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The Ethical Right to Healthcare in the Affordable Care Act

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THE ETHICAL RIGHT TO HEALTHCARE IN THE AFFORDABLE CARE ACT

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By

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ABSTRACT

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Dissertation supervised by Dr. Gerard Magill

Since the passage of the Affordable Care Act, It has been questioned whether the right to healthcare in it can be ethically justified. The objection to a right to healthcare in general has been prominent over many decades in the U.S. The concern over higher personal taxes, quality care, and national debt steered the opposition. Responding to these concerns has a direct effect on each individual in society. In particular, the lack of healthcare is very significant.

The idea of a comprehensive national healthcare in the United States caught the attention of the public in the 1970s. It was inspired by the positive results of the Medicare and Medicaid programs which were passed and signed into law in the 1960s. The public would see the benefit of access to healthcare, which led to acquiring the expansion of it. Most people were wiling to accept and agree on providing free healthcare to the elderly and the poor. There was, however, a

strong opposition to a system of a national healthcare. The opposition did not dishearten proponents to advocate for the right to healthcare in subsequent decades. After a vigorous congressional debate, the Affordable Care Act (ACA) was passed and signed into law in 2010. This dissertation engages the four standard ethical principles (known as principlism) to justify the right to healthcare that is provided in the Affordable Care Act. In addition, theories of distributive justice and normal functioning are used to argue and justify the provision of Affordable Care Act.

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I thank God for the initial inspiration to enter the PhD program.

I dedicated my dissertation defense to my father. My father, and he alone, called me by a masculine name at birth. The name carried the meaning of "to be a scholar". Sadly, he did not live to see me receive my PhD degree. He was an example of a scholar.

I thank my mother for always being supportive and encouraging. She has always allowed me to choose my path and take on new challenges. Her love is amazing!

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ACA Introduction

Section One. Introduction

This dissertation will argue that the right to healthcare in the Affordable Care Act can be justified by the four bioethical principles that characterize Principlism. The analysis sets the context for the discussion by providing a critical overview of the right to healthcare and its accompanying health benefits in the Affordable Care Act. Chapter two explains how these benefits can be understood in terms of three organizing categories: patients, populations, and healthcare organizations. The ethical analysis in the subsequent chapters focus on these organizing categories: chapter three deals with patients, chapter four deals with populations, and chapter five deals with healthcare organizations. Chapters three and four provide an ethical justification of this right to healthcare and its accompanying benefits by applying the ethical principles of autonomy, beneficence, non-maleficence, and justice to the organizing categories of patients and populations. Chapter five focuses on a particular dilemma that the ACA has created for healthcare organizations by mandating the provision of a free contraception benefit that conflicts with the teaching and practice of Catholic healthcare: the ethical principle of cooperation is adopted to resolve the dilemma and thereby further support the ethical legitimacy of the right to healthcare in the ACA.

Since the passage of the Affordable Care Act, it has been questioned whether the right to healthcare in it can be ethically justified. The objection to a right to healthcare in general has been prominent over many decades in the U.S. The concern over higher

personal taxes, quality care, and national debt steered the opposition. Responding to these concerns has a direct effect on each individual in society. In particular, the lack of healthcare is very significant.

The idea of a comprehensive national healthcare in the United States caught the attention of the public in the 1970s.[1] It was inspired by the positive results of the Medicare and Medicaid programs which were passed and signed into law in the 1960s. The public would see the benefit of access to healthcare, which led to acquiring the expansion of it. Most people were willing to accept and agree on providing free healthcare to the elderly and the poor. There was, however, a strong opposition to a system of a national healthcare. The opposition did not dishearten proponents to advocate for the right to healthcare in subsequent decades. After a vigorous congressional debate, the Affordable Care Act (ACA) was passed and signed into law in 2010. This dissertation engages the four standard ethical principles (known as principlism) to justify the right to healthcare that is provided in the Affordable Care Act.

In explaining the content of Belmont Report, Tom Beauchamp specifies the principles of respect for persons, beneficence, and justice are the core strength of the document on moral principles. The Belmont Report was officially published in 1978 for use as a basic framework for analyzing ethical issues in clinical research.[2] Dan Brock asserts the principles are influential because of their use in framing and discussing practical moral problems.[3] Later, the influence was noted in every area of activity in bioethics. It was further noted these three tenets became the supporting beam of federal law. Over the past few decades, the use of these principles has extended to guide ethical issues and moral concerns in medical practice.

Tom L. Beauchamp and James F. Childress first published *Principles of Biomedical Ethics* in1977. In their book, they delineate the standard bioethical principles that have been used as basic framework for analyzing ethical problems in the United States. The principles of autonomy, non-maleficence, beneficence, and justice have been applied in analyzing various clinical issues in healthcare.[4] They address the morality of obligation, rights, and actions that are bound within the rules of these principles. This dissertation argues that these four bioethics principles can justify the right to healthcare in a specifically distinct manner, that is, as established in the ACA.

There is an extensive literature on the right to healthcare in general and in the United States in particular. The debate tends to focus on the argument presented by Norman Daniels to support distributing healthcare to all members of society. For example, in his books *Just Health Care* and *Just Health* he argues for the justification of access to healthcare as a matter of distributive justice[5], which he adopts from Rawls's theory.[6] Daniels also asserts healthcare is of special moral importance because it is necessary for preserving normal functioning leading to opportunity,[7] welfare, and happiness.[8] These arguments about the right to healthcare are combined with principlism in this dissertation to focus specifically on justifying the right to healthcare that is provided by the Affordable Care Act. To date, no work has undertaken this specific analysis. Because the passage of ACA occurred in recent years, there is a need to apply the general debate on the right to healthcare as a function of justice to the circumstance of the ACA.

History was made when Patient Protection and Affordable Care Act (PPACA, abbreviated as ACA) was signed into law on March 23, 2010.[9] The new law divides this

nation into groups of proponents and opponents. Each side holds strong opinions on the policies of ACA. The new policies would essentially change healthcare delivery from employer-provision to government-subsidy.[10] The question is whether these new policies reflect a basic right to healthcare.

