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Empowering the Person and Reforming Health Care Financing: A Catholic Perspective

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KEY TAKEAWAYS

Health plans, like all other kinds of insurance, should be more tailored to personal preferences and needs.

Reversing consolidation and concentration in hospital and health insurance would boost competition and broaden personal choice among health plans and providers.

Pope John Paul II reaffirmed that "the free market is the most efficient instrument for utilizing resources and effectively responding to needs."

Personal liberty, our exercise of free will, is a gift of God. The great Pope Leo XIII described human liberty as "the highest of man's natural endowments," for it confers dignity on every living human being and provides the person with "power over his actions."[1]

Leo's profound encyclicals were a milestone in the development of modern Catholic social teaching, and in the more than a hundred years since his pontificate, the Catholic Church has consistently reaffirmed that teaching and stressed the primacy of the human person—specifically, the dignity, freedom, and responsibility of each person born into this world and the right to life of the precious innocents yet to be born.

Moral Obligations

Likewise, another central principle of Catholic social teaching is that there is a special obligation for members of civil society and government officials alike to show "special consideration" for the poor.

In *Rerum Novarum* (1891), Leo XIII clarified that responsibility: "The richer class have many ways of shielding themselves and stand less in need of help from the State; whereas the mass of the poor have no resources of their own to fall back upon and must chiefly depend upon the assistance of the State."[2] Affirming the continuity of Church teaching, Pope John Paul II re-emphasizes this "preferential option for the poor."[3]

Through its rich body of social encyclicals, the Church is speaking to the modern world. But the world, as C.S. Lewis reminded us, is Enemy-occupied territory. That is a given, and we must do the best we can to achieve what is good in the short time that is allotted to us. Our Lord has provided us with guidance in navigating the circumstances in which we find ourselves. According to Matthew 10:16, the Lord advises us that, while we must be as innocent as doves, we must also be as wise as serpents.

The World's Golden Rule. We all know it: Do unto others as you would have them do unto you. However, in navigating our way to achieve whatever good we can achieve, we must recognize the world's understanding of the "golden rule": He who controls the gold makes the rules.

In health care, we are blessed with rapidly advancing medical science and technology, but as John Paul II has warned us, we also face dehumanizing threats, multiplying moral and ethical challenges in a morally and culturally polarized environment: physician-assisted suicide, euthanasia, the use of embryonic versus adult stem cells, contraceptive mandates, genetic engineering and "designer" babies, mutilating transgender surgeries, and the rationing of care for the elderly amidst growing government deficits and debt, just to name a few.

In *Evangelium Vitae* (1995), Pope John Paul II reminds us that the right to human life is fundamental and inviolable. "Upon the recognition of this right," he explains, "every human community and the political community itself are founded."[4] Practically, that means that health care professionals have a duty to defend human life, both at the beginning of life and at the end of life. That also means that we are to judge advances in genetic science and medical technologies based on whether they enhance or detract from the dignity of the human person. Millions of Americans—Catholic, Protestant, and Jew—share these moral convictions. Health care policies and programs should therefore respect personal freedom, conscience, and religious liberty.

True liberty is not just doing whatever we want to do. Liberty, as Leo XIII defined this gift, is power over our actions. So the bigger question is this: Do our actions themselves have power? Without capacity to influence, guide, or direct, without personal agency, achieving these moral goods for the betterment of our society is little more than an aspiration. You can talk all day about the importance of respecting personal freedom of conscience, but unless you can act on your freedom of conscience, it remains little more than a metaphysical abstraction.

Economic Challenges

So let us look at the health sector of the American economy as it exists and how it constrains our individual actions. Consider just three features.

First, American health care accounts for $4.9 trillion of the national economy, or over $14,000 per capita. It is the highest level of spending in the world: almost 18 percent GDP on track to reach 20 percent, roughly $1 out of every $5 in the economy. We have the largest economy in the world, and we can and do spend a huge amount on health care. This spending, however, increases government deficits and debt and constrains our capacity to care for an ever-larger older population.

