

# The Family in America

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## **Family-Friendly Health Care: How to Make Health Care Pro-Marriage, Pro-Life, and Affordable**

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**THE PATIENT PROTECTION AND AFFORDABLE CARE ACT** no doubt has lowered out-of-pocket financial costs for some Americans, but at the moral cost of requiring many Americans to participate in the funding of contraception against the dictates of their conscience and at the social cost of diluting the consequences of individual irresponsibility across an unfathomably wide risk pool maintained by a cumbersome bureaucracy. The resulting system mistakenly regards health insurance as a prerequisite for health care, as if mandating the former somehow guarantees the latter; deceptively equates “reproductive health care” with procedures and prescriptions that are counter-reproductive and dubiously caring; and undermines the natural family through mandates and incentives that run contrary to marital fidelity and personal responsibility.

With problems so challenging, no easy correction to the ACA regime can be found. However, two alternatives to the health insurance framework of the ACA correct at least some of the deficiencies: “health care sharing ministries” fund health-care costs even for the less affluent, without requiring the violation of pro-life consciences; and direct primary care arrangements reward individuals who assume personal responsibility for routine care while saving the catastrophic and unpredictable for either insurance or a cost-sharing ministry. While neither of these approaches comes without challenges, each deserves careful contemplation by health-care consumers. In fact, some families may find it prudent to pursue both avenues simultaneously.

### **Does the ACA Make Health Care Unfriendly to the Family?**

As the statute's name implies, the Patient Protection and Affordable Care Act of 2010 was intended to protect patients and to make health care affordable. Although some of the provisions in the labyrinthine regulations established by the act may accomplish one or the other goal, other provisions in fact endanger patients and make health care less affordable. These downsides to the ACA can be most readily observed by viewing the law through the lens of the natural family. The ACA discourages marriages, subsidizes birth control, and makes only modest improvements in the coverage of pregnancies for newly insured mothers, all the while underwriting imprudent behaviors—such as extramarital intercourse and substance abuse.

The message of the ACA to couples is simple: better not to marry. For a cohabiting couple, each adult may qualify individually under the ACA for a premium subsidy, which phases out for each person as his or her income approaches 400% of the federal poverty threshold (FPT)—roughly \$47,000 per person, or \$94,000 for their joint household if each cohabiting adult brings home half the bacon. For a married couple, by contrast, 400% FPT comes to about \$63,000, since the FPT for a household of two adults is far less than twice the FPT for one adult. Because of additional quirks in the subsidy formula, the differential hits hardest in the center of the qualifying range, where a household earning \$40,000 per year suffers a \$1,400 marriage penalty.<sup>1</sup> Can families in the lower middle class really afford a penalty that effectively constitutes 3.5% of their household income just because they are married?

A policy designed to help single moms—the most uninsured segment of the population—now incentivizes both moms and dads to remain or become single. The ACA subsidies do not so much benefit middle-class *families* as they do middle-class *households*—collections of unmarried adults, possibly with children, who live under one roof but each collect state benefits separately while not formally promising each other to remain together for life. Ironically, couples who married before the ACA was enacted in order to secure the benefit of a spousal health insurance plan now realize that they no longer can afford the higher, less subsidized premiums. “I guarantee you,” confessed one millennial bride pinched in the ACA's marriage-penalty vise, “in six months I will either

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1. Devon M. Herrick, “The Health Exchange Marriage Penalty,” National Center for Policy Analysis, Brief Analysis 788 (November 7, 2013), Web.

be divorced or I will have a [second] full-time job.”<sup>2</sup> Oddly, the ACA does not require insurers to cover spouses (and in fact some employers dropped spousal coverage to trim costs<sup>3</sup>), but the law’s “individual mandate” does require each spouse to obtain insurance somehow, whether this makes marriage cost-prohibitive or not.