United States is one of the wealthy countries in the world. Its technology, economy, and medical advances are among the national top benefits. However, more than 44.8 million Americans did not have healthcare benefits according to the national health survey on 2013.[11] The U.S. healthcare system has long favored the free market approach.[12] Many people receive health insurance through employment.[13] The issue is that when an individual's employment ends, health insurance also ends. Another problem about access to healthcare is the affordability that affects vulnerable populations.[14] This issue of affordability raises the question whether there is a right to treatment and a right to basic healthcare. For a number of years, whether there is a right to healthcare has been disputed among politicians, insurance companies, healthcare providers, and the public. However, it can be argued that the right to basic healthcare constitutes a human right.

This essay presents a comprehensive account of this human right to basic healthcare by integrating the general bioethics literature on the topic with the four standard bioethics principles that characterize principlism. Each component of the principles is integrated in the argument that deals with the justification for national healthcare including preventive care, symptomatic care, patient care, and public care. The four principles will be discussed to enlighten the discussion of equal opportunity and equal access to resources, patient self-determination regarding end of life care, and health equity through public health services. In addition, the principle of cooperation will be

used to discuss situations of organizational conflicts to protect the right to preventive healthcare services such contraception without violating religious freedom. By developing the ethics argument in principlism, the right to basic healthcare is justified as a robust foundation for ACA.

Section Two. Affordable Care Act (ACA): Patients, Populations, and Organizations

Wider healthcare coverage has been noted and pursued in the United States since the time of Theodore Roosevelt.[15] As early as in 1927, an independent investigation, by the Committee on the Costs of Medical Care, was initiated to understand the cost and distribution of medical care. The conclusion of the investigation was to recommend healthcare cost through insurance, taxation, or both.[16] However, the recommendation did not develop into law, but the idea of providing affordable health services continued. One can consider the long term pursuit of affordable healthcare has an indication of importance to society. The unceasing effort, in the end, bore a historic result as manifested in the passage of Affordable Care Act.

1. ACA Overview: Key features of Affordable Care Act

This section explores the new health care features of ACA, the analysis examines the basic Titles of ACA and their impact on expanding coverage.

a. Ten Titles of the Affordable Care Act

There is a dramatic expansion of health coverage in the ACA.[17] This expansion is manifest in the ten titles used to explain the new system.

Title I. Quality, Affordable Health Care for All Americans. This act includes the benefits of cutting out-of-pocket cost, coverage of preexisting condition, full coverage of preventive care, coverage up to age 26, creating insurance exchanges,[18] providing tax subsidies, and penalties for individuals and employers who are non-complaint.[19]

Title II. The Role of Public Programs. This act increases Medicaid eligibility to 133 % of the poverty level allowing $29,300 for a family of four or $14,400 for a single person.[20]

Title III. Improving the Quality and Efficiency of Health Care. This act aims at improving the reporting system for physicians and skill facilities,[21] closing the "donut hole" in Medicare D,[22] creating the Independent Payment Advisory Board, establishing penalties for hospital-acquired infections, and establishing programs to reduce hospital readmission.[23]

Title IV. Prevention of Chronic Disease and Improving Public Health. A designated health council is responsible for promoting prevention and wellness such as smoking cessation and reducing obesity.[24] There are grants for small businesses to set up wellness programs.[25] Restaurant menus now must reveal calorie counts.

Title V. Health Care Workforce. This act provides scholarships and loan repayment programs to increase the supply of primary care physicians[26] and nurses[27] public health dentists,[28] and mental health practitioners.[29]

Title VI. Transparency and Program Integrity. This act requires transparency reports from pharmaceutical and health device manufacturers.[30] Nursing homes must disclose expenditures and errors.[31] Physicians are to report financial interests in relation to referrals.

Title VII. Improving Access to Innovative Medical Therapies. The FDA now has improved access to license a biological product that is biosimilar to one that has been on the market for 12 years. This act also includes providing affordable medications in hospitals particularly to certain children's hospitals and underserved communities.[32]

Title VIII. Community Living Assistance Services and Supports (CLASS). CLASS is a voluntary and self-funded public long-term care insurance program for individuals with functional limitation to purchase community living assistance services.[33]

Title IX. Revenue Provisions. New taxes are added on expensive health insurance plans provided by employers, indoor tanning services, elective cosmetic surgery, pharmaceutical manufacturers,[34] high-wage workers, and on employers regarding Part D subsidies.[35]

Title X. Strengthening Quality, Affordable Health Care for All Americans. This act amends the previous nine titles. In addition, it extends the Indian Health Care Improvement Act by improving health care delivery for American Indians and Alaska Natives.[36]

b. Expanding Insurance Coverage

The discussion of expanding insurance coverage involves the need to set priority and to remove obstacles to obtain insurance. The ACA benefits are constructed based on these areas.

i. Setting the Priority.

The central goal of ACA is to provide affordable and adequate health coverage for Americans. Wider health coverage is reached by extending to young adults up to age 26, individuals with income up to 133% of federal poverty line,[37] Medicare recipients, and private insurance purchasers. Individuals who are without healthcare coverage now have the option to choose and buy a health plan in exchange. The foundational approach is to make health care affordable to all Americans by targeting cost reduction. The projected outcomes are healthier population, decreased premature mortality due to lack of health insurance,[38] and decreased medical bankruptcy results from high out-of-pocket costs.[39]

ii. Removing Obstacles to Obtain Health Insurance.

ACA policies aim at removing the major obstacles that prevent one from getting health insurance. It reduces the overall health care premium resulting in access to all Americans to obtain health care coverage. More importantly, it eliminates the restriction of only getting health insurance through employment.[40] The Ten Titles strategically include benefits that cover almost all levels of needs. New policy poses mandates on individual and business owners. In all, each American falls into one of categories that

allows him to get health insurance. It is projected 95 percent of U.S. citizens and legal residents will have health insurance within six years of the passage of ACA.[41]

2. Patients and Populations

The connection between patients and populations in the ACA focuses upon preventive care for all and increased benefit to target populations.

a. Emphasis on Preventive Care for All

The aim to decrease the rate of chronic diseases places the emphasis on preventive care. It also raises the issues of free preventive care and different levels of preventive care.

i. Free Preventive Care Services.