Also, as Health and Human Services Secretary Robert Kennedy has reported, we are generally sicker than our friends and allies overseas. We outpace most of the world with our obesity and chronic illness, largely due to behavioral and metabolic factors, and our doctors and hospitals and specialists must work harder than those in Europe and elsewhere. This also swells spending. But how much of that spending on our own health is under our personal control?

Second, health care is an economic outlier. Americans enjoy widespread choice when it comes to most other goods and services. In contrast, whether as patients or consumers of health care goods and services, we have little or no economic power and exercise little or no control over the flow of dollars in this system. Almost all the major decisions are made by third or even fourth parties. For example, others decide:

- What kind of health plan you will get and what medical treatments and procedures are covered.

- What kind of access you will have to doctors, hospitals, specialists, or certain medical professionals.

- What you will pay in premiums, deductibles, copayments, or coinsurance.

For virtually every American, these are the key economic decisions in American health care. With few exceptions, most people are otherwise powerless. The gold—and the flow of gold—in this system is largely controlled by government officials, employers, corporate officials, or managed care executives. Liberal and conservative economists agree that the current system is remarkably uncompetitive and dominated by the large corporations that own or control insurance and hospitalization.[5]

Over the past 15 years, the Affordable Care Act of 2010 (ACA) has made this problem worse. It has empowered federal rather than state officials to be the key decision-makers in the financing and regulation of most Americans' health care—and financing drives care delivery. Medicare and Medicaid reimbursement rules and regulations and guidelines govern patient care, and the sheer size of these programs, particularly Medicare, greatly influences financing and care delivery in the private sector.

We may philosophically or theologically believe in the primacy of the person, his freedom, dignity, and responsibility. Still, we must recognize that neither individuals nor families control very much in health care financing. You and I are often on the receiving end of big decisions, including ethical decisions on health coverage, over which we have little or no control. Once again, this sector of our economy is an anomaly. This lack of personal agency exists in virtually no other sector of the economy, including complex sectors like financial planning and market investments.

Third, American health care is a textbook example of a mixed economy. About half of all health spending is direct government spending, largely through Medicare and Medicaid and other federal and state programs.

Federal entitlements are exploding. Medicaid will reach $879 billion by 2033. Medicare (growing at over 8 percent) is the biggest driver, which accounts for $1.2 trillion today and will exceed $2 trillion in health care spending within 10 years.

Government, then, is the major player. Michael Cannon, Cato Institute health policy specialist, observes that taken altogether, law and regulatory policy, either directly or indirectly, determine the flow of approximately 84 percent of all health care spending in the United States.[6] Again, he who controls the gold makes the rules.

Not surprisingly, because government directly makes or influences the key decisions or the dollar flows in this system, the health care sector is a cauldron of special-interest politics. Both in Washington and in state

capitals, armies of lobbyists, lawyers, and consultants connive to secure special advantages from Congress or state legislators at the expense of their rivals. So health policy is often driven by big insurance cartels pitted against hospital corporations, doctors battling insurers and hospitals, doctors battling each other—primary care physicians versus medical specialists—in securing a bigger piece of the Medicare and Medicaid payment pies.

Patients are often mere bewildered spectators if they can or care to follow any of this. And many can't and don't.

Access and Affordability

This year, America's uninsurance rate is roughly 8 percent, which is relatively low. Whatever the defects of the Affordable Care Act—notably, the breathtaking increase in health care costs—access to health coverage has greatly improved, mostly through the massive expansion of Medicaid, our largest welfare program.

Today, virtually any American citizen not enrolled in an employer-sponsored health insurance plan can secure heavily subsidized coverage, either through the health insurance exchanges that dominate the individual markets or the Medicaid program.

The Congressional Budget Office reports that about half of the remaining uninsured are people who simply do not sign up for subsidized insurance or, by law, are not entitled to coverage because they are illegally residing in the United States.[7] They most often can get "free" care through hospital emergency departments, the most expensive site on the planet, and under federal law, persons showing up for care cannot be turned away because of their financial incapacity to pay for it. Taxpayers cover the bills.

