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Whom Would Jesus Cover - A Biblical, Ethical Lens for the Contemporary American Health Care Debate

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WHOM WOULD JESUS COVER? A BIBLICAL, ETHICAL LENS
FOR THE CONTEMPORARY AMERICAN HEALTH CARE
DEBATE

JEFFREY R. BAKER¹

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I. INTRODUCTION

The United States spends more per capita on health care than any other developed nation by orders of magnitude, yet nearly 47 million people, including nearly 9 million children, do not have health insurance.² The vast majority of uninsured Americans are working poor people who make too much to be eligible for current public coverage and who make too little to afford private insurance or exorbitant private care. Despite a “safety net” of public and private charity, this lack of coverage causes unmistakable disparities in care, health, medical outcomes, quality of life and life expectancy.

Biblically, two questions spring from this “gap” in care. First, is access to health care for our uninsured neighbors a moral issue that should spur redress by a conscientious community? Second, if so, what should be the response in national health care policy? As demonstrated here, access to health care in America is a matter of wealth. In the light of scripture, this situation implicates at least two broad, moral imperatives: the call to care for the poor and sick and the aspiration toward justice regardless of social and economic status.

Christians, individually and in congregation, should respond with private care and public policy, making judicious use of democratic voices in the government, the law and the marketplace. Christians participate as voters and policy makers, as providers and consumers, so Christians have a responsibility to seek just, wise, efficient and excellent care for our sick and poor neighbors. If the goal is to provide equitable access to health care for all, we must struggle with attendant forces of federalism, individual autonomy, the free market, profit-motives, the pace of technological innovation, timely and beneficial service, soaring costs, service rationing, the demands of taxpayers, and the economics of distributive risk.

This paper attempts a view of the contemporary health care debate in America through the prism of Biblical scripture and proposes that people of faith should recognize the current state of the American health care system as a moral crisis of justice and charity. First, I provide a survey of the current state of American health care for the uninsured, describing the demographic and economic circumstances of the uninsured and the resources available to them when they need medical care. Second, I ask whether, in light of scripture, this state of affairs presents a moral question that should drive our communities to action, and I answer in the affirmative. Third, I ask, if access to health care for uninsured Americans is a moral issue, what

² Throughout, “uninsured” means a person who does not receive coverage from any private health insurance, Medicare, Medicaid, State Children’s Health Insurance Program, state sponsored or other government sponsored health plan, veterans or military health plan. In the political discourse during the 2008 election cycle, most candidates and commentators agree that about 47 million Americans are uninsured. Recent data from the Centers for Disease Control and Prevention of the Department of Health and Human Services indicate that 43.6 million Americans were uninsured in 2006. See Centers for Disease Control and Prevention, *2006 National Health Interview Survey* (June 2007) (downloaded April 2, 2009) (http://www.cdc.gov/nchs/data/nhis/earlyrelease/200706_01.pdf). Of course, this data predates the present global economic recession.

should be the ethical response in national health care policy, and I ask whether progressive use of the State is an appropriate option for Christians in light of apostolic teaching on government and the religious community. Observing the community of Christians described in the New Testament, I suggest that in the American republic, Christians rightly should consider the use of public, governmental policy to address an unjust health care system.

II. THE CURRENT STATE OF AMERICAN HEALTH CARE FOR THE UNINSURED

The United States spends more per capita on health care than any other nation.³ According to the Kaiser Family Foundation, in 2003 the United States spent \$5,711 per capita in total health care expenditures.⁴ The next highest spender in 2003 was Luxembourg with \$4,611 per capita in total health care expenditures. Canada spent \$2,998 per capita, and the United Kingdom spent \$2,317 per capita.

In 2003, health care accounted for 15.2% of the United States' gross domestic product, the highest percentage of GDP of any comparable nation-state.⁵ In 2005, total health care expenditures in the United States accounted for 15.3% of GDP; the next highest reported by the CDC was Switzerland at 11.6%.⁶ This percentage of GDP grew by 6.4% from 1990 to 2003, a faster rate of growth than any other developed nation. By comparison, health care comprises 7.8% of the United Kingdom's GDP, and it grew by 1.8% over the same period of time.

Health care and related subsidy or entitlement programs account for about 42% of the federal budget.⁷ Medicare, Medicaid and SCHIP accounted for 21% of the federal budget in 2007, about \$572 billion.⁸ Medicare spending consumed two-

³ See The Henry J. Kaiser Family Foundation, *Snapshots: Health Care Spending in the United States and OECD Countries*, at Exhibit 1 (2007) <http://www.kff.org/insurance/snapshot/chcm010307oth.cfm>. The source for the Foundation's data is the Organisation for Economic Co-operation and Development ("OECD").

⁴ See *id.*; see also The Henry J. Kaiser Family Foundation, *Health Care Costs: A Primer* (Aug. 2007) <http://www.kff.org/insurance/upload/7670.pdf>. (reporting that expenditures per capita in the U.S. grew to \$6,697 in 2005).

⁵ See *id.* at Exhibit 1.

⁶ See Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States 2008, Table 124 (2008) [http://www.cdc.gov/nchs/data/08.pdf](http://www.cdc.gov/nchs/data/hus/08.pdf) #124. Costs per capita does not capture the distribution of costs. In the United States, approximately 10% of the population demand 63% of spending on health care services. Twenty-one percent of health spending goes to the sickest 1% of the population. The healthiest half of the population accounts for only 3% of spending. See The Henry J. Kaiser Family Foundation, *Trends in Health Care Costs and Spending* (2009) http://www.kff.org/insurance/upload/7692_02.pdf.

⁷ Center on Budget and Policy Priorities, *Where Do Our Federal Tax Dollars Go?* (2008) <http://www.cbpp.org/cms/index.cfm?fa=view&id=1258>. The source for the Center's data is the Office of Management and Budget ("OMB"). In 2005, total health expenditures were approximately \$2 trillion, and 45% of that total were public funds. Thirty-one percent of the total were for hospital expenses, and 6.1% were for nursing homes. Physician and clinical services accounted for 21%, and 10% were for prescription drugs. See Centers for Disease Control and Prevention, *supra* note 6 at table 124, 127.

⁸ See *id.*

thirds of that bill, providing health care coverage to more than 40 million people over 65 or with disabilities.⁹

These public programs amount to about 45% of total health care expenditures in the United States.¹⁰ Private health insurance is the largest single source of health care spending, accounting for about 36% of health spending in 2005.¹¹ In 2006, among Americans under age 65, 16.8% were uninsured, and 66.5% were insured through private carriers. Among children under 18, 9.3% were uninsured. About 60% of children were insured privately, and about 32% were insured by public health coverage.¹²

Remarkably, health care spending has exceeded economic growth for at least the last 30 years. The United States' gross domestic product rose by 7.4% annually from 1970 to 2005, but health care spending rose by 9.8% annually over the same period.¹³ The cost for private, employer-based health insurance premiums have risen by 78% since 2001.¹⁴

Despite these massive costs and expenditures, approximately 46 million Americans, including 8 – 9 million children do not have health insurance of any kind. Although the United States massively outspends the nearest developed nation on health care, 16% of the population lacks affordable, predictable access to medical care.

Dr. Lawrence Brown in the *New England Journal of Medicine* observes that the American health care system actually is a non-system, a patchwork of uncoordinated, often adversarial, interests and entities plumbing the patients' marketplace:

[T]he U.S. health care system consists not of two sectors (public and private) but three, one of which, the safety net, rarely gets proper attention and is poorly understood. The safety net encompasses public and voluntary hospitals, community health centers, public health clinics, free clinics and services donated by private physicians. Configurations of safety-net providers vary markedly among communities, as does their financing, a shifting patchwork of funds from Medicaid, the State Children's Health Insurance Program (SCHIP), the federal disproportionate share program, tax levies, foundation grants, state appropriations, commercial payers, and other sources. These institutions often live on the financial edge, but with 11th-hour infusions, they mostly manage to stay afloat. This fact is of paramount importance, for these providers also extend a safety net for the legitimacy of the health care system as a whole. That Americans who lack coverage "still get care," as

⁹ *See id.*

¹⁰ *See* The Henry J. Kaiser Family Foundation, Health *supra* note 4, at 8.

¹¹ *See id.* (citing Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group).

¹² CENTERS FOR DISEASE CONTROL AND PREVENTION, EARLY RELEASE OF SELECTED ESTIMATES BASED ON DATA FROM THE 2008 NATIONAL HEALTH INTERVIEW SURVEY (2009) <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease200906.pdf>.

¹³ *See id.*

¹⁴ *See* The Henry J. Kaiser Family Foundation, *Employer Health Insurance Costs and Worker Compensation* (2008), <http://www.kff.org/insurance/snapshot/chcm030808oth.cfm>.

