The ACA and Healthcare Sharing Ministries: A Moral Comparison of Competing Healthcare Models

Author: Amit Nandal (MBA, Master's Computer Information Science, ITIL)
Email: nandalamit2@gmail.com
Independent Researcher, PA, US

Abstract

Right now, the United States' so-called "medical-industrial insurance complex" requires certain changes. Concerns about the most ethical means of guaranteeing access to healthcare, particularly for the most disadvantaged groups, emerge in light of the fact that millions of Americans still lack health insurance and that costs are steadily increasing. In this article, I compare and contrast the moral consequences of two popular alternatives to government-mandated health insurance—healthcare sharing ministries and individual mandates—and provide my findings. Part 1 of this series outlines some of the ethical issues surrounding government-mandated insurance for healthcare in the United States. These include, among other things, unfairness, a lack of respect for patients' autonomy, restrictions on their autonomy, the misuse of individuals for financial gain, the erosion of their right to conscience, collusion with evildoers, and scandal. Part 2 delves into the topic of risk and proceeds to outline a number of possible ethical benefits for medical ministries. These include upholding patient liberty and morality as well as allowing individuals to live out the charity and cooperation tenets of the Catholic religion.

A brief overview: Medical sharing organisations seem to alleviate some of the moral concerns that observant Catholics have with the United States' mandated insurance for health care. Since medical coverage and cost sharing both have their advantages and disadvantages, each person should be able to pick what works best for them.

Keywords: Medical care sharing ministries, medical coverage, healthcare policy, accessibility to healthcare, medical care finance.

1.Introduction

According to Luke 10:25–37, Jesus Christ is the ultimate "Good Samaritan" because he tends to the spiritual and physical needs of those who are hurt. The Church, inspired by his steadfastness and example, must remain in the forefront of providing humanitarian aid, particularly to the vulnerable and impoverished (John Paul II 1995, 27). A "gift of self" expressed in an outpouring of tangible assistance is needed, as the Good Samaritan figure in Luke's Gospel demonstrates,

in addition to the need of sympathy and empathy for the suffering (John Paul II 1995, 28). Medical

professionals, when motivated by a desire to spread the gospel, are like "Good Samaritans" among us. "From generation to generation carried out 'Good Samaritan' service" (John Paul II 1994, 29) is another way to describe certain organisations. These institutions, involving as health care facilities, charity clinics, faith-based office practices, and coverage organisations, were either established by or significantly altered by Christians in the pursuit of better healthcare (Benestad 2017, 18-19). Following Christ's example of the Good Samaritan, we have worked to expand access to high-quality medical care for all people at all times. Various sources have recently argued that the American medical-industrial complex—a conglomerate of healthcare providers, insurance companies, and government agencies—needs reforming (Ehrenreich 1970; Maloney 1998; Jupiter and Burke 2013). The word "insurance" being added to the mix highlights the close relationship between these groups; therefore, the name "medical-industrial insurance complex." Concerns about the most ethical means of guaranteeing access to healthcare, particularly for the most disadvantaged groups, emerge in light of the fact that millions of Americans still lack health insurance and that costs are steadily increasing. In contrast to medical treatment sharing departments, which are not insurance policies but are gaining popularity, this paper provides an excellent evaluation of the ethical effects of federally mandated health insurance, with a sole focus on the US situation. While the concepts are applicable everywhere, systems like Italy's mandatory health insurance program that has been in place since 1943 or the National Health Service in England may have quite diverse implementations of the specifics. It should be

doi: 10.48047/ijiee.2021.11.3.2

mentioned that these criticisms may be revised as more accurate information becomes available.

2.Unfairness in the United States' Mandatory Health Insurance Program

One group that is not required to have health insurance is those who are part of a healthcare sharing ministry. But in the United States, medical coverage is a legal requirement for any company with fifty or more workers. From a Catholic point of view, there are major moral dilemmas with the current medical system, particularly with the individual and company insurance requirement.Systemic unfairness seems to be created by excessive profit-seeking. Medical and health insurance firms are currently not being honest about treatment alternatives, charges, or rates, according to bipartisan surveys. In her 2017 book "An American Disease: How Healthcare Becoming Big Business and How You Can Take It Back," Bernstein details eleven "economic rules of the malfunctioning medical market," along with supporting information from various sources. The system's unwritten regulations reveal an absence of openness and imply widespread deceit and irregularity. While not every issue stems from insurance companies or the system in general, the majority are aspects of the current "medical-industrial insurance combination" that is inherently complicated.

1. Justice and Equity

Compulsory Health Insurance: It is aimed at providing the widest possible access to healthcare. However, it is also associated with systemic injustice in terms of the ways it lacks transparency of pricing mechanisms and possible exploitation of patients for profit. These problems can sharpen in their inequity with specific areas of weakness within the population affecting the fair delivery of healthcare services.

Healthcare Sharing Ministries: HCSMs establish mutual solidarity on the basis of members helping one another meet basic medical needs. Though they promise shared community support, critics question their ability to provide steady, comprehensive coverage especially to those who have pre-existing conditions; this variability may compromise equitable access to healthcare among members as in figure 1.

2. Autonomy and Freedom

Mandated Health Insurance: Critics also assert that mandated insurance can constrain individuals' autonomy. Choices may be limited because mandated insurance contains the categories of coverage offered to those patients and employees.

Healthcare Sharing Ministries: HCSM allows that freedom to members to choose medical services according to the church or personal beliefs. However, this poses a risk of non-guarantee of having these expenses covered, as HCSMs are not bound either legally or by contract to cover all medical services, which may affect members' decisions regarding healthcare.