For our citizens, the remaining problem is affordability. Though President Obama promised that the ACA would bend the overall cost curve downward and would save the typical American family buying individual insurance $2,500 per year, the opposite has occurred. Between 2013 and 2024, individual insurance market premiums soared by 133 percent; deductibles exploded, costing many thousands of dollars for individual and family coverage; and access to doctors and hospitals also sharply declined with 80 percent of ACA plans in 2024 having narrow or restrictive networks.[8]

Two Broad Options for Health Reform

The Church has authority to teach the truths of faith and the principles of natural moral law. The Church does not prescribe an economic or

political program. Developing specific policies is left to the laity, acting in good conscience to try to secure the common good. With regard to health care, policy analysts are deeply divided on how to resolve the problems of access and cost, but there are two broad approaches.

Single Payer. First, abolish all existing public and private programs and establish a single-payer system of government-run national health insurance. With this approach, Members of Congress and federal government officials authorized to act on behalf of Congress would make all the key financing and delivery decisions (including ethical decisions) determining what people get and when and under what circumstances they get it.[9] Traditional Medicare, governed by central planning and price controls, is the leading model of such a system.

Whatever its merits, a socialist system is a logically coherent approach to health care financing and delivery. You pay the government taxes—very big taxes—and the government provides you with health care coverage, which is comprehensive, universally available, and "free" at the point of service.

Though conceptually simple, the implementation of such a system, much like Fee-for-Service (FFS) Medicare, is enormously complex. This is evident from any cursory review of Medicare's massive regulatory regime, or of the legislative proposals by Senator Bernie Sanders of Vermont, or the companion single-payer bill backed by most House Democrats.[10]

It also involves major trade-offs. Universal coverage does not translate into universal care; an insurance card is not a medical treatment or procedure. And based on our rich experience, the leading tradeoff of government-designed universal coverage is an almost guaranteed reduction in access to care, as clearly seen in both the British and Canadian experience.[11] According to the British Medical Association, for example, 7.4 million people are awaiting medical care in the United Kingdom.[12]

According to Catholic social teaching, clearly articulated by Leo XIII in *Rerum Novarum*, socialism was never an acceptable remedy for social ills; it was, rather, a source of evils even greater than those it was supposed to cure. It promised equality but in practice robbed the person of his individual freedom and the fruits of his labor. [13] Writing in *Centesimus Annus* in 1991, John Paul II reaffirms that view:

> Socialism considers the individual person simply as an element; a molecule within the social organism, so that the good of the individual is completely subordinated to the functioning of the socio-economic mechanism. Socialism likewise maintains that the good of the individual can be realized without reference to his free choice, to the unique and exclusive responsibility which he

> exercises in the face of good or evil. Man is thus reduced to a series of social relationships, and the concept of the person as the autonomous subject of moral decision disappears, the very subject whose decisions build the social order.[14]

Market-Based Reforms. The second broad option, which I endorse, is a set of targeted reforms of the health insurance markets.

In the private sector, such reforms would continue to expand access to coverage and broaden, not narrow, patients' coverage options. By reversing the consolidation and concentration in hospital and health insurance markets, such reforms would boost competition and thus broaden personal choice among health plans and providers. And in a reversal of the trends we have seen over the last 15 years, such market-based reforms would slow the growth of health care costs. Nothing is more ruthless in rationally controlling costs and rooting out economic inefficiencies than the powerful incentives of a free and competitive market.

From the standpoint of Catholic social teaching, economic freedom is not, of course, an absolute value, but it can and does contribute to human flourishing. In *Centesimus Annus*, John Paul II reaffirms the central value of the free market as the best means to secure the efficient production and widespread consumption of goods and services: "It would appear that, on the level of individual nations and of international relations, the free market is the most efficient instrument for utilizing resources and effectively responding to needs."[15]

Targeted Reforms

It is humanly impossible to reform America's health care financing and delivery, almost one-fifth of the entire economy, in one fell swoop. Based on our unhappy experience, it is unwise to package health care reform in one gigantic omnibus bill like the 2,700-page Affordable Care Act of 2010. When Congress passes such a massive measure, few Members can or will read or digest it. The result is an unwieldy legislative product brimming over with mysteries, mistakes, unpleasant surprises, and unintended consequences.