The ACA includes puzzling provisions for young adults, too. For example, the legislation requires employer group plans to extend coverage to employees’ children under 26 years of age, but it does so regardless of whether these adult “children” are financially independent, living in their own households, or married.<sup>4</sup> “This is known as the ‘adult-dependent mandate,’” or ADM, “although dependency is not a condition for coverage.” In fact, the misnamed ADM even requires that employer health plans extend coverage to adult children who are gainfully employed and have the option to receive insurance from their own employer rather than from a parent’s employer. Nevertheless, spouses and children of the young adults are excluded from this mandate, but still subject to the individual mandate.<sup>5</sup> In other words, Dad, age 25, might be insured on Grandpa’s policy, while Mom and Junior have to seek coverage elsewhere. A more family-friendly regulation would instead foster cost-effective health-care plans for young adults who are holding down jobs and forming families—precisely the course charted by health-care sharing ministries (discussed below).

Meanwhile, the ACA’s phase-in provisions for plan years prior to 2014 fell short of guaranteeing maternity benefits, whether to principal policy holders or to their children of reproductive age. Although maternity and newborn care ostensibly were included among the ten “essential health benefits” of the ACA, and insurance providers were prohibited from excluding maternity coverage to the newly insured

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2. Garance Franke-Ruta, “The Hidden Marriage Penalty in Obamacare,” *The Atlantic*, November 5, 2013, Web.

3. “UPS Cuts Insurance to 15,000 Spouses, Blames Obamacare,” *CNN Money*, August 21, 2013, Web.

4. Tyler Hanson, “Barefoot and Pregnant: How the Patient Protection Affordable Care Act Will Leave Young Mothers to Fend for Themselves,” *Public Interest Law Reporter* 18.1 (Fall 2012): 23–6, at 23–4.

5. Paul Fronstin, “Mental Health, Substance Abuse, and Pregnancy: Health Spending Following the PPACA Adult-Dependent Mandate,” *Employee Benefit Research Institute Issue Brief* 385 (April 2013): 4, Web.

(being prohibited from excluding pregnancy as a pre-existing condition), large group policies initially were grandfathered into an exclusion of these new provisions. As of 2012, “roughly 70 percent of companies that pay their employees’ health-care claims directly ch[o]se not to provide dependent maternity benefits,” a ratio that some analysts projected to increase as the age of “dependent” rose to “children under 26.”<sup>6</sup>

Insurance companies had a financial incentive to limit the inclusion of young adult dependents when possible. During the early years of implementation for the ACA, the ADM cohort of newly insured incurred a disproportionate level of health-care expenses, especially in the categories of mental health, substance abuse, and pregnancy. The ADM cohort spent 27% more overall on medical services than a pre-ADM cohort of dependents aged 19 to 25 who were insured prior to 2011. Mental health and substance abuse treatments accounted for 42% of hospital in-patient claims for the ADM cohort, compared to only 28% for the comparison group; pregnancy rates (primarily non-marital) also were significantly higher: 19% versus 5% of hospital in-patient claims for each group.<sup>7</sup> In other words, the addition of new dependents to the insurance pool under the ADM has increased risk and, hence, cost. Compassionately, the government extended insurance to cover those with greater needs, but through a compulsive regulatory instrument that offered nothing to fix the root cause and, worse, incentivized the imprudent behaviors of some by requiring that others bear the consequences.

Most infamously, the ACA requires that employers provide insurance that covers the purchase of birth control, including abortifacients. Church-affiliated nonprofits as well as Christian-owned businesses have challenged this provision on the basis of a First Amendment conscientious objection to subsidizing behaviors classified as immoral by their religious beliefs.<sup>8</sup> The problem, however, runs deeper than the surface issue of church versus state, as significant as that controversy may be. In a broader sense, the hallmark case, *Burwell v. Hobby Lobby* (2014), represents the regression of American political culture from freedom of

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6. Hanson, “Barefoot and Pregnant,” 24.