President Bush recently declared, drains moral urgency from the health care reform enterprise.

This self-congratulatory proposition is half-true: many of the uninsured can make an appointment or drop in for care at a safety-net venue. Should they become seriously ill, however, and need referrals to specialists, in-patient care, high-tech procedures, or a regimen of prescription drugs, access becomes unpredictable and spotty, an ugly exercise in rationing.¹⁵

These pieces do not create an evenly distributed, economically rational system where patients engage providers with any legitimate choice or bargaining power. Instead, geography and affluence drive access to medical services, and endemic incentives in medical education, state government, industry and research create pockets saturated with luxurious medical care and expansive swathes lacking basic services.

In broad terms, American patients fall into three categories: the privately insured, the publically insured and the uninsured. For those who enjoy private insurance, American health care is among the best, if not the best, in the world. For those who receive public coverage, they may face limited options and lesser care than the “gold standard,” but they receive regular access to adequate care. For the uninsured, access to medical care often depends on inconstant charity, ad hoc improvisation, self-imposed rationing or the imposition of immense financial burden, and this lack of access causes poorer care and worse outcomes.¹⁶

A. Private Insurance

Employer-provided health insurance is the overwhelming source of medical insurance, covering about 90% of privately insured people under age 65.¹⁷ Sixty percent of all employers offered health care benefits in 2007.¹⁸ The likelihood of

¹⁵ Lawrence D. Brown, *The Amazing Non-Collapsing U.S. Health Care System – Is Reform Finally at Hand?*, 358 *NEW ENG. J. MED.* 325, 325-26 (2008).

¹⁶ In an empirical study discussed more fully at notes 89-92, *infra*, Dr. Jack Hadley concludes: “[T]he failure to address the problem of no insurance for US individuals will have adverse health consequences. Moreover, the fact that these consequences apply to uninsured individuals who experienced unintentional injuries or new chronic conditions runs counter to the perception that the uninsured receive care, either through the safety net or their own resources when they really need it. . . .” Jack Hadley, *Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition*, *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* at 1082 (May 13, 2008) (emphasis added).

¹⁷ See The Henry J. Kaiser Family Foundation, *Snapshot: Health Care Costs: Offer Rates for Smaller Establishments by Business Age* (2008), <http://www.kff.org/insurance/snapshot/chcm050608oth.cfm>.

¹⁸ See *id.* In 2001, 69% of private businesses offered health care benefits to employees. In 2005, approximately 34% of business with less than 10 employees offered health insurance to workers. About 60% of businesses with 10 to 24 employees offered health benefits, and 78% of employers with 25 to 99 employees offered coverage. Nationally, in 2005, about 12.8 million people work in 4.7 million firms with less than 10 employees. Approximately 20 million people worked in about 521,000 firms with 20 to 99 employees. See U.S. CENSUS BUREAU, *STATISTICS OF U.S. BUSINESSES, NUMBER OF FIRMS, NUMBER OF ESTABLISHMENTS,*

receiving medical insurance as an employment benefit depends greatly on the size and age of the business.¹⁹

The average cost of premiums for employer-provided health insurance for families was \$12,106 in 2007, including worker and employer contributions; for coverage of singles, the average annual premium is \$4,479.²⁰ Since 2001, these costs have increased by 78%.²¹

On average, workers contribute 16% of the premium for single coverage and 28% of the premium for family coverage.²² The average contribution by employees for single coverage is \$58 per month, and employees contribute \$273 per month on average for family coverage.²³

B. Existing Public Coverage

National and state governments presently provide significant public benefits and insurance coverage to many Americans. Medicare provides subsidized medical insurance in diverse forms to every American over 65, regardless of age, income or medical condition.²⁴ Medicaid provides medical care as a welfare benefit to poor elders, the very poor and certain poor people with disabilities.²⁵ The State Children's Health Insurance Programs ("CHIP") provide subsidized medical coverage for less poor children.²⁶ The Veterans Administration provides single-payer and subsidized care to veterans and certain veterans' spouses and dependants.²⁷ Adults younger than

EMPLOYMENT, AND ANNUAL PAYROLL BY EMPLOYMENT SIZE OF THE ENTERPRISE FOR THE UNITED STATES AND STATES, TOTALS – 2005 (downloaded April 3, 2009) (<http://www.census.gov/csd/susb/susb05.htm>) (U.S. & states, totals, spreadsheet).

¹⁹ U.S. Census Bureau, *supra* note 18. In 2005, approximately 34% of business with less than 10 employees offered health insurance to workers. About 60% of businesses with 10 to 24 employees offered health benefits, and 78% of employers with 25 to 99 employees offered coverage. Nationally, in 2005, about 12.8 million people worked in 4.7 million firms with less than 10 employees. Approximately 20 million people worked in about 521,000 firms with 20 to 99 employees. *See id.*

²⁰ *See* The Henry J. Kaiser Family Foundation, *Employer Health Benefits 2007 Summary of Findings* (2007), <http://www.kff.org/insurance/7672/upload/76723.pdf>.

²¹ *See* The Henry J. Kaiser Family Foundation, *supra* note 14.

²² *See* The Henry J. Kaiser Family Foundation, *Employer Health Benefits 2007 Annual Survey, Section 6, Worker and Employer Contributions for Premiums* (2007), <http://www.kff.org/insurance/7672/sections/ehbs07-sec6-1.cfm>.

²³ *See id.*

²⁴ Medicare is officially Health Insurance for the Aged and Disabled. *See* 42 U.S.C. § 1395, *et seq.* (Medicare's general enabling statute); 42 C.F.R. §§ 405-421 (Medicare's federal regulations).

²⁵ *See* 42 U.S.C. § 1396, *et seq.* (Medicaid's general enabling statutes); 42 C.F.R. 440.1, *et seq.* (Medicaid's federal regulations).

²⁶ *See, generally*, 42 U.S.C. §1397aa, *et seq.* (CHIP's enabling statute).

²⁷ *See, generally*, 38 U.S.C. §101, *et seq.* (Veterans' benefits enabling statute); *see also* 38 C.F.R. § 17.35 - .48 (Veterans' Administration eligibility regulations).

65 who have no disabilities have no option for governmental benefits or subsidies unless they are military veterans or exceptionally poor.²⁸

1. Medicare

Medicare is a federally subsidized medical insurance program. Medicare provides coverage in four component programs: Part A (Hospital Insurance),²⁹ Part B (Supplemental Medical Insurance),³⁰ Medicare Advantage (formerly Medicare+Choice or Part C) (Managed Care)³¹ and Part D (Prescription Drug Benefits).³²

²⁸ The only meaningful exception is for some young, poor pregnant women until their children are born. In Alabama, however, Medicaid extends prenatal care only to pregnant women who are otherwise eligible for Medicaid. See ALA. ADMIN. CODE. § 560-x-43-.02.

²⁹ See 42 U.S.C. §§ 1395c - 1395i-5; 42 C.F.R. Parts 405-421. Part A covers costs for inpatient hospital care, costs for skilled nursing facilities and some home-health and hospice care for people over 65 or for younger people eligible to opt-in at their own cost. Part A will pay for only “reasonable and necessary care,” that is, medically necessary care. “Medical necessity” is based on the treating physician’s professional opinion, and review by a hospital’s Utilization Review Committee and a region’s Quality Improvement Organization. Part A provides benefits at two levels: Acute care (inpatient hospital care) and Skilled Nursing in a nursing home or the patient’s home. *Id.*

³⁰ See 42 U.S.C. §§ 1395j - 1395w-4; 42 C.F.R. Parts 407 and 408. Part B, “Supplemental Medical Insurance,” provides coverage for non-hospital services, like outpatient care, clinic visits, physicians’ professional fees, laboratory costs, diagnostic procedures and durable medical equipment. Eligibility for Part B usually requires eligibility for Part A, although an applicant may purchase Part B “voluntarily” if they do not want Part A. Part B requires a monthly premium designed to cover 25% of the program costs. The standard premium in 2009 is \$96.40 per month. Also, Part B requires an annual deductible, \$135.00 per year in 2009. See also *Medicare Premiums and Coinsurance Rates for 2009* (http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faaid=2100).