Chronic diseases amount to 75% of health care spending in the United States, and they are responsible for 7of 10 deaths each year.[42] For instance, more than two-thirds of American adults are obese.[43] Obesity is linked to hypertension, dyslipidemia, diabetes,[44] and early mortality.[45] Most of these diseases can be avoided if Americans are given preventive care services without out-of-pocket cost. It is often seen that copayments and deductibles are the reasons people do not seek preventive care. Considering the benefit of mammograms or Pap smears, copayments reduce the likelihood for women to use these services.

Health prevention aims at maintaining and improving physical health of the general public. It is believed that less disease results in more wellness.[46] According to

Holland, this goal can be achieved by keeping public health in focus. He presents various concepts in his arguments in support of the effort to establish policies that promote a healthier society. Practically, implementing free preventive care services is the only way to reach a larger population moving towards the goal of increasing wellness in society.

ii. Three Levels of Preventive Care

The ACA policies, as described in the Ten Titles, cover the three levels of preventive care aiming at improving overall health and wellness. According to Katz and Ali, preventive care and public health can decrease specific diseases and promote general health.[47] Stephen Schimpff, MD, also suggests health maintenance, disease prevention, and wellness programs are needed to improve health quality and decrease overall cost.[48] Preventive care involves primary, secondary, and tertiary prevention levels,[49] and these three levels actually benefit all people regardless of their level of health. Primary prevention promotes exercise and dietary practices, smoking avoidance or cessation, and immunization. Secondary prevention refers to screening such as colonoscopy and lipid testing. Tertiary prevention encompasses rehabilitation to restore functional ability and prevent degeneration.

b. Increased Benefit for Target Populations

The increased benefit for target populations involves focus in on the poor and uninsured as well as the old and weak.

i. The Poor and the Uninsured.

It is noted that states with larger non-white population tend to spend less money on welfare programs.[50] It also reflects that minority groups in those states often receive less health care service through Medicaid.[51] Although some efforts have been made to improve health, disparities continue among medically underserved populations.[52] For example, African Americans have a high risk for developing colorectal cancer, and early detection has been seen in decreasing the overall deaths in new cases.[53] ACA intends to change the condition by raising Medicaid eligibility and removes out-of-pocket cost for preventive care. This is a new provision for people with low income and uninsured.

ii. The Old and the Weak.

New change in Medicare aims at improving Medicare prescription drug coverage. Medicare is meant to be a source to provide health care to the elderly who may have passed their employment years and no longer able to obtain health care coverage from employers. The problem is that the full cost of health services is not fully reimbursed resulting in out-of-pocket costs.[54] Because Part A and Part B do not cover all medical expenses, seniors have to purchase supplemental policies. For Part D, seniors and the government each share a portion of the cost. The total out-of-pocket cost can reach $6,000 per year. Adding on to the financial burden is the problem of "donut hole." The ACA policies help to reduce expenses in “donut hole” by providing seniors additional savings on prescription drugs until it is eliminated
by 2020.[55]

Under ACA, care management to Medicare patients with high risk for hospitalization is conducted by visiting nurses. This is arranged as an ongoing help to educate and train these patients on self-management skills.[56] These visiting nurses monitor patients' health status and report changes to providers. This intervention has the potential to improve patient health. One study shows care management reduced hospitalization by 8 to 33 percent among patients who were at high risk of hospitalization.[57] The reduction of hospitalization also means decrease Medicare spending.

3. Organizations and New Mandates

Changing the way to obtain health care insurance involves implementing new policies in health care organizations and new mandates in firms.

a. Insurance Provision with Inclusion of Contraception

The priority of expanding health care requires the involvement of employers and their participation in full preventive care to women.

i. Making Health Insurance a Priority.

Under ACA policies, employer with 50 or more full-time employees must now offer health insurance. Health plan benefits must satisfy the specified criteria stated in the ACA policies.[58] Employers who do not comply will pay a penalty per each unsponsored employee.[59] This is to intentionally increase the insured population. In the United States, about 43 percent of small companies that employ fewer than 50 workers offer health

insurance.[60] These small companies pay much higher premiums than large companies.[61] For low-income families, their out-of-pocket costs are higher.[62] That leads to some of these families opting out of purchasing insurance all together. This condition is projected to change once the ACA is fully implemented.

ii. Women's Preventive Services Including Contraception.

ACA added additional preventive health benefits for women. Many women in the United States are without routine reproductive health services resulting in health complications.[63] In July 2011, the independent Institute of Medicine recommended preventive health services to include medications, procedures, devices, tests, education and counseling to improve health and delay the onset of diseases.[64] Based on that report, ACA includes the following services without out-of-pocket cost: well-woman visits, gestational diabetes screening, HPV/DNA testing, STI counseling, HIV screening and counseling, contraception and contraceptive counseling, breastfeeding support, and interpersonal and domestic violence screening and counseling.[65] It is believed that these preventive measures carry the potential to reduce health care costs.

b. Quality of Care

One of the new health care goals is to produce better health outcomes at lower costs. New measures are put in place to improve health care quality and delivery.

i. Taking Care of the Vulnerable Population.

The ACA section 2730 indicates Health Home service for people with chronic conditions including mental health, substance abuse, asthma, diabetes, heart disease, HIV/AIDS, and obesity.[66] Using the approach of treating the whole person, Health Home coordinates care including primary, acute, behavioral health, and long-term services for chronically ill people. The effort is to improve health by providing comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow up, patient and family support, and referral to community and social support services.[67]

The Community-based Care Transitions Program (CCTP) is created to reduce hospital readmission for high-risk Medicare beneficiaries. It is estimated approximately one in five Medicare patients being discharged from a hospital are readmitted within 30 days totaling the cost over $26 billion every year.[68] The goal is to correct preventable errors in hospital and improve the components along the care continuum. Care transition services are carried out by community-based organizations to manage patient's transition and improve their care.[69]

ii. Improve Quality of Patient Care

To intentionally improve the quality of care, hospitals receive financial incentives on performance.[70] Hospitals are required to report publicly on their performance regarding heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. A national pilot program is established to reimburse hospital with a bundle payment for providing efficient services while

improving quality of care. Physicians who join the Accountable Care Organization also receive financial incentives through preventing disease and illness and reducing unnecessary hospital admissions. To further promote quality of care, physicians who provide higher value care will receive higher payment.