7. Fronstin, “Mental Health, Substance Abuse, and Pregnancy.”

8. Jessica Donoghue, “*PeopleV.US* [sic] v. *Obama*: An Analysis of Religious Challenges to the Patient Protection and Affordable Care Act,” *Rutgers Journal of Law & Religion* 12.1 (Fall 2010): 202–23; Holly Fernandez Lynch, “Religious Liberty, Conscience, and the Affordable Care Act,” *Ethical Perspectives* 20.1 (2013): 118–31.

contract back to the more primitive condition of competition for status. The deeper question at stake was not, as it may have seemed, whether Hobby Lobby would be free to choose for itself whether to fund contraception for its employees, but rather whether the federal government would grant a privileged status to a class of certain women (and pharmaceutical companies) who desire that government-mandated insurance policies fund contraception or grant a privileged status to a class of other women (and men) who, for religious reasons, object to funding abortifacient contraception. “A free society,” explains Cato Institute research fellow Trevor Burrus, “is like an operating system that helps diverse, civilized people live together cooperatively rather than combatively. Politics and overpoliticization, on the other hand, inevitably push us to live combatively rather than cooperatively, especially when it comes to issues like healthcare.”<sup>9</sup>

Burrus traced the problem back to its origin in five stages. First, the government imposed wage limits during World War II. In order to compete for highly qualified employees, companies began offering benefits in place of wages. Second, the IRS granted favorable tax treatment to companies that paid for health insurance as an employment benefit, thus encouraging the expansion of employer-based health plans. Third, Americans began to regard insurance as synonymous with health care, rather than regarding the former simply as one possible vehicle for funding the latter. Fourth, legislative sponsors of the ACA utilized the same rhetorical sleight of hand in order to persuade Congress that insurance must become mandatory for everyone in order for health care to become available for everyone. Fifth, the true costs of universalizing health care became masked by the requirement that insurance, rather than a direct government entitlement, fund it.

By this time, employers such as Hobby Lobby found themselves at odds with women seeking free birth control, when in fact neither of them was at fault for creating the conflict. Rather, “bad policies will often—if not usually—invent problems out of thin air. . . . For example, a bad policy regulating the national haircut would create the long-hair and short-hair factions, each trying to impose their views on the other.”<sup>10</sup> If

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9. Trevor Burrus, “From Status to Contract to Status: *Burwell v. Hobby Lobby* and the Primitivism of Politics,” *New York University Journal of Law & Liberty* 9.60 (2015): 60–69, at 69.

10. *Ibid.*, 61.

a haircut policy were to happen, then the only recourse (short of dismantling the entire haircut bureaucracy) would be to petition for favored status. Similarly, in the contraception controversy: Hobby Lobby's petition won a narrowly defined exception—a favored status alongside the favored status of women seeking government-sponsored birth control—while many other conservative litigants failed to obtain a favored status of their own. However, at the legislative stage of the status competition, one notable group of conservatives achieved a quiet victory and, in the wake of the ACA, their special exemption has given them ample room to multiply: the health care sharing ministries. A more libertarian society would not require a special exemption in the first place, and a more virtuous society certainly would not require an exemption in order to avoid becoming complicit in a public policy that subsidizes immoral acts, but citizens cannot always choose which kind of society they will have, only how best to cope with it.

### **Evangelicals Opting Out of the ACA: Health Care Sharing Ministries**

The Amish and Old Order Mennonites, due to their long-standing practice of sharing each other's financial burdens within a closed community and conscientiously objecting to government aid programs, are exempt from the individual mandate of the ACA.<sup>11</sup> A few other classes of individuals also are exempt: prison inmates, the very poor (who even with a subsidy still could not afford insurance), and persons who participate in a health care sharing ministry. The ACA defines a "health care sharing ministry" as:

an organization . . . members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed, . . . [and] which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999.<sup>12</sup>

It seems that only four organizations qualify under the grandfather

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11. Dayna Roane, "Religious Exemptions from the Health Care Individual Mandate," *Journal of Accountancy*, March 2014, web.