Therefore, health reform should be enacted step by step, bill by bill, so that it can be carefully debated and fully comprehended. There are literally dozens of changes that can and should be made to improve American health care. Consider, however, seven policy changes Congress could enact into law.

1. **Provide individual tax relief.** Under current law, you get unlimited tax relief for the purchase of health insurance if and only if you get

it through the place of work. The dollar value of employment-based coverage is *excluded* from federal income and payroll taxes.[16] This year, the employer-based tax break amounted to $391 billion, and it is expected to reach $676 billion in 2033.[17] That changes if you buy coverage outside of the place of work on the individual market without the employer-based tax break. Depending upon your income and the state of the market in your place of residence, you could end up paying much more in premiums for the same package of benefits you would have gotten at the place of work.

This federal tax policy imposes significant constraints and has severe economic and personal consequences. It confines, for all practical purposes, your options to whatever the employer can or cannot, may or may not decide to provide. If you do not or cannot get your coverage through the place of work, your options are limited: Enroll in an individual health plan without any favorable tax treatment; sign up with an ACA plan in the health insurance exchange in your area of residence and cope with narrow provider networks; or have an annual income low enough to qualify for Medicaid, which unfortunately has a long and unhappy history of problems with patient access to care. Too many doctors, already struggling with high administrative costs and Medicare payment cuts, simply will not—and many cannot—take Medicaid patients because they lose revenue every time a Medicaid patient enters the waiting room.

The Congressional Budget Office and a wide range of economists, liberal and conservative, have criticized the federal tax policy governing health insurance on various economic grounds.[18] On this, there are key points of consensus: It practically creates a monopoly of employment-based insurance in the private sector; it undermines portability of coverage; it curtails personal choice; it undermines competition; and it undercuts rational transactions in the purchase of health insurance coverage, meaning that some people are overinsured while some may be underinsured.

A New Policy. Grace-Marie Turner, the late President of the Galen Institute, also criticized the current federal tax policy as unfair and inequitable. In 1994, forging a consensus among Washington policy analysts, she proposed to retarget the hundreds of billions of dollars of federal tax relief for health insurance to individuals: Instead of tying

that generous tax benefit *exclusively* to the place of work, it would go to individuals in the form of an individual tax break—as the late Nobel Laureate Milton Friedman of the University of Chicago and many of his colleagues, liberal and conservative alike, argued many years ago. There are a variety of ways to provide this:

- As an individual non-refundable tax deduction combined with a set of subsidies for low-income people to access private health insurance, replacing the existing Medicaid program.

- As a non-refundable tax credit on the same basis, also with special provisions for low-income people as we do today.

- As a universal refundable tax credit and adjusted by income or by health expenditures compared to income.

I believe Grace-Marie Turner's original proposal is, ideally, the best option: Provide every American with a base, individual tax credit and make it refundable, which means that the poor would get a direct subsidy for their coverage. My colleague Edmund F. Haislmaier, currently a Senior Research Fellow at The Heritage Foundation, devised a "mathematically elegant" formula for ensuring that the tax break would provide sufficient assistance to persons who incurred large medical expenses. His proposal was to adjust the credit based on the ratio of health expenditures compared to income. In other words, the higher your health care costs compared to your income, the larger the individual tax credit. The implementation of such a program would be administratively complex. However, this approach would be no more complex than today's extremely complex system of multi-level adjustments required for the ACA's premium tax credits.

Major reform of federal tax law is a daunting exercise. Short of a comprehensive overhaul of federal tax policy, however, Congress could guarantee that any American without employer-sponsored coverage would be eligible for individual tax relief for the purchase of state-approved or federally approved health insurance, regardless of where that person got that coverage. In any case, whether in the form of a tax credit or direct premium subsidy, the federal assistance for low-income people—the poor—and those with high health care costs—the sick—should be appropriately generous. Again, Catholic social

teaching obliges us to maintain a strong preference for the welfare of the poor.