3. Solidarity and Community Support

Mandated Health Insurance: While pooling resources together, a mandated insurance system may fall short of truly having that personal, community-focused perspective of mutual support among its participants.

Healthcare Sharing

Ministries: HCSMs provide solidarity by enhancing the sharing of each other's burdens. The concept reflects the values of charity and communal responsibility within this model, making it a very critical supportive environment especially for the poor and marginalized.

4. Risk and Prudence

Mandated Health Insurance: Provides a systematic, regulated coverage whereby financial risks related to healthcare costs can be alleviated with an appropriate safety net.

Healthcare Sharing Ministries: Participation bears more personal risk because there are no legal bindings to cover medical expenses incurred within the health-sharing model. Members are expected to weigh their needs and the reliability of the HCSM before taking part in such arrangements.

doi: 10.48047/ijiee.2021.11.3.2

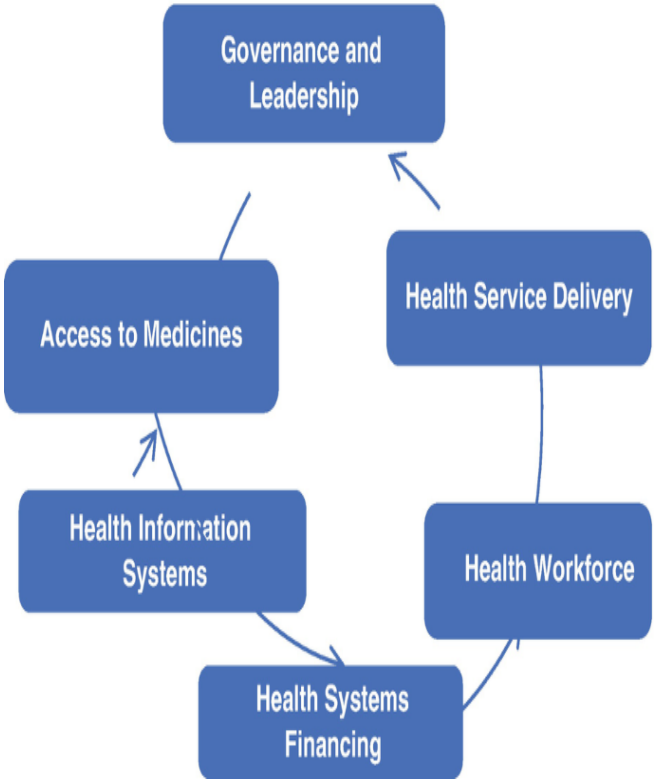

Figure 1: Fundamental Cycle of healthcare

5. Beneficence and Non-Maleficence

Mandated Health Insurance: Seeks to do good for the general population by providing access to health services. On the other hand, inefficiencies of the overall system and commercial value could lead to harm, particularly to vulnerable groups.

Healthcare Sharing Ministries: Want to do good for their members by assisting them in medical expenses. However, risks exist under the highly unregulated situation, such that if claims are denied, members could be left without essential medical coverage.

From the foregoing, it follows that both types of systems, mandated health insurance and then healthcare-sharing ministries, come with their own merits and drawbacks as they serve the poor and vulnerable. A virtue ethics perspective demands consideration of justice, autonomy, solidarity, prudence, and beneficence in the evaluation of programs. In so doing, policymakers and members of civil society must be cautious to critically examine these various ethical variables in an attempt to make certain that healthcare systems reach the target population in real need.

3.Disruptions to the Independence of Doctors and Patients?

Autonomy goes beyond being a self-directing principle or an abstract right unrelated to objective assessments, contrary to popular belief. When properly understood, personal autonomy rests on the idea that every person has the freedom and duty to make morally sound decisions based on his or her own assessment of the reality of the matters influencing their lives (John Paul II 1993, 40-41, 61). The only time another adult may help an adult maintain autonomy and make choices on their behalf is in cases of temporary or permanent incapacity. Insurance mandates, on the other hand, limit patients' autonomy in deciding whether or not to get health coverage (McKalip 2016, 437–438), and the Affordable Care Act (ACA) offers neither individuals nor businesses much leeway in determining which services and benefits their plans will cover. Concerningly, Catholic moral theorists assert that decision-making autonomy is influenced by available possibilities, with decreased independence for less desirable options (Finn 2010, 150). Central commissions routinely impose monetary sanctions on doctors, which forces them to perform treatments they would not normally suggest (McKalip 2016, 438). As a step towards mandatory health care, which leans against socialism, and since medicine under these circumstances may be coercive, required medical coverage poses another danger to doctor and patient autonomy. The goal of using emotional, psychological, or physical pressure to circumvent or impose a decision is known as coercion financial, or other forms of coercion that might cause a doctor's patient to consent to medication or service that they would have refused otherwise. The following are examples of well-documented repressive surgical procedures from government organisations:

A. proactive therapies, like sterilisations and hormonal contraceptives, which are sometimes strongly advised by medical professionals or even imposed on those who are at risk

B. any non-emergency implementation. that the individual or carer consciously rejects, like euthanasia

C. needless and costly therapies, pharmaceuticals, or services. The current health care system seems to be more and more focused on making money at the expense of patient care. Many additional injustices seem to have their origins in the profit-above-all motive.