12. 26 U.S.C. 5000a(d)(2)(B).

clause requiring continual operation since 1999, listed from largest to smallest membership: Samaritan Ministries International, Medi-Share Christian Care Ministry, Christian Healthcare Ministries, and Liberty HealthShare. The first three require members to affirm a specifically Christian statement of faith, whereas Liberty HealthShare, although also founded by Christians, requires only agreement with particular ethical convictions common to many Christians, Jews, Mormons, and people “who don’t identify with any of these groups.”<sup>13</sup> Since the enactment of the ACA in 2010, membership in these four HCSMs has tripled, nearly quadrupled, to over 400,000 individuals nationwide who share more than \$340 million annually.<sup>14</sup> As a fuller implementation of the ACA rolled in during the early months of 2014, monthly enrollments in the ministries doubled and even tripled prior records.<sup>15</sup> Samaritan Ministries experienced another record monthly enrollment in January 2015, likely from employees electing to view “open enrollment” season as time for abandoning health insurance altogether.<sup>16</sup>

Each health care sharing ministry (HCSM) operates in its own way, but the general pattern may be understood by considering Samaritan’s approach:

A family agrees to share about \$400 per month with any family having a healthcare need assigned to the first family. So, if Mr. Jones has a medical bill for \$4,000, Samaritan Ministries asks ten of its member families each to send a check to Mr. Jones for \$400 that month. Unlike traditional insurance, medical cost-sharing is charity-based, not contract-driven. Samaritan members do not pay premiums to the central office, but instead pay their shares directly to families in need. Moreover, biblical morality shapes the entire process, including both

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13. “Liberty HealthShare Member Beliefs,” *Liberty HealthShare Blog*, March 9, 2015, Web.

14. Lora Hines, “Christians Save on Health Care by Joining Ministries That Share the Costs,” *Houston Chronicle*, August 22, 2014, Web; Tracy Seipel, “Obamacare: ‘Health Care Sharing Ministries’ Increase Membership in Wake of New Law,” *Mercury News*, July 27, 2014, Web; Charlene Galameau, “Health Care Sharing Ministries and Their Exemption from the Individual Mandate of the Affordable Care Act,” *Journal of Bioethical Inquiry* (February 2015), Web; Alliance of Health Care Sharing Ministries, “What Is Health Care Sharing?,” [www.healthcaresharing.org/hcsm](http://www.healthcaresharing.org/hcsm), accessed May 30, 2015.

15. Kate Shellnutt and Kate Tracy, “Obamacare’s Bump: More Christians Now Sharing Health Care Costs,” *Christianity Today*, April 4, 2014, Web.

16. “A New Record Month of Growth,” This Month at Samaritan, February 2015, Web.

a prohibition of sponsoring immorality (such as abortion) as well as a positive command to bear the burdens of one's neighbor: "Bear one another's burdens, and so fulfill the law of Christ" (Galatians 6:2).<sup>17</sup>

Samaritan members are young and healthy: 1 in every 21 member households experiences the birth of a child each year (compared to 1 in every 31 households nationwide), but only 1 in every 1,115 member households experiences a death (compared to 1 in every 48 households nationwide).<sup>18</sup> Samaritan's monthly Christian Healthcare Newsletter features practical advice for healthy marriages, healthful cooking, and alternative approaches to obtaining medical care—including critiques of the vaccine industry and an overview of direct primary care. All four HCSMs combine prudent, responsible living with prayerful giving to keep costs low. Even so, medical needs occasionally must be prorated down 10% or so when the monthly shares fail to suffice for all requests. After this occurred a few times, Samaritan members voted to increase their monthly shares in 2014. Since that increase, however, members have experienced several surplus months; for example, in May 2015 Samaritan announced a 5% reduction in shares, because "the amount of needs submitted for publication this month was less than the amount of share money available."<sup>19</sup> Discounted membership rates are available for young adults, thus encouraging 20-somethings to take responsibility for themselves and their own children rather than remaining under a parent's insurance policy through the adult-dependent mandate of the ACA.