2. **Promote the sponsorship of health insurance coverage by faith-based or religious organizations.** Patients, as well as providers, should be able to exercise their freedom of conscience and not be forced to pay for morally objectionable medical treatments or procedures like abortion.[19] But the Kaiser Family Foundation found that about one-third of large firms cover abortion in most or all circumstances, and only about a quarter restrict or limit such coverage.[20]

   Too many of our fellow citizens mistakenly believe that their employers "pay" for their health insurance. The truth: Households, not employers, pay 100 percent of health insurance costs. Unfortunately, however, protection of patients' freedom of conscience in health insurance is limited. Under the ACA, the largely Protestant "health sharing" ministries, basically cooperatives, are a legal alternative for those who wish to secure medical care in accord with their moral and religious convictions. Still, while a wonderful alternative, these are not health insurance options.

   Given the sheer size of religious denominations that provide or sponsor hospital networks, such as the Adventists, the Presbyterians, the Southern Baptist Convention, there is no reason why they should not be able to sponsor health insurance plans and integrate their coverage with their own networks of doctors and hospitals. The Catholic Church and Catholic organizations can play a powerful role in this area, establishing a strong and direct relationship between Catholic moral teaching and health care financing and delivery. The Knights of Columbus, for example, sponsor an excellent life insurance program. Why shouldn't the Knights also sponsor health insurance?

   Beyond the commercial markets, there is also no reason why Catholic organizations should not sponsor health insurance in the government's huge Medicare Advantage (MA) program or the Federal Employees Health Benefits Program (FEHBP). Americans of all faiths, of course, should be able to spend their health care dollars on health plans that are compatible with their ethical, moral, or religious convictions. They should not be compelled to violate their freedom of conscience through a biweekly payroll system.

3. **Transform the entire Medicare program into a defined contribution system of insurance coverage modeled on the popular and successful Federal Employees Health Benefits Program.** The government would make a dollar contribution on behalf of enrollees that would reflect the real market pricing of benefits with additional subsidies on behalf of low-income people and people who are chronically ill.[21]

   We provide defined contribution financing today in MA and Medicare Part D, the drug program, and we can and should extend it to the entire Medicare program and compel Medicare FFS to compete on a level playing field with private plans. With this financing change, we should also open the Medicare program to a broader range of coverage options, including providing Medicare subsidies to employer-sponsored coverage for retirees who wish to keep it. Once again, Medicare offerings should be opened to a wider variety of health plans, including plans sponsored by unions, trade associations, and ethnic, fraternal, and religious organizations including Catholic organizations.

4. **Create "direct primary care" options in Medicare and Medicare Advantage.** Direct primary care (DPC) enables doctors to contract directly with patients for their care on a subscription basis, charging a monthly or quarterly fee, often with 24-hour access to a physician by phone or same-day appointments. It is a terrific model that improves patient access and strengthens the traditional doctor–patient relationship. Described in the recent past as concierge medicine—an option for the wealthy—it has become increasingly affordable and is growing among middle-class patients in the private sector.[22]

   Congress could authorize the creation of such accounts under Part B of Fee-for-Service Medicare while enabling MA plans to offer such an option to Medicare beneficiaries. MA plans focus heavily on case management and care coordination and preventive care, and they are very flexible in benefit design and could establish such an option without Centers for Medicare and Medicaid Services (CMS) micromanagement. In the case of FFS Medicare, Congress could authorize CMS to create such accounts for Medicare beneficiaries that want them and allow the market to set physician payment for services financed by these accounts rather than the traditional Medicare price control system.

5. **Allow Medicaid beneficiaries to enroll in private coverage of their choice if they wish to do so.** Historically, Medicaid has had a very spotty quality record. Congress could simply allow Medicaid beneficiaries to redirect their Medicaid funding to a health plan of their personal choice. This could include any state-approved or federally approved private health plan, including health plans in the individual market, whether on or off the ACA exchanges, or, if available, plans in the group market such as employer-sponsored plans or association health plans. Instead of being locked into a troubled government program, Medicaid beneficiaries should have the opportunity to get better coverage with superior access to physicians and specialists and a better shot at securing higher quality care and better outcomes than they do today in the traditional Medicaid program.[23]

   Alternatively, state governments should be able to set up special interest-bearing health savings accounts on behalf of Medicaid beneficiaries to cover the costs of their routine medical care, largely provided by primary care physicians.[24] This would cover routine medical conditions as well as preventive care such as wellness visits or childhood vaccinations: in short, DPC for Medicaid beneficiaries. When Medicaid beneficiaries leave the program and get a job, the funds accumulated in the state accounts would be transferred to the private health coverage of their choice or a health savings account if the former Medicaid beneficiaries wish to have one.