4. Medical Expenses and Payments

doi: 10.48047/ijiee.2021.11.3.2

A fair and appropriately beneficial remuneration for labour or investment is profitable, which is why businesses may lawfully attempt to make a profit. According to Aquinas (1955), in a fair trade, both the buyer and the seller benefit (ST II-II, q. 77, a. 1). As a result, the right to pursue wealth must always aim to preserve and safeguard the inherent worth and dignity of individuals (Pontifical Council for the Promotion of Peace and Justice [PCJP] 2004, 341). The worth of everyone and the benefit of everyone are frequently overlooked when profit is the only purpose of employment, leading to exploitation of other People and companies should not take advantage of those who are weak or engage in dishonest tactics in order to maximise their own profits (Leo XIII 1891, 20; Pius XI 1931, 132). A fair trade of commodities or services requires the honest disclosure of all pertinent facts on the item up for grabs. As John Paul II pointed out in 1991, 32, open negotiation does lead to a fair price. Before health insurance became the standard, individuals would pay for their medical care out of pocket, just as they did for food or clothes (Grisez 1997, 417). Providing healthcare is still quite similar to selling in many ways, even in the modern day. For the transaction to be fair, both parties involved must have reasonable expectations about the value of the items or services that are transferred. For the customer, this means paying a price they are willing to pay for the product or service in question, and for the seller, it means receiving payment appropriate for the value they provide. A value judgement about the product or service and its associated cost is, therefore, fundamental to the exchange of items and services. Aquinas (1955) states that judgement exists only when it is evident, as people assess what they know (ST II-II, q. 77, a. 3, ad 1). As a result, justice requires openness. According to Antoninus (1740, tit. 1, c. 16, § 3, col. 255-56), when determining a fair price for a product or service, one must consider its usefulness, scarcity, and attractiveness. A current surgical approach truly eliminates cancer in contrast to some less efficient technique; this is an example of how utility views the actual attributes of the object that may brilliantly and effectively answer to some requirement. The well-known law of supply and demand is illustrated by scarcity; a scarce good's higher price discourages hoarding and promotes equitable distribution based on need. The factors that influence an individual's perception of an object's worth and attractiveness determine the degree to which they find it desirable. One needs reliable and relevant information on the object being assessed in order to make an assessment of its usefulness, scarcity, and attractiveness. Sellers and providers must uphold the virtue of truth together with its sub virtues, honesty and openness, in order to guarantee fair pricing. Due to health care shortages and delivery challenges, providers must adjust rates to reflect the varying costs of delivering treatment in diverse contexts (Babcock 2019, 92). The patient is not acting rationally and may be committing fraudulent activity if he or she overstates the seriousness of the illness or seeks therapy mainly out of emotion, knowing that insurance will pay for the treatment. (Grisez 1997, 416). Health insurance policy applicants who knowingly withhold information that might affect their premium, such as a history of cancer, are committing fraud since both the insurer and the policyholder have a responsibility to be forthright. Such deception is appropriately denounced by insurance firms. Insurers or healthcare providers may commit fraud if they inflated the value, rarity, or desirability of a product or service to increase sales or price. Approximately 60% of the money spent on DME is likely fraudulent, according to certain studies (Silver and Hyman 2018, 234).

A valid worry in healthcare is the possibility of overtreatment. We have a lot of reasons. From the patient's perspective, guaranteed health care and, to a lesser degree, mandatory insurance, could lead to the "nonrational use of healthcare" (Grisez 1997, 417), wherein people seek medical treatment without considering their options carefully because they aren't financially obligated to do so (McKalip 2016, 436). For healthcare providers, there are a number of competing objectives, including minimising the risk of legal action for carelessness or misconduct and increasing their bottom line in the face of declining payment. Patients often pay for unneeded procedures based on physician recommendations, leading to inefficient resource allocation. According to research published in Health Affairs, chargemaster rates for treatment are, on average, 3.4% more than the real cost of patient treatment. In a sample of fifty hospitals, expenses were much higher, coming out at 10% (Bai and Anderson 2015). As a result of government price limitations, medical practitioners charge more for noncontrolled portions of their work, which leads to underpayments for such services (Babcock 2019, 91). Tragically, those without health insurance usually end up footing the bill

doi: 10.48047/ijiee.2021.11.3.2

(Anderson, 2007), which puts religious groups like the Amish at risk of poverty (Makary, 2019, 22–23). Along with the above-mentioned cost-shifting, predatory company procedures meant to eliminate concurrence are also directly against the Catholic concern and compassion for the poor. This is intended to reaffirm to people that from a Catholic point of view, businesses should also show mercy.

5.Ignored Authorisation?

When it's not an emergency, people usually seek treatment after signing a contract promising to pay in full when the bill arrives. According to Liguori (1953, lib. 3, tr. 5, c. 3, dub. 1, no. 707), a contract is inherently an agreement among two persons who willingly and deliberately commit themselves in some kind. Because they are effective instruments for making economic interactions more predictable, contracts contribute significantly to society's smooth operation (Finn 2010, 143). Honesty is key for relationships to work, which is to enable parties to trade goods and services in a way that they both agree upon. Before providing non-emergency services, providers must provide data on their utility, scarcity, price, and possibilities. Integrity and candour are cornerstones of the healthcare industry, as they are of any transaction. All of these qualities may aid a patient in determining the potential financial and other burdens that a medical procedure or gadget can cause for the individual as well as their family. No one can fairly assess the relative burden of a therapy unless they have access to reliable, comprehensive, and easily comprehensible information on the possible overall cost of a medical commodity or service. The patient will be unable to make an informed decision about whether or not the service is worth the expense (Babcock 2019, 91). According to Catholic bioethics, a prospective patient or their family may be put unduly burdened by the exorbitant cost of some medical procedures or services as in figure 2. It is reasonable to refuse therapies that are very costly, even if they save lives, because of the severe financial difficulties they impose. By allowing patients to make an act of conscious consent to treatments and their recommended prices or to reject them, transparent and honest communication prior to medical services is able to assist reduce needless and undesired expenditure. If healthcare providers were more forthcoming with information, individuals would feel more in control of their health and less powerless as a result. According to Blase (2019), openness can result in four advantages:

1. better-informed patients and consumers;
2. better-informed companies who can assist employees in finding significance;
3. enhanced capacity to track insurer efficacy and remove ineffective middlemen; and
4. an increased burden on expensive suppliers to provide more affordable rates.

