the federal government must take a greater role than even the one I suggest in the textual discussion that follows.

if they are to provide health care for all of their citizens and it is important that the federal government act as a backstop if more local efforts fail.<sup>161</sup> If some states lag in undertaking health reform, it may be appropriate for the federal government to adopt some form of incentive scheme to encourage such action.<sup>162</sup> Additionally, given the importance of cost containment to the effort to improving access, there may also be value in federal approaches aimed to cutting the cost of providing medical care. And, over time, it may be viewed as desirable for the federal government to impose some national minimal standards that states must adhere to. But all of these suggestions envision a role for the federal government that is much more consistent with the teachings of subsidiarity than a system of national health care; it envisions the federal government assisting in needs being met at an intermediate level rather than supplanting more local efforts.

### Conclusion

One commentator lamented that “[p]eople who live comfortably tend to spend little time thinking about poverty and exorbitant health costs. Indeed, many of us never have to imagine being unable, because of poverty, to visit the doctor when we are sick.”<sup>163</sup> The same commentator asked, “[h]ow do we create an environment wherein

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<sup>161</sup> For example, although there has been praise of the Minnesota Care system, budget cuts have resulted in a number of people losing coverage. See, e.g., *Ads Highlight Governor’s Broken Record on Health Care*, ALLIANCE FOR A BETTER MINNESOTA, May 27, 2006, available at [http://www.allianceforabettermn.com/news\\_detail.aspx?id=7](http://www.allianceforabettermn.com/news_detail.aspx?id=7).

Cf. Susan J. Stabile, *Subsidiarity and the Use of Faith-Based Organizations in the Fight Against Poverty*, 2 VILLANOVA J. CATH. SOC. THOUGHT 313, 366 (2005) (discussing need for government to remain a backstop in the fight against poverty, notwithstanding importance of efforts by faith-based organizations).

<sup>162</sup> Federal incentives may be necessary to counteract state fears that adopting meaningful health care reform may cause employers to move to other states. Such fears have not stopped states like Massachusetts and others who have enacted reform statutes in recent years, but may deter some.

<sup>163</sup> Jeff Teiman, *Poverty and Health: Connections that Can Spark a Dialogue*, HEALTH PROGRESS, May-June 2005, at 6, 7.

This is especially true of people who are young and single. In my own case, I spent several years not working in my twenties, with no health insurance during that period. Because I was young and healthy, I never gave a thought to trying to secure individual insurance. It was not until I had a child – and the ability

people not only view poverty and health care access as part of the same social problem but are persuaded to give them a high priority on the nation's action agenda?"<sup>164</sup>

Catholic Social Teaching helps provide an answer to that question at two levels. First, it rejects the notion that access to something as basic as health care can be left to the whim of an employer. The principle of the preferential option for the poor reminds us that we need be concerned with how the least of us fare, and that we have not had adequate regard for the needs of the working poor in this country. We can not have adequate respect for the dignity of the human person without a system that ensures that all people have the ability to receive medical care when they need it. Catholic Social Teaching thus demands that we find an alternative to the current voluntary employment-based system for providing health care benefits.

Second, it helps provide a framework<sup>165</sup> for thinking about way to increase access to medical care to those without it. It offers principles that help shape our views about how the problem ought to be addressed and how different proposed solutions should be judged.<sup>166</sup>

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to call a doctor whenever my child was sick – that I started to appreciate what it must mean to not have that ability.

<sup>164</sup> *Id.* at 8.

<sup>165</sup> By its nature, the Church's social teachings do not mandate specific answers to public policy questions, recognizing that much must be left to prudential judgment. Rather, the teachings provide a framework within which to think about problems like the health care one and to evaluate particular reform proposals. As the Catholic bishops explained, the Catholic tradition "offers principles for reflection, provides criteria for judgment, and suggests guidelines for action....Catholic teaching does not and cannot provide specific answers to many difficult and complex questions. However, it can offer direction and help shape the dialogue." U.S. Catholic Bishops, *A Fair and Just Workplace: Principles and Practices for Catholic Health Care* (1999), at Conclusion, Pt. II, available at <http://www.usccb.org/sdwp/national/workplace.htm>. There is, in fact, disagreement among various Catholic organizations about what approach should be taken to ensure access to quality health care. See *No Dearth of Second Opinions for an Ailing System*, Our Sunday Visitor, Feb. 1, 2004 (describing differing views of the Catholic Health Association and the Catholic Medical Association).

<sup>166</sup> Although beyond the scope of this Article, Catholic Social Thought has something to contribute to other aspects to the debate about health care in this country, including issues such as what appears to be a drive to correct every human physical imperfection and how we think about what care is appropriate at different stages of life.