6. **Require full and complete transparency on health care prices and the content of insurance coverage.** To its credit, the Trump Administration has taken the first major regulatory steps to require price transparency in the hospital sector—providing patients with information on common hospital prices. Compliance and enforcement of the rule have been weaker than either the Trump or Biden officials anticipated, but that can be improved through additional legislative and regulatory actions, and there is strong bipartisan support for legislative action.

   In December 2023, the House of Representatives passed a major transparency bill by a margin of 320 to 71, but the Senate failed to act. This year, Representative Warren Davidson, the Ohio Republican, introduced a new bill, H.R. 267, that would require hospitals to publish their negotiated rates with insurers, provide discounts for cash

payments, and clarify billing codes, while insurance plans must publish in-network and out-of-network charges for covered items.[25]

Meanwhile, patients should also have the right to know what is being covered in their insurance package, especially given the growth of unethical medical treatments or procedures, such as elective abortion, that they may be unknowingly funding through their premiums. Note that under the ACA, the portion of the premium for non–Hyde compliant abortion coverage is denied the tax credit.

Congress can take several steps to correct this problem. First, it can amend federal law by requiring explicit disclosure of morally objectionable items in the summary of benefits that an employer plan must provide to enrollees. Employees should know up front if their premiums are being used to subsidize abortion. Second, Congress could provide employees with a right to opt out of morally objectionable coverage and receive the full tax-free value of their coverage in cash to purchase an alternative and ethical health insurance plan. Finally, Congress could amend federal tax law to specify that abortion is not a medical expense and therefore does *not* qualify for favorable tax treatment under the Internal Revenue Code.

7. **Enable patients to share in the savings of any decision they make regarding care options that are cost-efficient.** Price transparency is good as far as it goes, but acquiring price knowledge does not amount to much if one cannot act on it. Today, if out of a range of possible options for care under standard health insurance a patient chooses the most cost-efficient alternative—high-quality but less expensive care—there is no financial benefit to the patient. Price transparency without price incentives is tantamount to teasing exercise.

   Congress could allow normal price incentives to operate in health insurance. Insurance companies could offer to share the cost savings directly with a patient, say on a 50–50 basis, who chooses a lower cost among alternative care options. This would be a voluntary option, not an insurance mandate. By offering such an option, however, the insurer would improve his benefit advantage in a competitive market. Specifically, Congress could specify the savings to the patients as tax-free income, which they could keep as cash or deposit in a health savings account.[26]

The Advantages of Effective Market Reforms

Imagine a new health care economy where individuals control the dollars and the key decisions over the kind of plans and benefits they get from insurers and the kind of care they choose among medical professionals. In such a scenario, patients will control health care financing and doctors will control health care delivery. With such a change, you would also revitalize the traditional doctor–patient relationship. Many other advantages would follow.

- **It would create unprecedented consumer choice of coverage and provider options.** In the area of insurance alone, people could remain with employer-sponsored plans if they wished to do so, but armed with individual tax relief, they could also choose plans sponsored by trade associations, unions, and even fraternal and religious organizations. Health plans, like all other kinds of insurance, would be more tailored to personal preferences and needs. Assuming a hard coverage cap on out- of- pocket medical expenses, the popular Liberty Mutual marketing campaign for auto insurance is basically correct: You should only pay for what you need.

- **It would break up oligopolistic control of health insurance and hospital markets.** With millions of Americans able to pick and choose the kind of coverage they want, giant health care insurance companies would be forced to compete head-to-head not only with each other, but also with new and innovative entrants on a level playing field. We will have what we do not have today: real price competition in the provision of health insurance. With price transparency in the hospital markets, you would see the crazy disparities between hospital pricing for the same procedure in the same geographic area disappear. Consumer decision-making will drive change. And real price competition is the very best means to control and lower costs.