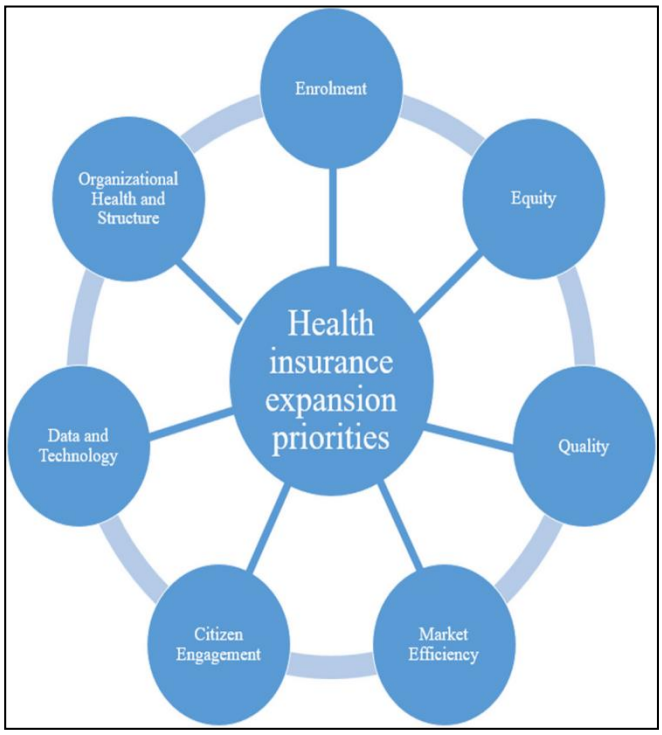

Figure 2: Expansion priorities with insurance

Patients are only invoiced after the product is provided, i.e., when the therapy is finished, much as in other service sectors. Patients' requirements aren't completely recognised until they're "in the actual moment of care," when the main worry isn't money but their health (Babcock 2019, 92), making it impossible to precisely estimate possible treatments and costs. However, many healthcare providers still conceal the whole possible cost (or range of costs) of all the products and services associated with a comprehensive treatment, even when they do talk about the price of a recognised operation, like surgery. One explanation for this is the seemingly arbitrary nature of medical treatment, test, and equipment pricing, which is more frequently driven by the financial resources of the patient or their insurance company than by actual expenses incurred by the provider (Makary 2019, 167-71).

Hospitals may need to charge more than cautious estimates to be financially stable, while the fundamental

doi: 10.48047/ijiee.2021.11.3.2

costs of treatment are unclear (Babcock 2019, 93). According to Aquinas (1955, ST II-II, q. 77, a. 1), overcharging occurs when a vendor decides to charge more for a product even if they might earn a decent profit by selling it at a regular price. This is particularly bad when the customer ends up losing a lot of money because of it. The cost of joint replacement surgery rose by 76.8 percent in only one year, suggesting that this is the situation for many institutions (Makary 2019, 29). Some so-called "charity" hospitals may get away with price gouging because to their special tax status (Bai, Yehia, and Anderson, 2020; Archer, 2017). Because industry billing rules and invoices are, to put it mildly, complex, patients have no idea how much their insurance will pay for a full course of treatment, even while they are aware of what their deductible and co-pay would be (Rosenthal 2017, 168-69). A contract with a hospital and an insurance policy loses some of its moral legitimacy when medical pricing and coverage are not clearly stated. Ideally, when entering into a contract, the parties should tailor it to their specific requirements and level of comfort with risk (Rougeau 2010, 126). Some people may often wind themselves on the losing end of private contracts in a culture that values individual liberty and free markets due to "imbalances of power, income, education, and societal status" (Rougeau 2010, 126), according to one study. There is obviously an imbalance in authority among a prospective patient and a healthcare provider, which leads to these kinds of lopsided arrangements happening often in medical facilities. Health treatment is often delivered on a take-it-or-leave-it basis, making it hard for patients to negotiate terms before signing a release form. Without an immediate medical emergency, a person signing a release or other legally binding instrument may lack the mental capacity to make an informed decision. According to Rougeau (2010), "grossly unfair" and "unconscionable" commercial agreements may result from healthcare agreements' lack of transparency, which reflects moral ideals shared with the Catholic Church. Referring to Finn (2010): 147–48 and Leo XIII (1891), 45, Catholics might make the point that the patient is a victim of injustice and coercion.

6."Medicine in a Socialised, Private System"