³¹ See 42 U.S.C. § 1395w-21 - 1395w-28; 42 C.F.R. Part 422. Part C offers an alternative to the standard fee-for-service Medicare scheme in which providers bill Medicare per procedure or device or hospital day. Medicare Advantage offers managed-care plans which provide less physician choice but which can be less expensive and easier to navigate. These can be privately organized provider / insurer plans which must adhere to strict rate rules and regulations. Part C delivery is in flux because of its economic model. Half of all plans stopped or cut services between 1999 and 2003. CMS increased rates in 2003 to promote stability, but the new rates to providers may be inflated and still may not secure provider participation. Part C offers beneficiaries certain advantages, including an emphasis on preventative care, comprehensive services with no claims, no need for Medigap coverage and easier budgeting. Part C also imposes significant disadvantages from regular Medicare, including periodic plan terminations and instability, limitations on specialized care, financial incentives on providers to limit services, limited provider options and choices, geographic limitations, higher co-pays and deductibles and disenrollment complications. *Id.*

³² See 42 U.S.C. §§ 1395w-101 to 1395w-151; 42 C.F.R. Part 423. Beginning on January 1, 2006, Medicare began a benefit for prescription drugs. Medicare beneficiaries voluntarily elect to obtain Part D coverage in three alternative ways: purchasing a stand-alone plan covering only prescription drugs issued through private companies, joining a Medicare Part C HMO that offers drug benefits, or maintaining Medigap insurance that provides drug benefits. Applications are voluntary, but an applicant must be eligible for Part A or Part B, unless the beneficiary is in Medicare Advantage, then he must be eligible for both A & B. Enrollees can

Medicare is available to citizens over 65 who are eligible for Social Security retirement benefits, which amounts to virtually every American at that age.³³ Because Medicare is an insurance program, insureds still must pay co-insurance payments (co-pays), premiums and deductibles for coverage.³⁴

2. Medicaid

Medicaid provides medical insurance for qualified people with very low-incomes and very few assets.³⁵ Medicaid actually provides a broader range of benefits than Medicare to its beneficiaries, because people eligible for Medicaid have such low

select from numerous Medicare Drug Plans, but most plans include these basic elements: (1) beneficiaries must pay a annual deductible of \$250; (2) beneficiaries pay a 25% co-pay for the next approximately \$2000 (depending on plan specifics) in prescription drug costs or \$500; (3) beneficiaries pay the next approximately \$2800 in drug costs, and no insurance may be sold to cover the gap (the “coverage gap” or “doughnut hole”); (4) beneficiaries whose costs exceed the coverage gap, that is, over approximately \$4800 of drug costs in a year, are eligible for “catastrophic coverage.” For all drug costs over the catastrophic threshold, the plan must pay 95% of the costs, and beneficiaries must pay the greater of \$5 per brand name drug, \$2 for generics or 5% of the drug cost. Part D provides much greater benefit for people with lower incomes. For example, “dual eligible beneficiaries,” that is, eligible for both Medicare and Medicaid, at or below 100% of Poverty Index, will pay not monthly premium or annual deductible if she has less than \$2000 in assets (\$3000 per couple). The beneficiary will pay \$1 for each generic prescription, and \$3 for each brand name, and the amount is linked to the consumer price index. Dual eligibles now cannot receive any drug benefit from Medicaid, with the addition of Part D. Therefore, some of the most poor actually receive less drug coverage under the Part D plans. *Id.*

³³ See 42 U.S.C. § 1395o, 42 C.F.R. § 426. Medicare also provides coverage for dialysis for people of all ages who are diagnosed with End State Renal Disease. Medicare provides Part A hospital-coverage for younger people who receive Social Security Disability Insurance benefits for at least 24 months. Social Security Disability Insurance is available for people who experience a disability that prevents them from working before they reach retirement age. For SSDI purposes, a person is disabled if they are unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that has lasted or can be expected to last for an continuous period of at least 12 months or that will not end until death. The Social Security Administration imposes a 5 month waiting period after the onset of a disability, and it relies on periodic medical examinations and vocational evaluations to determine whether a beneficiary can be retrained or rehabilitated for other “gainful activity.” The applicant bears the burden of proving a medical basis for the disability. See 42 U.S.C. §§ 416(i)(1), 423(d)(1)(A); 20 C.F.R. §§ 404.315(a)(4), 404.1505, 404.1512.

³⁴ See 42 U.S.C. §§ 1395d, 1395x; 42 C.F.R. Part 409. The Part A deductible for hospital coverage in 2009 was \$1068. In addition to the deductible, after 60 days of admission in the hospital or SNF, Medicare starts to require a co-payment for services. For each benefit period the beneficiary pays a total of \$1068 for a hospital stay of 1-60 days, \$267 per day for days 61-90 of a hospital stay, \$534 per day for days 91-150 of a hospital stay, and all costs for each day beyond 150 days. See Center for Medicare & Medicaid, *Fact Sheets: Medicare Announces Medicare Premiums & Deductibles for 2009* (2009) <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3272>.

³⁵ See 42 U.S.C. § 1396, et seq. States govern Medicaid under general federal statutory authority and generate most administrative rules and regulations themselves. See, e.g., ALA. CODE. § 22-6-1, et seq., and ALA. ADMIN. CODE §. 560-X-1-.01 through 560-X-61-.09.

incomes and resources that they cannot afford any services.³⁶ The greatest percentage of Medicaid benefits are expended to insure hospital services, followed by costs for long-term institutional care.³⁷

Medicaid is significantly different than Medicare. Medicaid is strictly need based and imposes very strict eligibility and coverage standards. Economically, Medicaid is a bigger program with broader coverage than Medicare, and Medicaid does not enjoy deductibles, co-payments, premiums or other forms of contributions from the insured. Thus, federal Medicaid and coordinating state agencies labor under intense fiscal pressure to limit enrollment or limit benefits.³⁸

Medicaid will only cover people who are truly poor, and to become eligible, the applicant must be or must become impoverished. Medicaid provides coverage for two classes of applicants: “Categorically needy,” the elderly poor and other categories of poor people, and “Medically needy,” those with very high medical bills who cannot afford their own care but who make too much to be eligible for Medicaid purely by need.

To be “categorically needy” an applicant must be 65 or over, blind or disabled and eligible for Supplemental Security Income (“SSI”). In 2008, SSI is available for individuals who earn less than \$694 per month or couples who earn less than \$1031 per month.³⁹ Also, if the individual has more than \$2000 in countable resources, or \$3000 for a couple, they are ineligible.⁴⁰

States have two options for determining “medical eligibility.” In most states, the participant can deduct their medical expenses from their total income to reduce their effective income and resources below the eligibility threshold.⁴¹ This process of

³⁶ See 21 C.F.R. § 440.210.

³⁷ See, e.g., ALABAMA MEDICAID AGENCY, DRAFT BUDGET FY 2009 (Jan. 16, 2008) (downloaded April 3, 2009) (http://www.medicaid.state.al.us/documents/News/Special_Presentations/FY08-09_Budget_Comparison_1-16-08a.pdf). The Alabama Medicaid Agency projected that hospital costs would be approximately \$1.4 billion. Nursing home costs would be about \$856 million. Alabama serves as an exemplar throughout this paper, a relatively poor, predominantly rural, yet industrializing state with diversifying economy, growing population and four major population centers. *Id.*

³⁸ The federal government provides much or most of a state’s Medicaid funding, but the states bear a substantial burden to finance the program. On average, the states provide about half of Medicaid funding, but in poorer states, the federal government provides more. For example, Alabama’s Medicaid budget for the FY 2009 is \$4.5 billion dollars. About \$3 billion dollars come from the federal government. About 930,000 Alabamans are eligible for Medicaid. See, e.g., *id.*

³⁹ See 42 U.S.C. §1382c(a)(1)(A), etc.; 20 C.F.R. § 416.202. See also, e.g., ALABAMA MEDICAID AGENCY, ALABAMA MEDICAID ELIGIBILITY LIMITS – 2009 (downloaded April 4, 2009) (http://www.medicaid.alabama.gov/apply/apply_information.aspx?tab=3).

⁴⁰ See Alabama Medicaid Agency, A Medicaid Primer 19 (2010) (http://www.medicaid.alabama.gov/documents/apply/2A-General/2A-4_What_is_Medicaid_1-19-2010.pdf). Some vital personal property is excluded from being counted as resources, like the home, household good, wedding rings, medical equipment and one car necessary for transport.

⁴¹ See generally, 42 U.S.C. § 1369(a)(10)(C).

deduction is called “spending down.” In “spend down states,” more people can be eligible, and most people with catastrophic costs can be eligible.

Alternatively, states can opt to be Section 209(b) “income cap” states. These states impose a hard income cap, usually a certain percentage over the federal poverty level, to make bright-line determinations of eligibility. For example, in Alabama, the cap is 300% of the SSI income level.⁴² If an applicant makes more than this amount, she is not eligible for Medicaid, regardless of her medical expenses. This permits states to reduce enrollment and to predict costs more easily. Most income cap states are poorer and rely on greater federal contributions for Medicaid.