- **It could create large national health insurance pools.** With individual tax relief coupled with a change in federal insurance rules to facilitate countrywide marketing, it is easy to imagine new companies offering coverage not only on a state or regional basis, but even on a national basis just like the major insurers do today in the Federal Employees Health Benefits Program. With such a large pooling of covered lives, administrative costs would decline and stabilize, just as they have in the federal employees' program.

- **It would drive higher quality.** Intense competition among insurers and medical professionals would put a premium on information concerning benefits, quality, service, and medical outcomes. In a transparent environment of price and provider performance, the quality of care delivery will increase.

With continued advances in biomedical research and medical technology, combined with intensely competitive health insurance markets and improved patient access to care, America would be at the global forefront of a health care renaissance. That is exactly the American health care future that the great Grace-Marie Turner always envisioned and for which she so tirelessly labored.

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Endnotes

1. Leo XIII, *Libertas Praestantissimum*, June 20, 1888, in *The Church Speaks to The Modern World: The Social Teachings of Leo XIII*, ed. Etienne Gilson (New York: Doubleday and Company, 1954), p. 55.
2. Leo XIII, *Rerum Novarum*, May 15, 1891, in ibid., pp. 225–226.
3. John Paul II, *Centesimus Annus*, May 1, 1991, Section 11, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_01051991_centesimus-annus.html (accessed December 15, 2025).
4. John Paul II, *Evangelium Vitae*, March 25, 1995, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html (accessed December 15, 2025).
5. For an excellent analysis of the potential of competition to improve health care financing and delivery, see Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg, "Making Health Care Markets Work: Competition Policy for Health Care," The Brookings Institution, April 13, 2017, https://www.brookings.edu/articles/making-health-care-markets-work-competition-policy-for-health-care/ (accessed December 15, 2025). For a conservative perspective, see Health Policy Consensus Group, "Health Care Choices 20/20: A Vision for the Future," November 18, 2020, https://galen.org/assets/HEALTH-CARE-CHOICES-2020_A-Vision-for-the-Future_FINAL-002-1.pdf (accessed December 15, 2025).
6. Michael Cannon. "U.S. Health Care: The Free-Market Myth," *National Affairs*, No. 65 (Fall 2025), https://www.nationalaffairs.com/publications/detail/us-health-care-free-market-myth (accessed December 15, 2025).
7. In a "deep dive" examination of the uninsured in 2019, CBO found that a full 67 percent of the uninsured were eligible for government-subsidized coverage but simply did not sign up; 33 percent were ineligible for subsidized coverage because their income was too high, they did not qualify for Medicaid, or they were residing in the United States illegally. See Congressional Budget Office, Who Went Without Health Insurance Coverage in 2019, and Why?" September 2020, https://www.cbo.gov/system/files/2020-09/56504-Health-Insurance.pdf (accessed December 15, 2025).
8. See Edmund F. Haislmaier, "Key Health Care Trends: Nationally and in Each of the States," Heritage Foundation *Special Report* No. 292, August 29, 2024, https://www.heritage.org/sites/default/files/2024-08/SR292.pdf.
9. Not surprisingly, abortion coverage is mandatory in Senator Sanders' "Medicare for All" legislation.
10. For detailed analyses of these measures, see *No Choice, No Exit: The Left's Plans for Your Health Care*, ed. Marie Fishpaw and Robert E. Moffit (Washington: The Heritage Foundation, 2020), pp. 41–104, https://static.heritage.org/2020/no-choice-no-exit.pdf?_gl=1*1w5ydfz*_gcl_au*MjEzMjEwMDkzMS4xNzY0MzUzODcw*_ga*MzUxNzkyMDkzLjE2NTQ5ODczNzQ.*_ga_W14BT6YQ87*czE3NjU4MzUzODkkbzM1MiRnMSR0MTc2NTgzNTQzMyRqMTYkbDAkaDA.
11. Canada has among the longest waiting periods among economically advanced countries. See ibid., pp. pp.153–187.
12. British Medical Association, "NHS Backlog Data Analysis," November 13, 2025, https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis (accessed February 2, 2026).
13. Leo XIII, *Rerum Novarum*, May 15, 1891, in Gilson (ed.) *The Church Speaks to The Modern World*, p. 207.
14. John Paul II, *Centesimus Annus*, Section 13.
15. Ibid., Section 34.
16. The technical term for the employer-based tax break is the employee's "tax exclusion," meaning that the dollar amount of the coverage is excluded from the government's calculation of your tax liability. For the employer, the dollar amount contributed to employee coverage is deducted as a business expense just as wages are.
17. Table A-2, "CBO and JCT's Projections of Net Federal Subsidies for Health Insurance, Billions of Dollars, by Fiscal Year," in Congressional Budget Office, "Federal Subsidies for Health Insurance: 2023 to 2033," September 2023, p. 19, https://www.cbo.gov/publication/59613 (accessed December 15, 2025).
18. For an excellent set of essays on the impact of current tax law and health insurance coverage, see *Empowering Health Care Consumers Through Tax Reform*, ed. Grace-Marie Arnett (Ann Arbor: University of Michigan Press, 1999).
19. For a discussion of the potential of religious or faith-based organizations sponsoring health insurance, see Jennifer Marshall, Robert Moffit, and Grace Smith, "Patients' Freedom of Conscience: The Case for Values-Driven Health Plans," Heritage Foundation *Backgrounder*, May 15, 2006, https://www.heritage.org/health-care-reform/report/patients-freedom-conscience-the-case-values-driven-healthplans; see also Phyllis Berry Myers, Richard Swenson, MD, Michael O'Dea, and Robert E. Moffit, "Why It's Time for Faith-Based Health Plans," Heritage Foundation *Lecture* No. 850, August 24, 2004, delivered June 24, 2004, https:// www.heritage.org/health-care-reform/report/why-its-time-faith-based-health-plans.
20. Only 10 percent of large employers, according to the 2023 Kaiser Family Foundation survey, don't cover abortion. Rachana Pradhan, "Abortion Coverage Is Limited or Unavailable at a Quarter of Large Workplaces," KFF Health News, October 18, 2023, https://kffhealthnews.org/news/article/abortion-coverage-kff-employer-survey/ (accessed December 15, 2025).
21. Several nationally prominent scholars have described how Congress could implement such a transformation. See *Modernizing Medicare: Harnessing the Power of Consumer Choice and Market Competition*, ed. Robert Emmet Moffit and Marie Fishpaw (Baltimore: Johns Hopkins University Press, 2023).