Since HCSMs are not insurance companies, membership provisions lack the legally binding guarantees that claims will be paid. Since they are exempt from the new ACA standards, they also generally exclude pre-existing conditions for the first twelve months. However, these ministries offer other benefits that continue to generate new enrollment, including: significantly lower costs (roughly half the monthly rate of a

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17. Ryan C. MacPherson, *Rediscovering the American Republic: Biographies, Primary Texts, and Study Questions—Exploring a People's Quest for Ordered Liberty, Vol. 2: 1877–Present* (Mankato, MN.: Into Your Hands, 2013), 724.

18. Annualized from Samaritan's monthly statistics for December 2014, as reported in *Christian Healthcare Newsletter*, January 2015, p. 2; compared with nationwide statistics for 2013 reported in Joyce A. Martin *et al.*, "Births in the United States, 2013," *NCHS Data Brief* 175 (December 2014); Kenneth D. Kochanek *et al.*, "Mortality in the United States, 2013," *NCHS Data Brief* 178 (December 2014).

19. Samaritan Ministries, *This Month at Samaritan*, May 2015.

typical bronze plan under the ACA, and without the \$5,000/individual deductible and 40% coinsurance), avoidance of subsidizing immoral acts (such as abortion), and the opportunity to receive beyond one's expectations. For example, although Samaritan Ministries does not include orthodontic expenses among its "publishable needs," it does list them in an optional "special need" category, and it treats pre-existing conditions similarly. If each member notified of such a special need contributes just \$20, the need will be met in full; members often do so, and many members also submit additional gifts to support families who cannot afford the full monthly membership share. Members also negotiate with providers for substantial cash-and-carry discounts. As a result of individual self-discipline and communal generosity, medical cost-sharing ministries have successfully provided even catastrophic coverage, such as for heart surgery. More common occurrences, like childbirth, often are fully absorbed by negotiated discounts and member-to-member sharing, resulting in zero out-of-pocket expenses for the patient. One family discovered that the birth of their son—under an employer's high-deductible, Health Savings Account plan—involved nearly \$4,000 in out-of-pocket expenses. The birth of their daughter—a few years later, and now on a health care sharing ministry—was fully reimbursed by gifts from fellow members. Moreover, HCSMs tend to be far more flexible than insurance companies in allowing patients the choice of their providers, including midwives for home births.<sup>20</sup>

Members generally experience high satisfaction; even while acknowledging imperfections in the system they tend to weather the storms and stay enrolled in the ministries.<sup>21</sup> Criticism comes primarily from non-members. For example, Charlene Galarneau, Assistant Professor of Women's Studies at Wellesley College, has identified five "significant ethical and policy concerns" of HCSMs: 1) they mimic insurance and yet seek to avoid regulations imposed upon insurance companies; 2) they pose as being distinctive religious communities (like the Amish), even though they are theologically diverse and otherwise participate

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20. Interviews with anonymous members of HCSMs, 2014–2015.

21. Lissa Anglin, "Samaritan Ministries Review: A Year Later," April 16, 2013, [www.lissaanglin.com/blog](http://www.lissaanglin.com/blog); "Health Care Sharing Ministry Members Share Their Experiences," November 27, 2013, [www.selfpaypatient.com](http://www.selfpaypatient.com); Jenn, "What We Think of Samaritan Ministries After One Year as Members," April 2014, [www.thepurposefulmom.com](http://www.thepurposefulmom.com); Holly Johnson, "Do You Believe in Health Care Sharing Ministries?," *The Simple Dollar*, January 29, 2015, Web.

in mainstream American culture; 3) they champion religious liberty at the expense of social justice; 4) they undermine the policy goals of the ACA; and 5) they arguably fail to comply with the ACA exemption requirements.<sup>22</sup> Upon closer inspection, each of these charges may be readily defused.