When healthcare professionals and insurance firms conspire, some wonder whether it's corruption (Silver and Hyman 2018, 101). In this context, corruption is seen as an underground agreement between service providers to maintain inflated rates or between service providers and authorities whose policies secure profits for certain service providers (Antoninus 1740, tit. 1, c. 16, § 2, col. 252D-E). There are many conflicts of interest due to the prevalence of government-insurance cooperation fostered by subsidised health insurance. According to Silver and Hyman (2018), 303–4, and Makary (2019), the tax structure promotes higher healthcare expenditure. According to Rosenthal (2017), Silver and Hyman (2018), and Makary (2019), corporations spend billions on political lobbying and "donations" to politicians who support their oligopoly. In a system that isn't open and honest about costs, mandatory insurance drives up the cost of all services and medications by increasing demand for them, including those that aren't required (Silver and Hyman 2018, 283–295). A portion of that profit makes its way back to the administration through lobbying, campaign contributions, and other favours. Politicians then aid participants of the medical-industrial coverage complicated in keeping healthcare provision under their control, which leads to even more profit and the cycle repeats itself (Silver and Hyman 2018, 82-84, 143-47). As an example, the pharmaceutical sector spent up to US$100 million on advertisements endorsing the Affordable Care Act (ACA) and pledged up to US$80 billion in projected future income before the law was passed (Silver and Hyman 2018, 145). At the time of the legislation's enactment, the industry's estimated growth was between $10 and $35 billion (Milne and Kaitin 2010). According to Rowland (2019), the medical device sector has placed the responsibility on insurance providers for the price hikes. While this was going on, insurance deductibles rates rose by 54% generally from 2016 to 2020 (Clason, Kopp, and McIntire 2020). Private insurance transactions still end up costing more, even while Medicare and Medicaid do their best to keep patient costs modest (Rosenthal 2017, 82). The fact that private insurance firms are now transferring funds from publicly-funded programs to medical services makes the conspiracy all the more worrisome. As a consequence, private insurance corporations end up keeping more of the money that individuals spend for health care (Belk and Belk 2020, 192).

In contrast to a completely free market system, the current method of healthcare delivery and funding is referred to as "state healthcare" (McKalip 2016, 425-26). "Privatised socialised medicine" (pp. 177–202) is

doi: 10.48047/ijiee.2021.11.3.2

the more direct outcome of government-mandated health care and the involvement of insurance intermediaries, according to Doctors Belk and Belk (2020). Businesses and people must work together for the greater good in order to navigate the complicated economic landscape. Cooperation often requires authorities, but a mix of the federal government and private oversight is ideal (Grisez 1997, 418). Authorities and third parties oversee most spending on healthcare (McKalip 2016, 426). Consequently, "privatised socialised medicine," which includes authorities and medical supply suppliers, controls over 17% of the GDP now and is projected to grow significantly in the next years (Mikulic 2020; Sawyer and Cox 2020). Since "the need for means of minimising, curing, and having difficulty with illness and accidental harm to the individuals is as limitless as a person the capacity to invent such translates as " and "there is no way of setting a term to the development of medical care resources," this predicament tends to breed socialism (Grisez 1997, 418). If the government cannot be reined in when it comes to healthcare spending and health care is integrated into almost every part of people's lives, then the two will eventually become inseparable.

According to Leo XII (1891, 14–15), private companies under socialism are either owned or regulated by the state. While not a complete socialist system in and of itself, the Social Assistance State (also known as the Welfare Society) does foster an environment favourable to socialism. Since the Catholic Church has condemned socialism as inherently unjust (Leo XII 1891, 9; Pius XI 1931, 117; John Paul II 1991, 13–14), Catholics have good reason to be worried about the effects of political corruption on both individual liberty and the public good. This complex includes the medical community and insurance companies. "For the advantage of the government, private insurance companies, big businesses, and doctors personally who get a bonus" (p. 427-30) is the slogan that describes the current "pay for efficiency" model of medical treatment rationing, which McKalip (2016) contends goes against Catholic principles concerning humanity, shared good, subsidiarity, and solidarity. This model is intricately tied to the insurance policies mandate and organisations like the Centre for the Medicaid program Services.

7. A Cult of Evil and a Scandal

According to the Catholic Health Association (2014), many Catholics are hesitant to become involved with the choices made by the medical-industrial insurance complex because they don't want to be associated with evil. As an example, the federal government has made it a law that all health insurance plans must cover all FDA-approved methods of birth control as "preventative health services" and not charge patients anything for them. Contraceptives, surgical sterilisations, and abortion-inducing medications like mifepristone and misoprostol are all part of this category. These birth control options are immoral according to Catholic moral teaching as they harm conception and, in the case of certain "morning after" pills, end the life of a defenceless human being. In a roundabout sense, Catholics are collaborating with evil by paying into the mandatory healthcare system (Liguori 1953, lib.II, tract. III, c. II, dub. V, art. III, no. 63; John Paul II 1995, 74). Though neither the incorrect actions nor formal collaboration would be caused by paying insurance firms, the wrong practices would be made feasible by the financial cushion and social acceptability that would result from such payments. Furthermore, in some US states minors can get a variety of medical services, including birth control, without their parents' consent. This leaves parents with no choice but to let their children get controversial treatments covered by their insurance, unchecked.1 As things stand, insured parents are complicit in their children's damage. Aquinas 1955, ST II-II, q. 43, a. 1 defines scandal in Catholic doctrine as anything that causes a person to do or say anything wicked. As a result of their concern for their fellow citizens, Catholics strive to avoid giving the impression that they are advocating for the acceptance and participation in a system that contains serious injustices (Liguori 1953, lib. III, tract. V, c. II, dub. II, no. 561). It is a kind of "voting with one's chequebook" to fund institutions, and paying faulty insurance firms turns Catholic money against Catholics and their good intentions. As a result, many Catholics would see mandatory support for these insurance plans as scandalous. This means that people's religious freedom and fundamental political rights might be infringed upon by government-mandated health insurance subsidies. It is unacceptable for the bureaucracy to dictate that an individual must purchase an item for another person, even if doing so goes against their religious beliefs as in figure 3.

doi: 10.48047/ijiee.2021.11.3.2

8. Healthcare Systems and Foundations for Collaborative Solutions

Rather of paying out of pocket for medical treatment, members of healthcare sharing ministries pool their resources and adhere to a shared set of religious principles to cover each member's medical bills. Every member must pay a certain amount each month that may be used for their personal healthcare costs or allocated to someone else who is struggling financially so that healthcare expenditures might be shared. This research just takes into account healthcare providing organisations that are guided by a certain religion. In order to be a part of these ministries, participants are asked to sign a declaration of faith. Ministry officials should make it clear that healthcare sharing is not the same as insurance as the government will not be covering anyone's medical bills out of its own pocket. Members are not compelled to follow the published criteria for expenditure sharing, but they are encouraged to do so. A healthcare shared ministries may provide several moral benefits to Catholics compared to government-mandated health protection. The potential advantages of non-guaranteed medical coverage may exceed the potential disadvantages.