22. For a description of this approach, see Daniel McCorry, "Direct Primary Care: An Innovative Alternative to Conventional Health Insurance," Heritage Foundation *Backgrounde*r No. 2939, August 6, 2014, https://www.heritage.org/sites/default/files/2024-09/Direct%20Primary%20Care_%20An%20Alternative%20to%20Conventional%20Health%20Insurance.pdf.
23. For a discussion of this and related Medicaid reforms, see Nina Owcharenko Schaefer, "Medicaid Deserves to Be 'Cherished and Loved'—and Reformed," Heritage Foundation *Commentary*, February 20, 2025, https://www.heritage.org/medicaid/commentary/medicaid-deserves-be-cherished-and-loved-and-reformed.
24. The author is indebted to the Hon. Nelson Sabatini, former Secretary of the Department of Health and Mental Hygiene for the State of Maryland, for this Medicaid policy proposal.
25. See H.R. 267, Health Care Price Transparency Act, 119th Congress, introduced January 9, 2025, https://www.congress.gov/119/bills/hr267/BILLS-119hr267ih.pdf (accessed December 15, 2025).
26. For a description of this savings option, see Robert Emmet Moffit, PhD, "Health Care Price Transparency: A Patient's Right to Know," testimony submitted to the Committee on Ways and Means, U.S. House of Representatives, May 17, 2023, https://www.heritage.org/testimony/health-care-price-transparency-patients-right-know.