In reply to the first concern, most states recognize by a “safe harbor” statute that HCSMs are distinct from insurance and exempt from insurance regulations; with a few exceptions, most notably a Kentucky Supreme Court ruling against Medi-Share in 2010, HCSMs have escaped legal challenges unscathed, and by amending its policies even Medi-Share now passes muster in Kentucky.<sup>23</sup> As for Galarneau’s second concern, although supporters of HCSMs sometimes deploy Amish-like rhetoric, the Department of Health and Human Services has certified that the four HCSMs discussed above qualify for a distinct exemption—as cost-sharing ministries rather than as separatist religious communities—and it is this HHS determination, not individuals’ rhetoric, that matters.<sup>24</sup> Third, in regard to compromising social justice, Galarneau has in mind that HCSMs do not cover contraception or abortion and, because of the ethical expectations they have of their members, HCSMs do not cover childbirth expenses for unwed mothers—policies that she considers a “gendered double standard.”<sup>25</sup> However, she neglects to mention that Samaritan Ministries, for example, has established a separate organization, called the Morning Center, “to provide free full-service maternity care to women in urban and under-served areas where quality care is limited and scarce.”<sup>26</sup> Many members of HCSMs also donate their money and time to support local crisis pregnancy centers that serve unwed mothers without restriction.<sup>27</sup> In essence, the members see their HCSM as a means for sharing each other’s burdens within a framework of responsible self-discipline while they seek to serve additional needs

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22. Galarneau, “Health Care Sharing Ministries.”

23. Benjamin Boyd, “Health Care Sharing Ministries: Scam or Solution?,” *Journal of Law and Health* 26.2 (2013): 219–83.

24. The HHS determination letters for two of the ministries may be found at: [www.healthcaresharing.org/about](http://www.healthcaresharing.org/about).

25. Galarneau, “Health Care Sharing Ministries,” [10].

26. The Morning Center, “Our Mission,” accessed August 10, 2015, Web.

27. Interviews with anonymous members of HCSMs, 2014–2015.

through compassionate giving to other agencies. As to undermining the policy goals of the ACA, Galarneau objects that HCSMs remove their members from the “national risk-sharing group” and therefore contribute to “higher (even if minimally higher) risks and costs to those who remain.”<sup>28</sup> However, another critic of HCSMs has concluded that “membership is unlikely to become large enough to undermine ACA risk pooling.”<sup>29</sup>

At present, membership amounts to roughly one out of every 1,000 Americans, all of whom are eligible to “claim a coverage exemption [from the individual mandate] for yourself or another member of your tax household for any month in which the individual was a member of a health care sharing ministry for at least 1 day in the month,” as specified in the instructions to IRS Form 8965.<sup>30</sup> The combined forces of evangelical enthusiasm and IRS permission likely will result in stable, if not growing, memberships for HCSMs, despite objections from third parties. Moreover, the high birthrate among member families suggests that HCSMs will have a more sustainable population pyramid than the larger, but rapidly aging, population participating in the ACA mandates.

### **No More Middle Man: The Growth of Direct Primary Care**

Whether funding larger health needs through a health care sharing ministry or health insurance, a growing number of American families are turning to direct primary care for their smaller, more routine health-care needs. Benefits include cost reduction, convenience, and flexibility. Generally, “direct care” means that the provider offers services on a cash-only basis, whether through monthly membership fees or through direct billing for services used. For the provider, this lowers overhead costs by eliminating insurance paperwork and also increases flexibility by removing both insurers and government regulators from the patient-doctor conversation of what constitutes appropriate care. These benefits in turn pass to the patient, who also enjoys increased transparency and greater autonomy throughout the process. Direct care does, however,

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28. Galarneau, “Health Care Sharing Ministries,” [10].

29. Timothy Stoltzfus Jost, “Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them,” *St. Louis University Journal of Health Law & Policy* 5.27 (2011): 27–82, at 44.