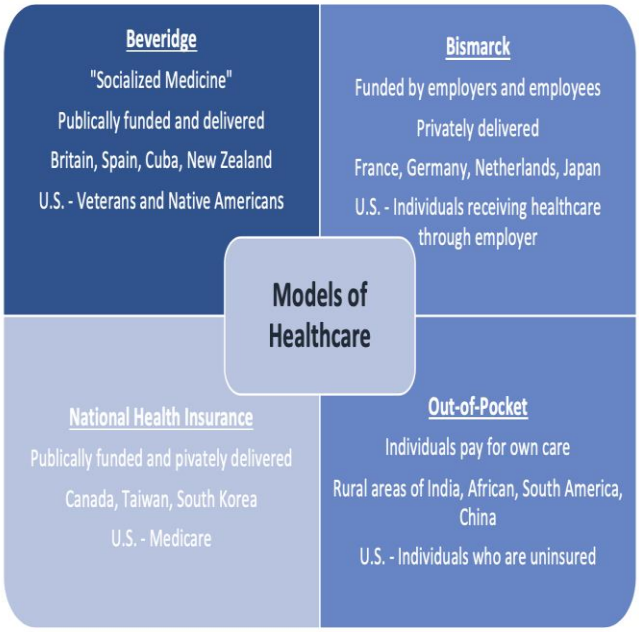

Figure 3: Models of the ACA

9. Problems Relating to Danger

For the avoidance of doubt, the insurance company runs the danger of paying out more money than it received in premium payments, and the insured runs the risk of losing the money if medical services are not needed. To balance probable payments against income that keeps the firm running, insurance companies have an incentive in collecting as much personal information as possible. Insurance firms are within their moral rights to conduct comprehensive investigations and provide fair judgements on claims. Since justice does not necessitate a company to run at a loss, an insurer has the moral authority to refuse to cover a person whose medical expenses are going to be significantly higher than the premiums, particularly if the costs are going to be exceptionally high. If insurers have access to so much precise data, some moral philosophers contend, they can accurately predict their customers' future medical expenses, so they will almost certainly make a profit regardless of how much the insured pay (McHugh and Callan 1958, 282). It would be unethical for an insurance company to take premiums from an insured person and then not pay out on medical bills as agreed upon in the policy, or to alter or cancel an existing policy using false reasons to avoid payouts, or to conspire with medical providers to set higher prices and then rob the insured (McHugh and Callan 1958, 284–85). Rather than a benefit plan, an insurance policy safeguards against loss by committing the insurer to pay out under certain, predetermined circumstances (McKalip 2016, 435–437).

Both insurance companies and healthcare sharing ministries face distinct risks due to their various legal structures. In a healthcare sharing ministry, members agree to split the expense of medical treatment between themselves, but no one is obligated to pay for anybody else's treatment, and if someone doesn't pay, the others have no legal recourse. Because of this, the risks to the ministry are relatively modest compared to insurance companies, but the patient may face a bigger risk if they choose to participate in the ministry. It is only fair that insurance companies charge greater premiums to compensate for the additional risk they face. Furthermore, stakeholders who invest their own money in for-profit insurance firms have a fiduciary obligation to the company. Therefore, insurance firms have an ethical obligation to structure their company in a way that allows for the payment of dividends or their equivalent, in contrast to healthcare sharing ministries that are not obligated to do so. For insurance companies, these are only a few of the good reasons to have a lot of money on hand (Davis 1943, 402). Yet, a policy shouldn't be inflated beyond what is fairly judged to be the cost of the many risks involved, including the

doi: 10.48047/ijiee.2021.11.3.2

individual's medical risks. Anecdotally, hospital CFOs have seen that it falls on the hospital to collect payments made by patients using funds provided by the health share ministry or program to cover healthcare expenses. Having said that, it doesn't necessarily work. The hospital doesn't always get paid; sometimes the patient does. Payment becomes impossible for the hospital. This also amounts to stealing and is unfair. To gauge the policy's efficacy in benefiting healthcare providers and patients alike, it would be helpful if patients could provide a copy of their fully paid receipts for medical services. People are allowed to think about the pros and downsides of insurance policies vs healthcare sharing ministries as a means to pay for any medical bills in the future. There are a number of considerations that should be considered by an individual (and his family) before settling on a course of action.

People should estimate future medical expenses as precisely as feasible in the lack of more formal methods. Factors such as age, medical history, family background, current health, occupation (especially if it's a high-risk one, like law enforcement), and frequency of risky behaviours would fall into this category. "An individual who does not take out insurance gambles more than one who does" (McHugh and Callan 1958, 281), which might be a problem for those whose medical expenses are likely to exceed the limits of healthcare sharing ministries. Everyone has the right to decline medical treatment if they believe it would place an undue financial burden on themselves or their family, and no one should have to risk going bankrupt over a minor medical issue. A person's priorities in life are determined by their aspirations; in the end, they will make decisions based on what they believe will bring about the most good at the lowest possible cost and with the least amount of danger.