For either Categorically or Medically needy, to be eligible, the applicant must not have resources over a certain amount. Medicaid defines resources as “countable” or “not countable.”⁴³ To be eligible, a person may not have more than \$2000 in countable resources, and a couple may not have more than \$3000 in countable resources.⁴⁴ The policy here is that the person should be able to liquidate their resources to pay for their care before the government should intervene and provide coverage. A person whose countable resources exceed the limit must “spend down,” or liquidate their assets at fair market value to pay for their own medical care. Once their countable resources are below the maximum limit, then they are eligible for Medicaid.

The government anticipates that many applicants will transfer property out of their estate before applying for less than market value to trusts or loved ones in order to become resource eligible. To confront this tactic, the federal laws, via state regulations, impose a 60-month “look back” period.⁴⁵ States must “look back” at transfers made before application to determine resource eligibility, and any transfer made for less than market value is added to the applicant’s countable resources and

⁴² See ALA. ADMIN. CODE r. 560-X-25-.10. “Income Cap” states create a problem for retired people whose income from pension and SSA Retirement Benefits exceeds the income cap but is less than the cost of nursing home care. In “income cap” states, they cannot “spend down,” to become eligible. Often, these people have had to improvise care, rely on family members or move to a non-income cap state. As a result of this harsh effect in income-cap states, Congress required income-cap states to permit the use of Qualifying Income Trusts or Miller Trusts. In a QIT, the beneficiary creates an irrevocable trust and diverts enough income into the trust to become eligible. Two essential requirements for a QIT: (1) Res can only be the beneficiary’s income from SSA, pensions or elsewhere and accumulated interest, and (2) The beneficiary must designate the state to receive the res upon the beneficiary’s death, up to the amount that Medicaid paid on his behalf. Anything remaining can go to his estate or other beneficiaries. See L. RUSH HUNT, ET AL., UNDERSTANDING ELDER LAW: ISSUES IN ESTATE PLANNING, MEDICAID AND LONG-TERM CARE BENEFITS at 194 (2002).

⁴³ See, e.g., ALA. ADMIN. CODE r. 560-X-25-.06.

⁴⁴ See *id.*

⁴⁵ See, e.g., ALA. ADMIN. CODE 560-X-25-.09. Before the Deficit Reduction Act of 2005, (DRA), Medicaid used a 36 month look-back period for transfers to individuals and a 60 month look-back period for transfers to trusts. Now, for transfers made after February 6, 2006, all transfers get a 60 month look back period. Thus, Medicaid can count all countable resources transferred in the past 5 years to determine resource eligibility.

assessed in a penalty period.⁴⁶ Medicaid provisions contemplate some relief if the penalty will work an “undue hardship” on the applicant.⁴⁷

3. SCHIP

The State Children’s Health Insurance Program (“SCHIP”) is a joint federal-state program “to initiate and expand the provision of child health insurance to uninsured, low-income children.”⁴⁸ As with Medicaid, the federal statutes empower states to establish eligibility criteria within broad limitations.⁴⁹ The federal statutes also require that states provide coverage for eligible children that meet certain basic benchmarks; the coverage must include inpatient and outpatient hospital services, physicians’ surgical and medical services, laboratory and x-ray services and well-baby and well-child care, including age-appropriate immunizations.⁵⁰

The federal government also enables states to charge premiums for the coverage so long as those premiums do not favor families with higher incomes, and federal government imposes greater protections for children in families who earn less than 150% of the FPL.⁵¹

Eligibility requirements vary from state-to-state. To illustrate, Alabama represents one of the poorest states receiving a greater percentage of its SCHIP

⁴⁶ See, e.g., ALA. ADMIN. CODE. § 560-X-25-.09. Medicaid imposes a penalty period to account for transfers or wealth “disposal” during the look-back period. Medicaid will not pay for benefits during the penalty period. It runs for a period of months equal to the number of months that Medicaid would have paid with the same amount of money. Under the DRA, the penalty period begins to run from the later date of (1) the first day of the month in which the transfer was made or (2) the date on which the individual is eligible for Medicaid benefits and would otherwise be receiving nursing home care but for the penalty.

⁴⁷ For example, the Alabama rule on undue hardship is strict:

The applicant must demonstrate “by clear and convincing evidence that the imposition of such a penalty will cause the individual to suffer undue hardship. Undue hardship will only be considered in extreme cases where the individual has been denied admission to or discharged from an institutional facility or denied home and community based waiver services under circumstances which would deprive the individual of medical care such that the individual’s health or life would be endangered, or of food clothing, shelter or other necessities of life. Undue hardship does not exist where a transfer penalty causes an individual or the individual’s family to experience inconvenience or would cause [an] individual to restrict his/her lifestyle.”

ALA. ADMIN. CODE r. 560-X-25-.09 (10)(a) (2006).

⁴⁸ 42 U.S.C. §1397aa.

⁴⁹ See 42 U.S.C. § 1397bb(b). The statute provides these broad standards for state eligibility: “Such eligibility standards--(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and (ii) may not deny eligibility based on a child having a preexisting medical condition.” *Id.*

⁵⁰ See 43 U.S.C. §1397cc(c).

⁵¹ See 43 U.S.C. §1397cc(e).

budget from federal contributions. The Alabama Department of Public Health reported that about 84,000 children were enrolled in 2006.⁵² Alabama's plan covers all children under age 19, Alabama's age of majority, in families earning up to 200% of the FPL and who are not eligible for Medicaid.⁵³

Currently, Alabama imposes modest premiums and co-pays for children in families with income less than 150% of FPL. These families must pay \$50 annually per covered child but no more than \$150 per family.⁵⁴

4. Veterans Administration

Medical benefits are available to most veterans and the veteran's dependents.⁵⁵ The Department of Veterans' Affairs provides benefits covering basic inpatient and outpatient medical services and some preventative care.⁵⁶ The level of coverage and access to services depends on the veteran's rank within a statutory priority, with veterans with service-connected disabilities rated at 50% or greater at the highest priority.⁵⁷ Dependents may receive coverage if they are the spouse, widow, dependent or surviving child of a veteran with a 100% rating from a service-related disability.⁵⁸

C. Demographics of the Uninsured

1. Adults without Children and the Uninsured Generally

Among those under age 65, the poor and near poor were much more likely. About a quarter of uninsured people are eligible for public programs but are not enrolled, and most of these to be uninsured than families with higher incomes; that is, those with incomes less than 200% of the federal poverty line (FPL).⁵⁹ Fifty-six percent of uninsured people are not eligible for public programs but have incomes below 300% of the FPL.⁶⁰

This is the "gap," those who make too much to be eligible but who make too little to afford private insurance realistically. Currently, for a family of three, 200% of the FPL currently is about \$30,000 for a family of three, and 300% of the FPL is about

⁵² See CENTERS FOR MEDICARE & MEDICAID SERVICES, ALABAMA TITLE XXI PROGRAM FACT SHEET (2007) <http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/ALCurrentFactSheet.pdf>.

⁵³ See *id.*

⁵⁴ See *id.*

⁵⁵ See, generally, 38 U.S.C. §101, et seq. (Veterans' benefits enabling statute); see also, Pensions, Bonuses, and Veterans' Relief, 38 C.F.C. § 13.35 - .48 (2009).

⁵⁶ See 38 C.F.R. § 17.38(a)(1), (2).

⁵⁷ See 38 C.F.R. § 1705(a).

⁵⁸ See 38 U.S.C. § 1713(a).

⁵⁹ See NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8 at Figure 139.

⁶⁰ See John Holahan, et al., *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?* at 3 (Kaiser Commission on Medicaid and the Uninsured), Feb. 2007.

\$46,000 annually. A family making 300% of the FPL is at the lower limits of a realistic ability to pay for private insurance out of their pockets. At this threshold, families would pay about 17% of their income for premiums, and singles would pay about 14% of their income for premiums.⁶¹ In 2005, 27% of people with family income below the FPL paid more than 10% of after-tax income on out-of-pocket health care expenses, including insurance premiums.⁶²

By age, the largest population of uninsured people, 29.7%, is between ages 18-24, followed by those aged 25-34 at about 26%.⁶³ In every age group, men are more likely to be uninsured than women.⁶⁴

About half of all uninsured people are white.⁶⁵ About 32% of Hispanic people are uninsured.⁶⁶ About 16% of the Black people are uninsured, and about 10% of white people are uninsured.⁶⁷

About a quarter of uninsured people are eligible for public programs but are not enrolled, and most of these are low-income children and their parents.⁶⁸ Only 8% of uninsured adults without children are eligible for public programs.⁶⁹ Sixty-nine percent of uninsured adults without children are not eligible for public programs but earn less than 300% of the FPL.⁷⁰ Over half of these people are older than 29 with family incomes below the FPL.⁷¹

2. Children and Their Parents

About 8.1 million children have no medical coverage, public or private.⁷² About 9% of all children under age 18 were not insured in 2005, but 15% of children at 150% of the federal poverty line were uninsured.⁷³

⁶¹ *See id.* at 2. The authors include this warning, “Nonetheless, using a single threshold is arbitrary and involves risk of designating some as having affordable coverage who in fact do not, perhaps because of age or health status.”