Section Three. Patients: Autonomy and the Right to Health Care

Respect for autonomy is to consider the person's individual right in preference and decision making. It is to recognize each person has the right to choose what is best for him and has the liberty to decide on that action. Relating it to healthcare, if an autonomous person chooses health care to be the best for himself; he should be given the liberty to decide on health care coverage without resistance. At such end, ACA satisfies the individual right to autonomy.

1. Autonomy and Human Rights

The discussion regarding the use of federal funding to expand health care coverage needs to include the fundamental reasons of dignity and human rights.

a. Human Dignity & Sanctity

Health care is designed for human to use thus the explanation on the value of human beings is essential to providing health care to all citizens.

i. The Intrinsic Value of Every Human Being.

Human dignity is generally known as the foundation of human rights. It is

concerned with the respect for intrinsic value of every human being and the entire humanity. Human existence must also be perceived from the spiritual dimension in order to understand that dignity cannot simply rely on the interpretation from genetics.[71] It does not change its level or degree when a person becomes ill, disabled, or disfigured. Dignity is not earned or gained by labor or achievement; it is simply related to being humans.[72] It means humans naturally inherit rights to all necessities to sustain living. It then provides human rights with the protection of life, freedom, and property. It further extends to protect against oppression and unequal treatment.[73] These reasons justify equal access to health care for the purpose of eliminating diseases that disrupt health.[74] That means medical goods and services should be guaranteed to all members in society to sustain their existence regardless of race, socio-economics, and religion.[75]

ii. Life is Sacred.

Christian theory supports human life is sacred because of its dignity, destiny, and integrity.[76] Human beings are created in God's image and participate in God's holiness. Humans are the symbols of God, and the sacraments of God are revealed in them. God chooses His created beings as a people, a chosen race, and a society. Humans are commanded by God to keep charge of the earth, which strongly indicates the superior value of human beings. The recognition of sanctity of life brings the import of supporting a reasonable degree of quality of life. That implies the rightness to preserve life through using health care services. More clearly, it is the life preservation of the poor and the rich without partiality. It is not to advocate providing unlimited resources on each person. Rather, the quality of each life must be considered.[77]

b. Personal Autonomy

Justifying the right to health care involves personal autonomy and the freedom to self-rule.

i. The Right to Make Choices.

Personal autonomy is free from the control of others and from the limitation of making preferred choices. An autonomous person has the freedom to act on his own values and carry out his self-chosen plan without the interference by others. This is in line with Aristotle's perspective that humans act by choice generated from the inner personal will as opposed to outside force.[78] It indicates natural free will to determine action for self. Immanuel Kant explains simply the logic of the right for human determination. To be a moral agent is to take responsibility for one's own actions. To be a responsible agent is to be able to choose freely. To choose freely is to be autonomous.[79] This concept of human determination is significant in individuals' decision-making regarding health care choices. It reflects the state of independent self-governance as being able to consider the good of health care and make the decision to obtain it without the controlling interference of others.[80] This is the nature of autonomy applied in health care. In contrast, individuals, such as prisoners and persons with retardation, who cannot make decisions often are controlled by others. As seen in health care, these people often receive inadequate health care services. In these cases, it is said that their liberty in autonomy is denied.[81]

ii. Self-governance.

Self-governance allows people to manage their own life including the decision on healthcare. The principle of respect for autonomy demands the acknowledgement of people's right to self-rule and make choices based on their personal values.[82] Daniels claims in the *strong assumption* that individuals should be given the freedom to pursue economic advantage from their physical condition even when they are ill and disabled.[83] Relating it to health care, the emphasis is on respecting one's freedom to have health care services as he wants[84] to the extent that physicians have an obligation to help patients make sound medical decisions by overcoming their obstacles such as medical impediments.[85] Even autonomous persons who have self-governing capacities of their health might have constraints caused by illness, depression, coercion, or other conditions that restrict their options.[86] Not receiving health care service during illness is one of the times that restrict people's options. In most people, illness prompts the desire to seek treatment for relief of physical suffering. Respect for autonomy involves maintaining people's autonomous choice and eliminate conditions that destroy autonomous action. In contrast, disrespect of autonomy involves actions that ignore and inattentive to autonomous choice.[87] The case of not providing health treatment when needed falls in the latter condition.

2. Beneficence & Non-Maleficence

The topics of the right to treatment and the right to forgo treatment are discussed using the principles of beneficence and non-maleficence.

a. Right to Treatment

Using tax money to provide health care for members of society raises that question whether each one is obligated to do good to others.

i. The Obligatory Action to Give Benefit.

In the United States, the lack of coverage of health care to a large number of people compels a discussion on the right to treatment. Morality requires people to do good to others, and beneficence demands taking actual actions to benefit others' welfare.[88] Beneficence is associated with acts of mercy, kindness, charity, and humanity. The principle of beneficence specifically stresses the moral obligation to act for the benefit of others. In a broader sense, these obligations can apply to support the provision of healthcare to everyone securing basic protection of treatment. The act of beneficence is particularly pronounced when giving healthcare access to those who cannot afford it. The core element of the moral theory demands obligatory actions to give benefit, to prevent and remove harms, and to consider the goods and harms of an action.

ii. Health Services for All Americans.