30. “Instructions for Form 8965: Healthcare Coverage Exemptions” (2014), available at [www.irs.gov](http://www.irs.gov).

require a new (or rather, an old-fashioned) mindset. As the recently launched IAMDirectCare website explains, direct care shifts the consumption of health care away from an attitude of collecting entitlements through government-mandated insurance policies toward responsible planning for one's needs:

You have car insurance, right? But you don't use that car insurance at the pump, or for oil changes, do you? Of course not, because that wouldn't make sense. You pay the mechanic or gas station directly for those day to day things, and save the insurance for the more emergency-type situations such as accidents, or major repairs. You wouldn't dream of filing a claim each time your gas light comes on, so why would you file a claim for a flu shot?<sup>31</sup>

Direct payments for health care significantly improve transparency. Continuing the car analogy, when a motorist brings a car to a mechanic for a repair, the mechanic diagnoses the problem, provides an estimate for parts and labor, and may also offer to complete additional maintenance (new wiper blades, a new v-belt, *etc.*), estimating additional costs for those parts and labor. The motorist then evaluates the costs and benefits and authorizes some or all of the proposed work. Upon picking up the vehicle, the motorist pays the bill—usually quite close to the mechanic's initial estimate. There are no behind-the-scenes negotiations with third-party bureaucracies, no preferred-provider restrictions, and no “estimate of benefits” forms that arrive in the mail two months later, nor is there any toll-free number to call and remain on hold awaiting someone who will explain it all in plain English. Direct-care advocates believe that health care should, and can, be that simple—especially when it is routine care; direct-care participants choose to save insurance for the catastrophic and unpredictable.

So how does it work in practice? Membership-based direct primary care involves a monthly fixed rate (for example, \$75 per individual or \$150 per family) that covers as many office visits as necessary, including routine diagnostic procedures, such as blood tests and EKGs. Those preferring not to pay the membership fee may instead purchase health care *à la carte* after contemplating the menu of services and price list

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31. “What Is Direct Care?,” [iamdirectcare.com](http://iamdirectcare.com), accessed August 10, 2015

on the provider's website.<sup>32</sup> Frustrated with insurance paperwork and financial incentives that ran contrary to patient needs, Bruce Jung, M.D., went off the insurance grid to open the Doc Shoppe in Corbin, Kentucky, where he charges a pure-and-simple \$50 per 15 minutes for an office visit, thus \$200 for a full hour, plus \$20 for urinalysis, \$25 for a complete blood count (CBC), \$30 for an EKG, and \$50 per inch for stitches. Alternatively, the charge for stitches will be discounted by 90% and the other fees waived entirely for patients enrolling as members: \$50 per month per individual, \$100 per couple, or \$150 per family—whether paid by patients or by their small-business employers who, although exempt from the ACA employer mandate, desire to assist their workers in obtaining affordable care.<sup>33</sup>

For those who cannot afford even the cost-efficient terms of direct primary care, some communities offer faith-based free health clinics. For example, the Good Samaritan Clinic in Tuscaloosa, Alabama, began in 1999 when a physician, a social worker, and a nurse discussed, at a meeting of the Tuscaloosa Baptist Association, the possibility of providing health care free of charge to those who could afford no other option. Ten years later, on the eve of the passage of the ACA, the Good Samaritan Clinic was serving 600 new patients annually, totaling 2,000 to 3,000 visits throughout the year.<sup>34</sup>

### **Policy Recommendations**

Scenarios, whether real or imagined, can easily be presented to demonstrate the superiority of either the ACA, HCSMs, or direct care; none “wins” all of the time. However, both HCSMs and direct-care arrangements offer distinctive advantages in situations that are common to many Americans—including Americans toward the bottom end of the socioeconomic spectrum who were supposed to benefit under the ACA. Social consciousness therefore should recognize, at minimum, that HCSMs and direct care deserve some turf of their own in the American health-care landscape. This point draws further support, especially in

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32. Jed Stuber, “Member Doctors Adopt New Model for Primary Care,” *Christian Healthcare Newsletter*, May 2015, 8–9.