⁶² *See* NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8 at Table 31.

⁶³ *See* CENTER FOR DISEASE CONTROL AND PREVENTION, *supra* note 2.

⁶⁴ *See id.*

⁶⁵ *See* NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH, UNITED STATES 2007, Figure 30 (2007) [http://www.cdc.gov/nchs/data/07.pdf#highlights](http://www.cdc.gov/nchs/data/hus/07.pdf#highlights).

⁶⁶ *See* NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8 at Table 30. Table 139 reports that Hispanic, American Indian and native Alaskan people were more likely to be uninsured during a point in time in 2005 than other racial or ethnic groups. Additionally, 40% of people of Mexican origin were uninsured at some point in the 12 months preceding the 2005 interview.

⁶⁷ *See id.* at Figure 1.3.

⁶⁸ *See* John Holahan, *supra* note 60, at 3.

⁶⁹ *See id.* at 10.

⁷⁰ *See id.* at 11.

⁷¹ *See id.*

⁷² *See id.* at 19, Table 2; *See* CENTER FOR DISEASE CONTROL AND PREVENTION, *supra* note 2. (reporting 6.8 million uninsured children in 2005).

⁷³ *See* NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8, Figure 138.

Nearly three-fourths of uninsured children, under age 18, are eligible for SCHIP or Medicaid but are not enrolled.⁷⁴ Ninety-three percent of children who are eligible for public programs but who remain uninsured are in families with income below 200% of the FPL, and 60% live in families below the poverty line.⁷⁵ Seventy percent of eligible, uninsured children live in working families, and 60% live in families where the primary earner works in a small business with less than 25 employees.⁷⁶

Most children who are eligible but uninsured are teenagers, but 27% are under age 6.⁷⁷

Forty percent of eligible, uninsured children are Hispanic.⁷⁸ About 33% of eligible, uninsured children are white, and 18% are black.⁷⁹

About 900,000 children, 11% of the total population of uninsured children, are not eligible for public assistance but live in families with income below 300% of the FPL.⁸⁰ Forty percent of these children are white, but 42% are Hispanic, a much higher proportion than the general population.⁸¹

Only 28% of uninsured parents are eligible for public programs.⁸² About 75% of uninsured, eligible parents live in families earning below the FPL, and 76% live in working families. Similar to their children, 60% of these uninsured, eligible parents live in families where the principal earner works for a business with less than 25 employees.⁸³

Ninety-seven percent of uninsured parents who are not eligible for public programs are in working families.⁸⁴ Fifty-seven percent of uninsured parents are not eligible for public coverage but earn less than 300% FPL.⁸⁵

D. The Effect on the Health of the Uninsured

In 2007, the Centers for Disease Control and Prevention reported that nearly 20% of adult Americans do not have access to the health care they need.⁸⁶ These adults

⁷⁴ See John Holahan, *supra* note 60, at 4; see also CENTER ON BUDGET AND POLICY PRIORITIES, IMPROVING CHILDREN'S HEALTH: A CHARTBOOK ABOUT THE ROLES OF MEDICAID AND SCHIP, 2007 EDITION, Section 1, Figure 3 (2007) <http://www.cbpp.org/schip-chartbook.htm>.

⁷⁵ See John Holahan, *supra* note 60, at 4

⁷⁶ See *id.* at 5.

⁷⁷ See *id.*

⁷⁸ See *id.*

⁷⁹ See *id.*

⁸⁰ See *id.* at 6. See notes 60 and 61, *supra*, for discussion of affordability of private coverage for families earning more than 300% of the FPL.

⁸¹ See Holahan, *supra* note 60 at 7.

⁸² *Id.*

⁸³ See *id.* at 8.

⁸⁴ See *id.*

⁸⁵ See *id.* at 9. See CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra* note 63 (discussing the presumption of affordability above this income level).

reported that in the previous year they did not receive needed medical care, prescription medicines, mental health care, dental care or eyeglasses because they could not afford them.⁸⁷

Hispanic people, that racial group with the lowest rates of coverage, also have the highest proportion of adults with fair or poor health.⁸⁸

A recent empirical study investigated “whether uninsured individuals who experienced a health shock caused by either an unintentional injury or the onset of a chronic condition received the same amount of medical care and had similar short-term health outcomes as insured individuals.”⁸⁹ At the baseline before the health shock, more uninsured subjects in the survey reported being in fair or poor health and reported family incomes below 100% of the FPL than insured subjects.⁹⁰

Uninsured individual were significantly less likely to see a clinician following an unintentional injury or a new chronic condition. However, if an individual did see a clinician, he/she was equally likely to have further care recommended regardless of insurance status. Despite the equal recommendations for further care, uninsured individuals in the unintentional injury sample were significantly more likely to have received none of the recommended follow-up care and significantly less likely to have received all of the recommended follow-up care. In the new chronic condition sample, uninsured individuals also were significantly more likely to have received none of the recommended follow up care and were significantly less likely to still be receiving treatment for their chronic condition.

. . . . In the new chronic condition sample, uninsured individuals had significantly more emergency department visits and similar number of inpatient hospital visits as those with insurance.

. . . . [U]ninsured individuals in the chronic condition sample reported significantly worse short-term health changes at the first follow-up interview (approximately 3.5 months after the health shock), and . . . uninsured individuals in the unintentional injury sample were significantly more likely to report that they were not fully recovered and were no longer being treated.⁹¹

These findings are consistent with other studies which have found a significant relationship between a lack of insurance and worse medical outcomes.⁹²

⁸⁶ See NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8, Figure 138.

⁸⁷ See *id.*

⁸⁸ See NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8, Figure 21.

⁸⁹ Hadley, *supra* note 16 at 1074.

⁹⁰ See *id.* at 1076. Of the sample studying those with unintentional injuries, 18.5% were uninsured. 16.1% of those with new chronic conditions were uninsured. See *id.*

⁹¹ *Id.* at 1077-1078.

⁹² See *id.* at 1073, 1080.

III. IS ACCESS TO HEALTH CARE FOR UNINSURED AMERICANS A MORAL ISSUE THAT SHOULD SPUR REDRESS BY CHRISTIANS?

Access to health care for the uninsured, working poor is a moral issue that demands attention by people of faith and a determination to create a workable solution. This contemporary situation presents problems of stewardship and sustainability, justice, charity and the ethic of life. In the interest of life, the uninsured suffer reduced quality of care and abbreviated lives and lesser quality of life. In the interest of justice, our communities should not accept a situation where access to basic health care is determined by socio-economic status, and we should not accept a situation where services are rendered and costs are born without equity. In the interest of stewardship and sustainability, communities should be alarmed by paying exceptionally high costs with remarkably reduced returns, by promoting a system that is not economically viable and by promoting a weakening health care infrastructure.

If this disparity in access and care is a moral issue, a question of justice, then people of faith cannot rest before the problem. Citizens in community should engage the issue judiciously, prudentially and with haste.

Sufficient health care is as essential and necessary to humans as sufficient food, shelter and security. Without food, shelter and security, people suffer and die. Without basic health care, people suffer and die. As a nation and national culture, Americans have chosen to employ the state, alongside private efforts, to feed those who cannot afford food, to provide shelter for those who cannot afford housing and to provide security through public police and courts to all people. As a nation, we have chosen to provide universal education to all, regardless of capacity to afford it. As a nation and a national culture, we should not leave those without access to adequate health care to suffer and die merely because they cannot afford it. Access to sufficient health care is a question of social justice, no less important than food, shelter, security and education.

A. *The Sick and Poor*

In Matthew 25, Jesus instructed his disciples in Jerusalem. He taught them about judgment when the Son of Man returns:

Then the King will say to those on His right, "Come, you who are blessed by my father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.

Then the righteous will answer him, ". . . .When did we see you sick or in prison and go to see you?"

The King will reply, "I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me."⁹³

⁹³ Matt. 25:34-40. Throughout, all scripture quotations are from the New International Version of the Bible.