10. Ministries for Healthcare Cost Sharing

If healthcare sharing agencies took moral considerations into account while making decisions, they could be better able to meet the standards of fairness. Patients participating in these ministries may practise independence as patients by making decisions about their care based on what they think is best for them and what is consistent with their religious beliefs. Members of healthcare expressing ministries are better able to resist pressure to subsidise illegal treatments or assistance for others as they are not dependent on insurance companies' choices. Although openness and truthfulness are important in the medical-industrial insurance industry, they are often prioritised by independent brokers and organisations. For instance, similar to the Kelley Blue Book that shows reasonable automobile costs, Jeffrey Rice created a "Healthcare Bluebook" when he was overpaid for medical services (Makary 2019, 172–73). This Healthcare Bluebook goes above and above by gathering price information from participating businesses, reviewing the actual amounts paid, and identifying providers with exorbitant rates. Because it allows consumers to make an educated decision about their medical bills, healthcare sharing ministries ought to be happy to support this kind of effort. Members of a pharmaceutical cooperative ministries are better able to assert their right to informed authorisation for all treatments, solutions, and billing activities due to the financial power structure's relative autonomy from the healthcare insurance system. Patients with health insurance are frequently unable to know what their final bill will be since they are dependent on pricing agreements between hospitals and insurance companies; it's worth noting that individual doctors aren't always privy to this information either. Also, healthcare sharing ministries are upfront about the rates they'll pay out. If the provider still refuses, the ministry will represent the member in negotiations with the provider to get an alternative pricing. In order to promote transparency and avoid conflicts of interest, the ministry has representatives negotiate costs with healthcare providers. Healthcare sharing ministries should be forthright about the frequency with which members fail to pay doctors, which impacts other members' access to hospitals and doctors, or the frequency with which members deliberately withhold their "share" of costs, leaving other members to cover the shortfall.

However, it may also have a substantial impact on healthcare reform overall. Unsubsidised rates have risen since the ACA's start, making it unaffordable for millions of individuals, even though over 20 million people have gotten subsidised coverage via the legislation (Eisenberg 2015; Editorial Board 2017). Also, due to noncompliance with the ACA, millions of Americans lost access to inexpensive coverage. Health insurance exchanges have grown at an unprecedented rate due to these factors and the fact that the Affordable Care Act's penalty for going without coverage was repealed by Congress in 2017. The burden on insurance

doi: 10.48047/ijiee.2021.11.3.2

companies will grow in proportion to the growth of healthcare sharing. At this time, the largest healthcare sharing ministries are run by Protestant Christian denominations. The Catholic Church offers a real alternative to the current system of health insurance via its autonomous healthcare sharing mission. As a result, they are able to shun any kind of material collaboration that goes against their strongly held ideals. Plus, they won't have to deal with the inevitable scandals and counter witnesses that come with financially supporting a system that may make them feel guilty. Catholics would have an opportunity to morally carry out Christ's command to serve one's neighbour via a faith-based healthcare sharing ministry. According to the "Good Samaritan principle," all practicing Catholics have an obligation to help their neighbours in need, especially when it comes to medical treatment. One practical way that sharing ministries may help people is by making it easier for them to split the bill for medical treatment. According to John Paul II (1988, 37, 40), "solidarity" is a virtue in Catholic social teaching that encompasses caring for others and dedicating one's life to promoting equality as well as charity for the benefit of everyone. To promote collaboration, the "more influential" can with caution share access to goods and services, while the "weaker" should not be apathetic and work for the good for all while claiming their legitimate rights (John Paul II 1988, 39). Because it forces doctors to prioritise profit above all else, even when their best judgement suggests a more altruistic use of time or money, the current insurance system has the potential to weaken physician-patient solidarity and the capacity of doctors to provide charity to patients (McKalip 2016, 438-39, 441-42).

11. Disclosure of Potential Conflicts of Interest

Regarding the study, writing, and/or publishing of this piece, the author(s) disclosed the following possible conflicts of interest: Stand Together. As long as I could write on whatever I wanted and submit it to a peer-reviewed journal, I was good to go. They were in agreement, and they gave me money to do research and a consultancy stipend. A document containing my analysis was sent to Solidarity. An expanded and revised version of that memo is the piece that was submitted to The Linacre Quarterly. I wrote it entirely on my own, without any influence or involvement from Solidarity, and it conveys my personal thoughts.

References

1. Anderson, Gerard F. 2007. “From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing.” Health Affairs 26, no. 3: 780–89. doi: 10.1377/hlthaff.26.3.780.
2. Antoninus of Florence. 1740. Summa Theologica: Pars Secunda. Verona, Italy: Augustus Caratonius. Archer, David L. 2017. “Will Catholic Hospitals Survive without Government Reimbursements?” The Linacre Quarterly 84, no. 1: 23–28.
3. Austriaco, Nicanor. 2011. Bioethics and Beatitude: An Introduction to Catholic Bioethics. Washington, DC: Catholic University of America Press. Aquinas, Thomas. 1955.
4. Summa Theologiae. Rome, Italy: EditionesPaulinae. Babcock, Paul. 2019. “Paralyzed by Prices: An Analysis of Price Theory within the Context of Health Care.” The Linacre Quarterly 86, no. 1: 89–102.
5. Bai, Ge, and Gerard F. Anderson. 2015. “Extreme Markup: The Fifty US Hospitals with the Highest Charge-toCost Ratios.” Health Affairs 34, no. 6: 922–28. doi: 10.1377/hlthaff.2014.1414.
6. Bai, Ge, Farah Yehia, and Gerard F. Anderson. 2020. “Charity Care Provision by US Nonprofit Hospitals.” JAMA Internal Medicine 180, no. 4: 606–07. doi: 10.1001/jamainternmed.2019.7415.
7. Beauchamp, Tom L., and James F. Childress. 2009. Principles of Biomedical Ethics, 6th ed. Oxford, UK: Oxford University Press.
8. Belk, David, and Paul Belk. 2020. The Great American Healthcare Scam: How Kickbacks, Collusion and Propaganda Have Exploded Healthcare Costs in the United States. New York: Scam watch. Bellaigue, Christopher de. 2019. “Death on Demand: Has Euthanasia Gone Too Far?” The Guardian, January 18. https://www.theguardian.com/news/2019/jan/18/ death-on-demand-has-euthanasia-gone-too-far-nether lands-assisted-dying. Benedict, XVI. 2009.
9. Caritas in Veritate: On Integral Human Development in Charity and Truth. http:// www.vatican.va/content/benedict-xvi/en/encyclicals/ documents/hf_ben-xvi_enc_20090629_caritas-in-veri tate.html.