33. [www.docshoppe.net](http://www.docshoppe.net).

34. Linda L. Dunn, “Making a Difference: Initiating and Maintaining a Faith-Based Free Health Clinic,” *Family and Community Health* 32.4 (2009): 339–44.

the case of HCSMs, from the fact that the ACA includes several provisions that either by explicit intention or by unavoidable effect assault the natural family. The following recommendations seek to ensure the availability of health care that is pro-life, pro-family, and affordable:

- The ACA must be amended to eliminate the marriage penalty currently embedded in the subsidy formula. A similar recommendation is in order regarding the 3.8% investment surtax on high-income taxpayers, since the ACA assesses this tax on net investment income only for single filers with an adjusted gross income exceeding \$200,000 each (or up to \$400,000 for a cohabiting couple) versus \$250,000 for a married couple filing jointly.
- Existing provisions that permit individuals to opt out of health insurance by participating in HCSMs should be preserved, as should the liberty of providers and patients to adopt a cash-only arrangement through direct-care contracts.
- States that have not already done so should adopt a “safe harbor” statute clarifying that HCSMs are distinct from insurance and therefore are not regulated as insurance. Earlier this year, Wyoming became the 29th state to do so.<sup>35</sup> The American Legislative Exchange Council has drafted model legislation as the “Health Care Sharing Ministries Freedom To Share Act.”<sup>36</sup>
- States should follow the example of Missouri in permitting tax deductions for a member’s payments toward a person’s medical bills through a qualified health care sharing ministry, thereby offering parity with insurance participants who receive tax benefits when paying their health-care expenses.<sup>37</sup> The American Legislative Exchange Council has drafted a model Health Care Sharing Ministries Parity Act, including multiple suggested phrasings for core provisions of tax credits and tax deductions in

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35. Samaritan Ministries, *Prayer Guide*, May 2015.

36. American Legislative Exchange Council, “Health Care Sharing Ministries Freedom To Share Act,” June 6, 2011, available at [www.alec.org](http://www.alec.org).

37. Missouri Department of Revenue, Form MO Form–1040: Individual Income Tax Long Form (2013), line 18.

order to make the model adaptable to state tax code variations.<sup>38</sup>

- Congress should rescind the grandfather clause in 26 U.S.C. 5000a(d)(2)(B) that restricts the definition of “qualified” HCSMs to those organizations continuously in existence since 1999. Just as providers have the liberty to switch to direct-care models for routine services, so also health-care consumers should have the liberty to establish a new HCSM if it meets all other qualifications in the individual mandate exemption for HCSMs. Especially since not all Americans share the Christian, or quasi-Christian, creeds of the four grandfathered HCSMs, new groups should be free to form an alternative HCSM conforming to their own religious beliefs.
- Congress should enact H.R. 1752, to amend “the Internal Revenue Code to treat membership in a tax-exempt health care sharing ministry as coverage under a high deductible health plan for purposes of the tax deduction for contributions to a health savings account.”<sup>39</sup>

For the last three recommendations, if the intention behind existing health-related tax breaks is truly to assist people in obtaining health care (not to subsidize insurance companies nor to win re-election by subsidizing substantial portions of the electorate), then there is no reason why persons who fund their health care through HCSMs should be disqualified from the analogous benefits to which persons choosing to obtain health insurance are already entitled. Moreover, both federal and state governments serve a legitimate interest in permitting, and even encouraging, the formation and preservation of HCSMs: these organizations foster virtuous family living, which in the long term makes for a healthier society, benefiting everyone.

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38. American Legislative Exchange Council, “Health Care Sharing Ministries Tax Parity Act,” January 9, 2014, available at [www.alec.org](http://www.alec.org).

39. H.R. 1752 (114th Congress), introduced April 13, 2015, available at [www.congress.gov](http://www.congress.gov).