Undoubtedly, Jesus' healing ministry and the apostles' teaching call for followers to care for the sick, as a core purpose of the gospel community on the earth.⁹⁴ Throughout his earthly ministry described in the gospels, Jesus healed the sick.⁹⁵ Often his healing miracles were vehicles for other lessons, but often they are healing for the sake of compassion and mercy.⁹⁶ The apostles carried on this mission, healing as they preached throughout the known world.⁹⁷

Intertwined with a calling to care for the sick is the Christians' calling to serve the poor. This is Christ's own mission, as He declared it to the synagogue:

The Spirit of the Lord is on me,
Because he has anointed me
To preach good news to the poor.
He has sent me to proclaim freedom
For the prisoners,
And recovery of sight for the
Blind,
To release the oppressed,
To proclaim the year of the Lord's favor.⁹⁸

James takes up this purpose when he teaches, "Religion that God our Father accepts as pure and faultless is this: to look after the orphans and widows in their distress and to keep oneself from being polluted by the world."⁹⁹

In this instant health care policy discussion, the uninsured in America are disproportionately poor, mostly working poor.¹⁰⁰ These poor people realistically cannot afford private health insurance, and most adults are not eligible for public

⁹⁴ Matt. 5:16: From the Sermon on the Mount, "In the same way, let your light shine before men, that they may see your good deeds and praise your Father in heaven."

⁹⁵ See, e.g., Mt. 12; Mk. 5:24b-34 (the woman subject to bleeding, also Lk. 8:40-48); 7:31-35 (the deaf man); 8:22-25 (the blind man at Bethsaida); Lk. 4:38-41 (Simon's mother-in-law and many others); 13:10-13 (a crippled woman on the Sabbath); 18:35-43 (a blind man on the road to Jericho); Jn. 5:1-14 (the invalid at the pool).

⁹⁶ For example, when Jesus healed the man lowered through the roof, he explained that he healed him "that you may know that the Son of Man has authority on earth to forgive sins . . ." Mk. 2:11. In John 4:43-53, Jesus healed an official's son while he was teaching and said, "Unless you people see miraculous signs and wonders, you never will believe." Jn. 4:48. In John 9:1-11, Jesus heals a blind man to teach a lesson: "Neither this man nor his parents sinned, but this happened so that the work of God might be displayed in this life." Jn. 9:3.

⁹⁷ See, e.g., Ac. 3:1-10 (Peter and John with the beggar at the gated called Beautiful); 5:12-16 (the apostles heal many).

⁹⁸ Luke 4:18-19 (quoting Is. 61:1,2).

⁹⁹ Jas. 1:27. Later in the letter, James writes, "Suppose a brother or sister is without clothes and daily food. If one of you says to him, "Go, I wish you well; keep warm and well fed," but does nothing about his physical needs, what good is it? In the same way, faith by itself, if it is not accompanied by action, is dead." Jas. 2:15-17.

¹⁰⁰ See Holahan, *supra* note 60 at 2; see also NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8 at 79.

programs.¹⁰¹ Confronted with exorbitant costs for care or insurance, many or most delay or neglect needed, necessary care for themselves and their families.¹⁰² Among these and even among those who seek primary care despite the cost, medical outcomes and deteriorating health is significantly worse among the uninsured, working poor, than those with coverage. These people are sick in America with little reliable recourse.

Although the policy of service and care may be debatable among reasonable, faithful minds, the call to care for the sick and poor is an unswerving and inescapable Biblical edict. Scripture teaches that people fulfill righteous purposes when they care for the sick and take up the cause of the poor.¹⁰³

B. Justice

“He has showed you, O Man, what is good. And what does the Lord require of you? To do justly, to love mercy, to walk humbly with your God.”¹⁰⁴

Justice often eludes clear definition. Justice encompasses concepts of fairness, liberty and equality. Throughout the Bible, however, justice includes special attention to the poor. Where the Bible’s writers invoke justice, it almost always is a call to lift up the poor, vulnerable and disenfranchised.

In Exodus, as the Lord elucidates the Law through Moses, He gives this instruction to those rendering justice:

Do not follow the crowd in doing wrong. When you give testimony in a lawsuit, do not pervert justice by siding with the crowd, and do not show favoritism to a poor man in his lawsuit. . . . Do not deny justice to your poor people in your lawsuits.¹⁰⁵

In the Psalms, the writers invoke justice from the Lord. In Psalm 72, “Of Solomon,” David prays that the Lord will endow the King with justice:

Endow the king with your justice,
O God,
the royal son with your
righteousness.
He will judge your people in
righteousness,
your afflicted ones with justice. . . .
He will defend the afflicted among
the people
and save the children of the

¹⁰¹ See NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8; see also CENTER FOR DISEASE CONTROL AND PREVENTION, *supra* note 2.

¹⁰² See NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 8; see also Hadley, *supra* note 16; see also *Matthew* 25:34-40.

¹⁰³ *Matthew* 5: 16.

¹⁰⁴ *Mi.* 6:8.

¹⁰⁵ *Ex.* 23:2-3, 6; see also *Lev.* 19:15: “Do not pervert justice; do not show partiality to the poor or favoritism to the great, but judge your neighbor fairly.”

needy;
 he will crush the oppressor. . . .
 For he will deliver the needy who cry
 out,
 the afflicted who have no one to
 help.
 He will take pity on the weak and
 the needy
 and save the needy from death.
 He will rescue them from
 oppression and violence,
 for precious is their blood in his sight.¹⁰⁶

In Psalm 82, Jehovah is seen to preside over other, false “gods,” and He issues this admonishment:

How long will you defend the
 unjust
 and show partiality to the wicked?
 Defend the cause of the weak and
 fatherless;
 maintain the rights of the poor
 and oppressed.
 Rescue the weak and needy;
 deliver them from the hand of the
 wicked.¹⁰⁷

Near the close of the book of Proverbs, the author declares this precept: "Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy."¹⁰⁸

In his bleak assessment, the Teacher of Ecclesiastes observes the ubiquitous denial of justice: "If you see the poor oppressed in a district, and justice and rights denied, do not be surprised by such things. . . ."¹⁰⁹

Isaiah addresses the rebellious nation on behalf of the Lord:

Take your evil deeds
 out of my sight!
 Stop doing what is wrong,
 learn to do right!
 Seek justice,

¹⁰⁶ Ps. 72:1-4,12-14.

¹⁰⁷ Ps. 82: 1-4.

¹⁰⁸ Prov. 31:8-9.

¹⁰⁹ Eccl. 5:8.

encourage the oppressed.
Defend the case of the fatherless,
plead the case of the widow.¹¹⁰

Ezekiel prophesied against Jerusalem and listed her sins against the Lord: “The people of the land practice extortion and commit robbery; they oppress the poor and needy and mistreat the alien, denying them justice.”¹¹¹

Amos lists three sins for which the Lord “will not turn back his wrath, ” including this transgression: “They trample on the heads of the poor as upon the dust of the ground, and deny justice to the oppressed.”¹¹²

In Jesus’ early ministry, as the Pharisees began to plot against him, he withdrew:

Many followed him, and he healed all their sick, warning them not to tell who he was. This was to fulfill what was spoken through the prophet Isaiah:

Here is my servant whom I have
chosen,
the one I love, in whom I delight;
I will put my Spirit on him,
and he will proclaim justice to the
nations.¹¹³

In his epistle, James forbids favoritism and injustice to the poor within the Christian community:

Suppose a man comes into your meeting wearing a gold ring and fine clothes, and a poor man in shabby clothes comes in. If you show special attention to the man wearing fine clothes and say, “Here’s a good seat for you,” but say to the poor man, “You stand here,” or “Sit on the floor by my feet,” have you not discriminated among yourselves and become judges with evil thoughts?

Listen, my dear brothers: Has not God chosen those who are poor in the eyes of the world to be rich in faith and to inherit the kingdom he promised to those who love him? But you have insulted the poor. Is it not the rich who are exploiting you? Are they not the ones dragging you to court? Are they not the ones who are slandering the noble name of him to whom you belong?

If you really keep the royal law found in Scripture: “Love your neighbor as yourself,” you are doing right. But if you show favoritism you sin and are convicted by the law as lawbreakers¹¹⁴

¹¹⁰ Is. 1:16b-17.

¹¹¹ Ez. 23:29.

¹¹² Am. 2:7a.

¹¹³ Mt. 12:15b-18.

¹¹⁴ Jas. 2:2-12.

In these passages and others, the prophets and poets link justice with care and attention to the poor, and the messianic description of Jesus' proclamation of justice for the nations is surrounded by stories of healing the sick and distressed.