The moral right to healthcare advocates health for all members in society in support of fair opportunity. This is only possible through government-funded health services, which means a national health policy is needed.[89] With millions of people in the United States without health insurance coverage primarily due to unemployment, poverty, and limited government-funded health resources, national health policies that include equal distributions of health services are essential.[90] The policy should guarantee

necessary care to prevent illness, diagnose and treat disease, treat injury, improve disability, or health conditions associated with avoidable morbidity and mature mortality.[91] This is the aim of ACA.

b. Right to Forgo Treatment

The concept of not to do harm to another individual is being considered in the context of the right to forgo treatment.

i. Medical Wishes.

The Patient's Self-Determination Act assures that individuals who receive services from Medicare and Medicaid are informed of their rights under state law to make decisions regarding medical care including the acceptance and refusal of treatment.[92] This will ensure the autonomous right of the patient and protect the use of the principle of nonmaleficence for physicians. The policy applies to institutional providers and health plans that participate in Medicare or Medicaid. These include hospitals, nursing homes, home health care providers, hospices, and health maintenance organizations. The participated providers and institutions are required to provide enrollees written information on their rights to make decisions concerning medical care and the right to execute their advance directive.[93] However, the provision of care does not base upon whether the patient has an advance directive. The PSDA protects individual's preferences about treatments, and advance directive is a source of making his preferences known particularly in the case when he becomes unable to communicate his medical preferences. The advance directive is important in that it gives direction to health care professionals

regarding withholding or withdrawing life-sustaining procedures.[94] The providers are to honor patients' medical wishes to treat if treatment is requested and not to treat when treatment is refused. The failure of executing both conditions violates moral principles.[95] This measure is to support personal right and autonomy specifically at end of life.

ii. ACA Includes End-of-Life Services.

In 2009, Bill HR 3200, section 1233 states the need to have an advance care planning consultation between the patient and a medical practitioner regarding advance care planning. The practitioner should explain the care planning including advance directive, living wills, and durable powers of attorney along with explanation of the role and responsibilities of a health care proxy. The practitioner is also responsible for explaining end-of-life services including palliative care, hospice, and life-sustaining treatment. Regarding life-sustaining treatment, an explanation of its benefits shall be explained to the patient and his family. The practitioner, namely physician, nurse practitioner, or physician assistant, can order life-sustaining treatment according to state approved guidelines and regulations. The patient shall receive information from the practitioner regarding designating a legal surrogate for decision making on his behalf.[96] This is to ensure patients are informed of their rights to make their final medical decisions and to avoid having physicians to make decision whether to treat or not to treat which can lead to moral concerns.

3. Patient Protection and Affordable Care Act

This section discusses the connection between the right to basic health care and

responsibility and the Affordable Care Act.

a. Right to Basic Healthcare

Tying to the concept of the right to treatment is the right to basic health care. ACA policies aim at providing services that meet basic health needs.

i. The Right to Health.

The ethical demand requires individuals, state, and non-state parties to implement and achieve compliance with a right to health according to human rights principle.[97] The goal is more likely to achieve with individual and collective efforts in domestic social, political, and economic activities. Human rights supports the liberty to pursue life goal which can only be accomplished by having good health and good functioning which justifies the demand for the right to health. The right to health is understood as a right for every human being[98] to enjoy the highest attainable state of physical and mental health. In this sense, every person should entitle to the right to health through the demand for equality of access to health services.[99] This can only be made possible through government-financed policies, such as ACA, that guarantee health services to everyone. In this way, it requires every person in society to understand the obligation to help achieve the right to health by committing to tax contribution. This sense of societal contribution satisfies reciprocity-based beneficence. All these efforts work in reclaiming a concern for health for every member in society regardless of income level and health status.[100]

ii. Minimum Coverage for Evidence-based-Services.

ACA is a policy that assures quality and affordable health care to all Americans. It aims at improving health care coverage by prohibiting lifetime or annual limits of benefits for participant.[101] It provides minimum coverage for evidence-based services that are based on the current recommendations of the United States Preventive Services Task Force. For example, the immunization practice and screenings for infants and children are provided under the guidelines supported by Health Resources and Services Administration. As for women, breast cancer screening, mammography, and prevention should be under the current recommendations of the United States Preventive Service Task Force.[102] These guidelines are set up for services to follow the current evidence-based research recommendation to ensure quality care for everyone regardless of income level and employment status.[103] Furthermore, ACA policies include wellness and prevention programs advocating smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention.[104] All of these measures focus on promoting general health as well as making available of health services to all Americans. The provision of preventive care and treatments potentiates normal functioning leading to fair opportunity that results in the satisfaction of life goal. More importantly, the new policies satisfy the moral rules that defend the rights of others by not restricting health services based on employment status, financial ability, and health status.

b. Balancing Right and Responsibility

Utilizing a national health system, such as ACA, involves the consideration of

balancing the right for health services and the responsibility to maintain the resources.

i. Benefiting from Health Care.

The current condition of limited resources did not occur overnight. Shortly after World War II, U.S. Government funded many various medical-related programs such as medical research, medical education, and hospital construction to improve people's health condition. The interest in medical science prompted the proliferation of high technology and advanced medical facilities.[105] In particular, the diagnostic technologies such as computerized tomography, magnetic resonance imaging, and positron emission tomography were highly valued for their potential to advance medicine. Advanced medical treatments were used to treat coronary artery disease, premature newborns, and intensive treatments for the critically ill. It was noted that 70% of Medicare funding was spent on critically ill patients who were roughly 9% of its recipients,[106] and up to 1% of the total gross national product was spent on people in their last year of life.[107] The global sentiment was promoting health care benefits, which overshadowed the burden of cost. Despite the growing expenditure, people were feeling good about better health services, and almost everyone was expected to receive medical treatment. While the new medical technologies were greatly appreciated, the unseen adverse effect of long-term health care cost escalation was emerging resulted in the current state of high cost health care.