10. Benestad, J. Brian. 2017. "Foundations of Authentic Medical Care." In Catholic Witness in Health Care: Practicing Medicine in Truth and Love, edited by John M. Travaline, and Louise A. Mitchell, 3–30. Washington, DC: Catholic University of America Press.
11. Blase, Brian. 2019. "Transparent Prices Will Help Consumers and Employers Reduce Health Spending." Galen Institute, September .https://galen.org/assets/Blase_ Transparency_Paper_092719.pdf.
12. Catholic Health Association. 2014. "CDF Principles for Collaboration with Non-Catholic Health Care Entities: Ministry Perspectives." Health Care Ethics USA 22, no. 3: 24–34.
13. Catholic University of Valencia, Bioethics Observatory— Institute of Life Sciences. 2017a. "Review of Countries Where Euthanasia Has Been Legalised. Increasing Involuntary Euthanasia, without Consent by Patients." Bioethics Observatory—Institute of Life Sciences— UCV (Blog). https://bioethicsobservatory.org/2017/08/ euthanasia-in-patients-who-have-not-requested-it/ 12046/.
14. Catholic University of Valencia, Bioethics Observatory— Institute of Life Sciences. 2017b. "Involuntary Euthanasia Increases in Holland as in the Other Countries That Has Been Legalized." Bioethics Obervatory— Institute of Life Sciences—UCV (Blog). https://bioethic sobservatory.org/2017/11/involuntary-euthanasiaincreases/23467/.
15. Clason, Lauren, Emily Kopp, and Mary Ellen McIntire. 2020. "Ten Years into Obamacare, Cost and Access Issues Abound." Roll Call. https://www.rollcall.com/ 2020/03/10/ten-years-into-obamacare-cost-and-accessissues-abound/.
16. Cohen-Almagor, Raphael. 2015. "First Do No Harm: Intentionally Shortening Lives of Patients without Their Explicit Request in Belgium." Journal of Medical Ethics 41, no. 8: 625–29. doi: 10.1136/medethics2014-102387.
17. Davis, Henry. 1943. Moral and Pastoral Theology: Volume Two: Commandments of God, Precepts of the Church, 4th ed. New York: Sheed and Ward. Editorial Board. 2017. "Opinion | The Senate's Unaffordable Care Act." The New York Times, June 23. https:// www.nytimes.com/2017/06/23/opinion/senate-obama care-repeal.html.
18. Ehrenreich, Barbara. 1970. The American Health Empire: Power, Profits, and Politics. New York: Random House. Eijk, W. J., L. M. Hendriks, J. A. Raymakers, and John I. Fleming, eds. 2014. Manual of Catholic Medical.
19. Ethics: Responsible Healthcare from a Catholic Perspective, English Edition. Translated by Sr. M. Regina van den Berg, and J. A. Raymakers. Ballarat, Australia: Connor Court. Eisenberg, Richard. 2015. "For Many, Obamacare Is Becoming the Unaffordable Care Act." Forbes, July 5. https://www.forbes.com/sites/nextavenue/2015 /07/ 05/for-many-obamacare-is-becoming-the-unafford able-care-act/.
20. Bansal, A. (2020). An effective system for Sentiment Analysis and classification of Twitter Data based on Artificial Intelligence (AI) Techniques. International Journal of Computer Science and Information Technology Research, 1(1), 32-47.
21. Mythily, D., Renila, R. H., Keerthana, T., Hamaravathi, S., & Preethi, P. (2020). Iot based fisherman border alert and weather alert security system. International Journal of Engineering Research & Technology (IJERT).
22. CentesimusAnnus: On the Hundredth Anniversary of Rerum Novarum. http://www.vatican. va/content/john-paul-ii/en/encyclicals/documents/hf_ jp-ii_enc_01051991_centesimus-annus.html.
23. Yadav, V. (2019). Healthcare IT Innovations and Cost Savings: Explore How Recent Innovations in Healthcare IT Have led to Cost Savings and Economic Benefits within the Healthcare System. International Journal of Science and Research (IJSR), 8(12), 2070–2076. https://doi.org/10.21275/sr24731181300.
24. Jupiter, Jesse, and Dennis Burke. 2013. "Scott's Parabola and the Rise of the Medical–Industrial Complex." Hand 8, no. 3: 249–52. doi: 10.1007/ s11552-013-9526-5. Largent, Mark. 2007.

25. Breeding Contempt: The History of Coerced Sterilization in the United States. New Brunswick, NJ: Rutgers University Press. Lawrence, Jane. 2000. "The Indian Health Service and the Sterilization of Native American Women." American Indian Quarterly 24, no. 3: 400–19.
26. Lawrence, Ryan E., Kenneth A. Rasinski, John D. Yoon, and Farr A. Curlin. 2011. "Adolescents, Contraception, and Confidentiality: A National Survey of ObstetricianGynecologists." Contraception 84, no. 3: 259–65. 91

doi: 10.48047/ijiee.2021.11.3.2