In the current state of American health care, most citizens enjoy insurance coverage for expensive medical care, affording them access to care and service, affordable examination, treatment and diagnosis for disease and injury.¹¹⁵ Millions of uninsured, working, poor Americans, however, present an issue of biblical justice. This is not a question of justice because humans have a natural right to medical care. Rather, this is a question of justice because the disparity in access to this fundamental staple of life is driven by wealth. Once engaged in the enterprise, if a solution is within its capacity, a body politic, a society, a democratic republic cannot justly abide denying access to medicine to its citizens and neighbors on the basis of affluence or poverty. This is social oppression, and it requires social justice.

In America, those who do not have medical coverage, those who cannot rely on basic health care, are the poor, mostly the working poor. The working poor suffer the misfortune of sickness and injury without reliable, affordable access to the medical care that the middle-class and rich enjoy as an expected benefit of employment. The current system, or non-system, of health care delivery in the United States generates injustice for the poor.

C. Community Burdens

These virtues and moral burdens do not rest solely on individuals but should be manifest within communities of the faithful. In Acts, the fledgling Christians in Jerusalem lived, taught and served in community, even communally:

They devoted themselves to the apostles' teaching and to the fellowship, to the breaking of bread and to prayer. Everyone was filled with awe, and many wonders and miraculous signs were done by the apostles. All the believers were together and had everything in common. Selling their possessions and goods, they gave to anyone as he had need. Every day, they continued to meet together in the temple courts. They broke bread in their homes and ate together with glad and sincere hearts, praising God and enjoying the favor of all the people.¹¹⁶

In I Corinthians, Paul instructs the church there in the propriety of their fellowship meals, the Lord's Supper, and he demonstrates that the community of believers should be a unified fellowship, not a coincidence of individuals:

In the first place, I hear that when you come together as a church, there are divisions among you, and to some extent I believe it. No doubt there have to be differences among you to show which of you have God's approval. When you come together it is not the Lord's Supper you eat, for as you eat each of you goes ahead without waiting for anybody else. One remains hungry, another gets drunk. Don't you have homes to each and drink in? Or do you despise the church of God and humiliate those

¹¹⁵ See CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra* note 2; THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 17, 20; U.S. CENSUS BUREAU, *supra* note 18.

¹¹⁶ Ac. 2:42-47a.

who have nothing? What shall I say to you? Shall I praise you for this?
Certainly not!¹¹⁷

Throughout his letters, Paul uses metaphors to describe the community of believers and their function as a fellowship and in the world. The disciples are a field of crops and a building.¹¹⁸ The community of believers is one body with many parts.¹¹⁹ The church is the household of God, a building on a single foundation that becomes his Temple.¹²⁰

In the Old Testament, God most often admonished, judged, exiled and blessed the people as the People.¹²¹ He rendered individual judgment, but He regularly judged the nation of Israel upon its collective, community virtue or sin. Biblical teaching and prophecy extends through individuals into the actions, failures, successes, policies and righteousness of communities.¹²²

In Isaiah, the prophet exhorts the people of Israel to return to faithful observance of the Law and commitment to God. Isaiah calls on the people to turn from the competing religions of their neighbors and to return to the faith of their forefathers or else suffer the judgment of defeat and exile. In Chapter 58, he admonishes the religious community who adhered to technical religious practice with tenacious obedience but who neglected the foundational moral purpose of God's teaching:

'Why have we fasted,' they say,
'and you have not seen it?
Why have we humbled ourselves,
and you have not noticed?'
"Yet on the day of your fasting, you do as you please
and exploit all your workers.

Your fasting ends in quarreling and strife,
and in striking each other with wicked fists.
You cannot fast as you do today
and expect your voice to be heard on high.

Is this the kind of fast I have chosen,

¹¹⁷ I Cor. 11:18-23.

¹¹⁸ I Cor. 3:5-11.

¹¹⁹ I Cor. 12:26, Eph. 4:25. In Romans, Paul writes, "Do not think of yourself more highly than you ought, but rather think of yourself with sober judgment, in accordance with the measure of faith God has given you. Just as each of us has one body made up of many members, and these members do not all have the same function, so in Christ we who are many form one body, and each member belongs to all the others." Rom. 12:3b-5.

¹²⁰ Eph. 2:19-21.

¹²¹ See, e.g., notes 112-114, *supra*.

¹²² See, e.g., *id*. Some might say that the United States of America is a "Christian Nation," exceptionally ordained for His purposes in the world. If this is so, then how much more will the United States be judged for injustice to the poor, just as Israel's prophets judged those chosen people.

only a day for a man to humble himself?
 Is it only for bowing one's head like a reed
 and for lying on sackcloth and ashes?
 Is that what you call a fast,
 a day acceptable to the LORD ?

“Is not this the kind of fasting I have chosen:
 to loose the chains of injustice
 and untie the cords of the yoke,
 to set the oppressed free
 and break every yoke?

Is it not to share your food with the hungry
 and to provide the poor wanderer with shelter—
 when you see the naked, to clothe him,
 and not to turn away from your own flesh and blood?

Then your light will break forth like the dawn,
 and your healing will quickly appear;
 then your righteousness [a] will go before you,
 and the glory of the LORD will be your rear guard.

Then you will call, and the LORD will answer;
 you will cry for help, and he will say: Here am I.
 "If you do away with the yoke of oppression,
 with the pointing finger and malicious talk,

and if you spend yourselves in behalf of the hungry
 and satisfy the needs of the oppressed,
 then your light will rise in the darkness,
 and your night will become like the noonday.¹²³

IV. IF ACCESS TO HEALTH CARE FOR UNINSURED AMERICANS IS A MORAL ISSUE,
 WHAT SHOULD BE THE BIBLICAL, ETHICAL RESPONSE IN NATIONAL HEALTH CARE
 POLICY?

Very few people of faith would dispute the callings, burdens and ministries owed to the sick, poor and vulnerable as the work of God. The contemporary debate occurs between those who would argue that God has placed this work only on individual followers or congregations, not in the state, and those who would argue that this work and this problem reside with the nation-state or dominant culture where we reside together. This debate arises from two issues: whether Christians have any business engaging the secular state or whether Christians believe that engaging the secular state is effective to achieve the moral goal.¹²⁴

¹²³ Is. 58:1-10.

¹²⁴ This paper primarily addresses Christians' and churches' engagement with public, governmental policy. Of course, individual Christians, churches and denominations certainly

A. Philosophy of Government and the Religious Community

Romans 13 is the most direct address in the New Testament on the role of government and the governed. There, Paul admonishes the faithful subject of the Roman Empire “to submit himself to the governing authorities, for there is no authority except that which God has established. The authorities that exist have been established by God.”¹²⁵ Paul describes the sovereign’s governor and explains the need to submit:

He is God’s servant, an agent of wrath to bring punishment on the wrongdoer. Therefore, it is necessary to submit to the authorities, not only because of possible punishment but also because of conscience.

This is also why you pay taxes, for the authorities are God’s servants, who give their full time to governing. Give everyone what you owe him: If you owe taxes, pay taxes; if revenue, then revenue; if respect, then respect; if honor, then honor.¹²⁶

Paul marks a clear delineation between the governor and the governed, the sovereign and the subjects. In Rome, as in most of the world until the Enlightenment, subjects and citizens had virtually no peaceful voice in their government. Sovereigns ruled by Divine Right or force of might with complete authority. The Emperor ruled, and the subjects served.

As a Roman citizen, Paul enjoyed some privileges in the Empire, but by the time of his writing, Emperor Nero ruled as a dictator with no obligation to any representative Senate. Even so, Paul describes the government in terms of righteous ministry from God, and he teaches Christian citizens to submit and to pay their dues to the State. Jesus famously replied to those religious leaders who sought to trap him with a question of taxation by the occupiers: “Give to Caesar what is Caesar’s, and to God what is God’s.”¹²⁷

After centuries, Western thought reclaimed Greek notions of democracy. Enlightenment philosophers began to criticize unreasoned, obsequious genuflection to a throne and bridled against the notion of a Divine Right. These ideas found their experimental home in the British colonies of North America, and perhaps for the first time in human history, the stark distinction between Sovereign and Subject, Governor and Governed, blurred as a new social compact became manifest. The boldest and clearest articulation of this experiment appears in the Declaration of Independence:

must and should engage this problem privately and independently. Of note, Catholic, Baptist, Methodist and Jewish denominations and organizations operate extensive, successful hospital systems that treat the poor and indigent with great compassion, charity and effect. Individual doctors and their clinics operate with great losses to provide care to people without insurance. Inner-city ministries offer clinics and health programs. The examples are myriad, diverse and extensive and often secret. These ministries and efforts are immense, necessary, godly and consistent with this gospel ethic.

¹²⁵ Rom. 13:1.

¹²⁶ Rom. 13: 4b-7.