Other factors that contributed to the uprising health care cost was the practice of reimbursing physician fee for whatever they billed the insurance company. In fact, insurance companies encouraged physician and hospital to provide any and all interventions that promised health benefits. In so doing, physicians were allowed to

provide as many services as possible and reimbursement was comfortably high. The insurance companies would also readily reimburse hospital care than outpatient care. As for the patients, many of them were exempted from any direct cost for health care because of the first dollar coverage by their employers. They were then able to demand the best intervention as they pleased. The combination of allowing physicians to prescribe any treatment and the patients' demand on the best health benefits contributed to the escalation in premium health care costs resulted in the current increased overall cost[108] and millions people without health services.

ii. Changing Practice.

Morreim looks at the problem in the health care system from the roles of physicians and patients. Although she shares the view of the Catholic Health Association (CHA) on eliminating unnecessary expenditures instead of denying health services to individuals in need.[109] Unlike CHA's perspective, she does not think government policy bears the sole responsibility on solving limited health care resources. Rather, she asserts new obligations should apply to both the physician and patient. For physicians, their obligation to patient care is no longer a single-minded commitment; it is now in consideration with health care regulation.[110] They are not obligated to bypass health care program limits to satisfy the patient's demands. For patients, they are now expected to make responsible lifestyle choices that lead to better health. The active participation of the physicians and patients in their new roles is expected in order to shape the new health care economy.[111]

Section Four. Population Health: Vulnerability, Justice, & Entitlement Programs in the ACA

This section focuses on the distribution of health care to vulnerable population including the elderly, poor, and disabled.

1. Vulnerability

The concern for population health raises the awareness of unequal distribution of health care that affects individuals with disadvantage. The problem can be corrected by using a statewide health policy that distributes health resources equally.

a. Physical Limitation

Physical limitation is linked to diseases and disability. Individuals who suffer these conditions are disadvantaged and vulnerable, and the level of vulnerability is depended on the severity of damage to their physical ability to function. No doubt, these individuals are in need of health care.

i. Disease

According to Center for Disease Control (CDC), approximately 117 million US adults, representing half of the adult population, have one of the 10 chronic diseases.[112] One of the significant affects from chronic diseases is decreased functional capacity.[113] The commonly accepted definition of disease clearly expresses such affect on the human body. Disease causes organ and system malfunction leading to disorder in body functioning.[114] For example, arthritis decreases joint movements and congestive heart

failure decreases physical endurance for activities. Besides physical illness, the psychological conditions such as depression also decreases functioning.[115] These conditions notably decrease the individuals' ability to perform their roles in families and communities. On personal level, diseases affect the use of their talents and skills. The worse outcome is when a disease causes permanent damage to the body resulting in disability. In other word, disease and illness reduce individuals' means to achieve goals[116] and chances of success.

ii. Physical and Mental Disability

In the United States, approximately 56.7 million people, reflecting 1 in 5 people, had some kind of disability in 2010.[117] Among them, about 38.3 million had a severe disability. Those who need assistance with activities of daily living (ADL) amount to approximately 12.3 million. Severe disability and the need for ADL increase with age. Based on the same Census Bureau's report, severe disability prevented 55.5 percent among the 16 to 64-year-olds disabled from being employed. The challenge to perform ADL and work restricts an individual's overall participation. Impairment of normal physical and mental function as in disability destroys individuals' fundamental way to exercise their talents and skills. Disability, mild or severe, restricts an individual's opportunity and ability to perform his skills and talents forcing him to void his life plan. His fair share of normal range in life is then taken because of disability.[118] It should also be noted that not being able to use one's ability to purposefully pursue goals diminishes happiness and satisfaction.

b. Financial Limitation

This section discusses the vulnerability in individuals without employment, in poverty, and who are unemployable.

i. Unemployment and Health

Researchers have documented the correlation between unemployment and health. Depending on the duration of unemployment, the longer period of financial hardship has greater consequences. This is because employment provides means to meet basic human needs.[119] It also satisfies the desire for achievement resulting in higher esteem that inspires greater goals. Conversely, unemployment causes stress and anxiety that are the commonly seen immediate human response. As the period of unemployment continues, other conditions such as depression, cardiovascular disease, musculoskeletal issues as well as death also emerge.[120] It indicates that unemployment affects physical and psychological health as well as the overall wellness of the individual. In the 6-month study conducted by Linn et al., the unemployed group visited their physicians five times more that the employed group and took twice as many medications than the employed.[121] Reasons for medical attention include both physical and psychological. The unemployed men were also found to stay in bed more days than the employed. Their psychological function is affected by stress, anxiety, and depression as manifested by loss of appetite, sleep, and sexual interests. Pharr et al also reached a similar conclusion on the connection between psychological health and loss of work and added that the unemployed were likely to experience inadequate or delay treatment due to limited health care.[122]

ii. Poverty and Beyond Working Years

Based on the 2012 report, there were 46.5 million people in poverty in the United States.[123] Poverty is noted to have correlated with health risks.[124] Living in poverty decreases the individuals' ability to remain healthy posing direct effect on personal growth.[125] They face limitation in developing skills that contribute to the work force. According to Center of Disease Control, low-income individuals experience higher rates of disease as compared to higher-income individuals. Higher mortality rates are consistently found in the lowest income,[126] and individuals with higher incomes have better health and live longer. Conversely, health improves when family income increases.[127] However, children's health is directly affected by low-income condition. Children who live in low-income condition have poorer health outcomes including physical, psychological, and learning readiness.[128] One study shows exposure to poverty in early years leads to hypertension and schizophrenia in adult years.[129] Often, they have difficulty receiving adequate health care.[130] Adult health is a result of health habit begins in early years. Evidence now shows that poverty in childhood links to poor health in adults.[131]

In 2012, 20.4 million people in the United States reported income below 50% of their poverty threshold, and 1.2 million of them were aged 65 and older.[132] The number of these elderly in poverty would have been closer to 15.3 million if social security payment not administered. It should be noted that among the people of the general population, people aged 65 and older represented 13.9 percent. The number of elderly increased to 3.9 million from 3.6 million in 2011. The population over age 65 generally has decreased ability to work posing the risk for poverty. That leads to the decrease in

financial ability to afford preventive care, drug, and even necessities.[133] It is noted their poor health condition yields the need for health care.[134] In one particular study, the findings indicate the health of the elderly improved after receiving Medicare as compared to uninsured prior to enrolling in the program.[135]