¹²⁷ Mt. 22:21; Mk. 12:17; Lk. 20:25.

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. — That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed, — That whenever any Form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it, and to institute new Government, laying its foundation on such principles and organizing its powers in such form, as to them shall seem most likely to effect their Safety and Happiness.¹²⁸

Justifying the proposed Constitution and urging its ratification, James Madison articulated the theory of American republican government in *The Federalist No. 39*:

What then are the distinctive characters of the republican form? . . . [W]e may define a republic to be. . . a government which derives all of its powers directly or indirectly from the great body of people; and is administered by persons holding their offices during pleasure, for a limited period, or during good behavior. It is *essential* to such a government, that it be derived from the great body of the society, not from an inconsiderable proportion, or a favored class of it. . . It is *sufficient* for such a government, that the persons administering it be appointed, either directly or indirectly, by the people . . .¹²⁹

In Romans, Paul admonished citizens and subjects to submit and to pay rightful dues. Christ called his followers to be salt and light, to be shining lights, to glorify God and to transform the world by their presence in the world.¹³⁰ Christ did not call for the overthrow of governments or the co-opting of the state to achieve spiritual ends. The apostles did not advocate for reform of the Roman state to ensure justice, although the apostles and prophets certainly do call for justice.

Paul explained that governments exist by God's hand to administer His will. When Christ encountered government officials, functionaries and soldiers, he did not command them to leave their posts but to act justly and to love mercy.¹³¹ When Paul taught Roman soldiers, even his own jailers, he did not teach them to leave the Empire's service, but he converted them to the way of Christ.¹³² In Romans, he declared magistrates and functionaries to be God's servants to administer justice and government.¹³³

¹²⁸ THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776)(quoted in pertinent part, emphasis added).

¹²⁹ *Federalist* No. 39 (quoted in pertinent part, emphasis in original).

¹³⁰ *See* Matt. 5-7 (The Sermon on the Mount).

¹³¹ *See, e.g.*, Mt. 8:5-13, Lk. 7:1-10 (Jesus praising the faith of the centurion on behalf of his servant); Lk. 19:1-9 (Zacchaeus, the wee little man); Ac. 10 (Peter and Cornelius the centurion in the Italian Regiment); Ac. 24-26 (Paul before Felix, Festus and Agrippa, concluding, "Short time or long – I pray that not only you but all who are listening to me today may become what I am (a Christian), except for these chains," at 26:29).

¹³² *See, e.g.*, Ac. 16:28-34.

¹³³ *See* Rom. 13: 4-6.

In the United States of America, however extraordinarily, individual subjects are the collective sovereign. The governed govern themselves. The sharp distinction Paul observes between the State and its citizens does not exist in the United States. Rather, the roles coalesce where the people have an active, fruitful voice in their own affairs, representatives and policies. The government responds directly to the will of the people, at least regularly at the ballot box, if not more frequently as private interests press the government to move. Thus, every American, including American Christians, bears the dual burdens of submissive citizenship and righteous, merciful sovereignty. In matters of governance and policy, Christian Americans must abide the Rule of Law, must submit to just laws and must seek to implement just and useful governmental policies and laws.

Scripture asserts an obligation is to “do all things to the glory of God,” to approach all of the work given to a believer as if it were God’s very work.¹³⁴ If Americans are both subject and sovereign, then American Christians are bound to consider public policy and the role of the public, secular government as if it were God’s own work, to His glory. At the very least, Americans who seek to obey this scriptural mandate must consider public policy, law and the government as potentially just, useful, prudential, wise and effective solutions to the problems besetting neighbors in the great community.

In the instant health care debate, Christians must consider their roles as governed and government. If the public policy is unjust, then Christians must answer as participants in that public policy, as self-governors. If the free marketplace is unjust, then Christians must answer as suppliers and demanders, buyers and sellers, consumers and providers, individually and communally, being cautious to avoid holding the free market as sacrosanct before unjust effect. If our health care system obstructs basic care for the poor, entrenches illness and hastens the death for those on the economic margin of our nation, then Christians should be aware and active to remove those obstacles.

If Christians would seek to rectify an unjust policy or state of circumstance, then Christians rightly should consider the judicious use of the State to address the problem. If progressive use of government is a useful means to address the great disparity in health care for the working poor in the United States, the great waste of resources in a skewed marketplace and the adverse effect on the life and health of less affluent neighbors, then Christians should make good use of the available tools.

B. Policy Considerations

The United States of America has the capacity to provide universal health care to every citizen, regardless of wealth or station. These solutions range across a spectrum, from a libertarian, pure free market, wholly dependent on a voluntary, private, charitable safety net, to a purely socialized system in which the government employs every doctor and owns every hospital. Probably, neither of these extremes is realistic, politically expedient, efficient or effective in America. If Christians are to engage this problem as a moral imperative, they should do it with informed, sophisticated, practical excellence.

¹³⁴ See I Cor. 10:31; Col. 3:23-25 (addressing slaves: “Whatever you do, work at it with all your heart, as working for the Lord, not for men, since you know that you will receive an inheritance from the Lord as a reward. It is the Lord you are serving. Anyone who does wrong will be repaid for his wrong, and there is no favoritism.”).

Very likely at this moment in history, the political will exists to attempt a policy solution to the dual and related problems of the vast uninsured population and hysterically rising prices. The problems are of such complexity and engage so many stakeholders, that a single, unified compromised policy probably is not practical or achievable. Probably, policies will arrive in piecemeal, confronting the vast, uncoordinated and often adversarial marketplace. Policy solutions must at least engage these principal actors:

- Private companies who insure most Americans,
- Employers who provide most of the premiums for most Americans,
- Private physicians and providers who make healthy profits from private-pay patients but who barely break even with Medicare and Medicaid patients,
- Pharmaceutical companies who enjoy massive profits but who invest enormous treasure in risky research and development,
- Medical schools whose cost and rigor dramatically drive career options and opportunity for new physicians,
- Federal administrative agencies who do not directly administer health care but who monitor it and distribute funds for it,
- State governments who already labor under immense budgetary pressure to provide
- SCHIP and Medicaid programs, under federal mandate and with federal contributions,
- The uninsured, working poor whose plight drives the debate,
- The insured majority with a great interest in maintaining quality, choice, access and affordability.

Policy solutions must at least contemplate these dynamic forces pressing on the marketplace and its participants:

- Profit-motive as a natural motivation for providing services, innovating practices, developing drugs and equipment and entering the field,
- The “cost of poverty” that drives increased prices for all, then increased premiums for all, as private actors absorb the cost of free care to the uninsured without public support,
- A great desire for perceived patient choice among providers,
- Prices rising radically faster than inflation or gross domestic product,
- Distributive risk and risk assessment as integral theories of insurance,
- Federal and state budgetary priorities and revenue generation,
- National economic recession, depression or recovery,
- Baby Boomers rapidly approaching retirement and Medicare eligibility,
- Specialty selection among new physicians,
- Overall perceived quality-of-care, timely access and medical outcomes,
- Preventative care and disease maintenance at contrast with disease treatment,
- Disproportionate costs generated by a small fraction of patients, particularly with preventable, life-style oriented chronic conditions.

American Christians interested in extending health care to the poor and committed to rectifying the injustice of health care based on wealth, should consider policy proposals that are just but that also are effective and seek excellence and justice throughout the marketplace. Individual liberty and governmental capacity, free-market economic forces and administrative regulation, personal responsibility and community charity, private sector and public policy all meet in this debate, but they all should bend toward solutions that achieve a sustainable, profitable and just health care system.

V. CONCLUSION

As a nation, we should not leave those without access to adequate health care to suffer and die merely because they cannot afford it. Access to sufficient health care is a question of biblical, ethical, social justice, no less important than food, shelter, security and education. In the interest of justice, Christians should not accept a situation where access to basic health care is determined by affluence or poverty.

This disparity is not necessary or inevitable. The United States spends vastly more per capita on health care than any other nation, publically and privately, yet the gap and this unjust disparity persists. In the instant health care debate, people of faith must consider their dual roles as governed and government. If the public policy is unjust, then we must answer as participants in that public policy, as self-governors. If the free marketplace is unjust, then we must answer as suppliers and demanders, consumers and providers, individually and communally. If our health care system obstructs basic care for the poor and entrenches illness for those on the economic margins of our society, then we should be aware and active to remove those obstacles.

If people of faith would seek to rectify this injustice, then we rightly should consider the judicious use of the State to address the problem, because we all are the State. Religious communities should engage the government to promote a just, merciful, loving and smart public policy. Progressive use of government is a prudent, useful means to address the great disparity in health care for our working, poor neighbors.