2. Justice

The principle of justice calls for equal treatment based on fair, equitable, and appropriate distribution of social goods that is owed to the persons. The current medical ethics justifies healthcare as a kind of social good,[136] and moral justification also demands distribution of medical services for the reason of well being.[137] Both perspectives strongly support the provision of health services to all people based on justice.

a. Theories of Justice

i. Distribution of Healthcare as Social Goods

Most theories of justice are based on the principles of equal share and need. Those that concern with healthcare often uses need base for their arguments. For example, unemployment subsidies, welfare assistance, and many public healthcare programs are distributed on a need base. The approach of distributive justice on the basis of need presumes the obligation of providing basic needs to sustain living, and healthcare is part of the basic needs.[138] Without healthcare, the duration of living can be shortened. That leads to the recommendation of providing decent minimum healthcare services.[139] In addition, the argument for equal share is also used in healthcare setting involving equal

access of medical research benefits. Both material principles aim at the provision of healthcare to every member in society.[140]

Various theories of justice have attempted to explain justifiable distribution of social benefits and burdens. Quality egalitarian theory of justice views healthcare as part of social goods that should be distributed equally with the acceptance of inequalities so long as they benefit the disadvantage in society.[141] Although egalitarians do not believe equal sharing of all possible social benefits, they consider healthcare as basic goods that should be equally distributed.[142] The well-known Theory of Justice claims that 1) each person should be permitted with maximum basic liberty and 2) inequalities in income, rights, and opportunities are only allowed if they benefit everyone based on fair equality of opportunity. These are the basic principles of justice.[143] Although the focus of Theory of Justice is not on healthcare, other theorists have extended these principles to apply in health policies.

ii. Two Positions on Justice

Justice basing on utility claims the action is right only when it can maximize the good; that is to produce the greater happiness possible. The thought is that as long as the "greater good" requires it, the claims of all personal rights can be overlooked.[144] Mill proceeds to explain that justice is grounded on utility, not just a feeling, and justice is useful to society. He supports the rules of justice in circumstances in which the need to promote happiness and security in society is present. In other words, the rules of justice exist to preserve order in society, which is correlative to the idea of utility. This is particularly concerned with the dispute over possession that leads to the issues of

distributive justice. In this sense, Mill agrees that justice arises from the necessity to settle societal disputes, thus, it calls for a higher moral obligation than any others.[145]

According to Rawls, people in the original position, that is the ignorance of each other's society and social status, would prefer principles that protect their own interests rather than solely looking out for the interests of the greater good. They consider the social and economic inequalities are just only if they result in benefiting everyone, in particular for the least advantaged, which is termed "difference principle".[146] Much consideration for the "least advantaged" is apparent in Rawls' writing. He writes about the strategy of "maximin" in that the members in the original position would choose policies that maximize the minimum.[147] Hence, Rawls would allow inequality so long as the least advantaged can be benefited. This perspective can apply to the approach of ACA.

b. Needs & Fairness

i. The Principle of Need

One principle of justice specifies the characteristics for equal treatment from the perspective of need base. Material principle of justice demands that social resources including health care to be distributed according to needs. This is speaking of the obligation to provide health services on the basis of need rather than the ability to pay.[148] Based on the principle of need, a person will be harmed without what he needs. This is presumably referring to the fundamental needs such as food, shelter, and important information for making critical decisions. Not meeting these needs can have detrimental effect. For this reason, all public and institutions use principles of justice to specify,

refine, or balance policies.[149] Some of the proposed principles are accepted and have been used for material of distribution justice. They are 1) to each person an equal share, 2) to each person according to need, 3) to each person according to effort, 4) to each person according to contribution, 5) to each person according to merit, 6) to each person according to free-market exchanges.[150] Examining these principles from the perspective of health care, they indicate the obligation to distribute health services to those who need them.

ii. Justice as Fairness in Healthcare

Daniels writes the moral importance of health drawing on the insight of Rawls' theory of justice as fairness. The theory of justice as fairness emphasizes the importance of protecting opportunity so that each person will have a fair share of the normal opportunity range.[151] Daniels advocates for a just health care system using the principle of "fair equality of opportunity."[152] In his argument, just health care with considered arrangement of health care distribution allows each member in society to have a fair share of opportunities to pursue life goals. It also means to eliminate barriers that prevent fair equality of opportunity and correct disadvantages. One significant barrier to pursue life goals is illness and societal disadvantages; both put restriction on one's opportunity to life goals. In this sense, equal access to healthcare is critical to sustain health leading to the result of the awareness of opportunities. It then becomes clear that health care is needed to achieve, maintain, and restore functioning by preventing disease, illness, or injury as well as providing treatments. For example, a patient who has emphysema and cannot work full time due to tiredness from decreased oxygen level. The government is

obligated to provide treatment so as to resume the patient's level of opportunity. Going further, the government might consider that getting smokers to quit smoking before they have emphysema is the best way to maintain functioning; that leads to preventive health campaigns that provide information about the risks of cigarette smoking.[153] In this sense, justice is ensured through distributing health care resources, which in turn secure fair equality of opportunity.[154]

3. Entitlement Programs in the ACA

This section focuses on health care justice for the elderly and the poor. The discussion involves the justification for Medicare and Medicaid benefits.

a. Medicare

The following discussion is concerned with health services for the old population in the United States. This is the group tends to have more health issues and lower financial means which poses a greater demand for access to health care.

i. Opportunity for Every Stage of Life

Distributive justice requires equal opportunity for each person. It then is agreeable to distribute health care fairly in society to meet the needs of the young and the old. Daniels asserts that fair share of health care distribution should be done from behind the veil of ignorance that keeps the age unknown to ensure the older population receive adequate health services.[155] The importance of health care is the enabling of normal functioning, which in turn allows one to have fair share of opportunity. Daniels

recognizes opportunity at each stage of life, thus protecting health will ensure ongoing enjoyment of opportunity.[156] On the contrary, decreased health level, a result of lacking health care, impairs normal functioning that can affect every stage of life including the later stage. In that sense, the elderly should be guaranteed adequate health care to protecting their functioning and opportunity. Furthermore, the traditional values of recognizing their past contributions and efforts made in society must be considered.[157] Jonsen also points out the peremptory approach to respect people equally.[158] Moreover, understanding that each person passes through the same stages of life, thus, all persons should be treated the same.[159] This perspective is to apply to health care distribution.

ii. Medicare for the Elderly

For the elderly groups who are eligible for Medicare, part of the improvement in the Medicare program is the establishment of the Center for Medicare and Medicaid Innovation (CMI) to conduct research by clinical and analytical experts with expertise in medicine and health care management for better services for Medicare as well as Medicaid. The purpose of the CMI is to test innovative payment and service delivery models in attempt to control cost while preserving the delivery of quality of care.[160] The idea of improving Medicare also leads to using bonus payments in assessing Medicare Advantage insurer's level of care coordination and care management.[161] Furthermore, improvement in Medicare prescription drug including 50% coverage gap discount for brand-name medications to Part D enrollees. The initial coverage limit in the standard Part D benefit will be expanded by $500 for 2010.[162] These new arrangements intend to deliver quality care to the elderly population through public health programs with

reduced out-of-pocket cost. The efforts satisfy justice demand for distributing health care resources to those who cannot financially afford it.

b. Medicaid

This section discusses the health needs for the poor and disabled population.

i. Equal resources for the Disadvantaged Population

Justice demands intervention to remedy disadvantage condition and prevent nocuous consequences.[163] The groups of the poor and disabled are entitled to equal respect considering they are full moral agents. The stigma attached to the poor and disabled is said to have negative effect on their well being,[164] and it is unlikely these individuals are able to improve their health through their own efforts. Unfortunately, the long-term disadvantage without health resources places these individuals at risk for shorter life expectancy.[165] Such detrimental consequence also affects the young as seen in infants and children in low-income families.[166] Their chances of opportunity to pursue life goal is severely reduced. Ronald Dworkin asserts that justice demands redistribution of resources to compensate their disadvantage so as to restore opportunity.[167] The benefit of health care is its potential to maintain or restore human functioning enabling individuals to compete for social positions.[168] These conditions are significant to living. Hence, equal health care resources are justified.

ii. Medicaid for the Low Income

Justice for health is seen through the ACA expansion of eligibility for persons

with lower income. It expands the eligibility for Medicaid to all children, parents, and childless adults who are not entitled to Medicare. The qualifying criterion requires individuals with family incomes at or below 133 percent federal poverty line. To strengthen the program, the cost of covering newly eligible enrollees will be funded with federal medical assistance percentage for two years during the period between years 2014 and 2016.[169] ACA also provides enhanced federal support in simplifying Medicaid and CHIP enrollment, improving Medicaid quality for patients and providers, and providing new options for long-term services and supports. The role of public programs also includes enhancing federal support for the Children's Health Insurance Program by receiving a 23 percentage point, not to exceed 100 percent, increase in the CHIP federal match rate between years 2014 and 2019.[170] These are the provisions for those who do not qualify for Medicare. Intentionally, ACA makes plans to improve the quality and delivery of care for Medicaid and Medicare participants.

Section Five. Organizations: The HHS Contraceptive Mandate in the ACA

Part of the ACA policy aims at providing women care with full basic health care services. The new policy intends to cover the range of services from well visit to free contraceptive devices. However, the provision of contraception offends certain organization values. This chapter discusses this particular organizational dilemma.

1. Right to Preventive Care

The right to care includes preventive care as well as treatment for illness for all Americans. This section discusses preventive services for women.

a. The Conflict between Government Mandate and Religious Conviction

The inclusion of contraception in preventive health services does not align with Catholic beliefs resulted in a serious conflict between the Catholic Church and the Obama administration.

i. Health and Human Services (HHS) Announcement

On January 20, 2012, the U.S. Department of Health and Human Services (HHS) announced its final decision, as part of ACA, requiring most health insurance plans to provide women with free contraceptive devices as part of the overall preventive services. It also requires most employers to provide free sterilization and some abortion-inducing drugs.[171] This policy is intended to resolve the issue of women not getting contraceptive services through their employment. HHS affirms that all forms of FDA approved contraception are within the recommendation for preventive care and should be covered under insurance policy. It further claims that the ruling is consistent with the laws in most states regarding provision of contraceptive services, and the coverage should be without cost sharing.[172]

ii. A Compromise

HHS supports its decision stating scientific evidence shows prescribed contraceptives have significant health benefits for women and their families. They are known as common measures being used by young and middle-age women in the United States. It is noted nearly 99 percent of these women rely on prescribed contraceptives,

however, more than half of these women cannot afford them.[173] Besides health benefits, contraceptives have also been documented to reduce healthcare costs. These reasons support the mandate of contraceptive coverage. For employers who do not offer contraceptive services in their health insurance plan, the new mandate allows religious employers an additional year to comply with the new law. However, organizations are required to include service locations where contraceptive devices can be obtained based on income level.[174] It is simply understood that, based on the mandate, religious organizations do not have to provide contraception but their health insurance company will.[175]

b. Needing More Provision of Women's Health Services

ACA policies aim at providing health care to all men and women. This involves providing health care that meets their health needs.

i. IOM Recommendations

Institute of Medicine (IOM) released their report in July 2011 advising preventive services for women.[176] IOM promotes optimal health by recommending women's preventive services ranging from well woman visit to screening to contraception. These services are inline with the goal of ACA to provide health care to men and women of all ages. IOM noted medical research for women's health needs received less attention as compared to men. Health care premium is reported higher for women than for men. The difference can reach as high as 48 percent.[177] However, female population was slightly more than half of the total U.S. population in 2010.[178] The lack of research on women's

health needs has found to decrease the availability of health information that could improve their quality of health.[179]

ii. Women's Health Concerns

Research in recent years found that harmful behaviors such as smoking, poor diet, and sedentary life style contribute to a great number of deaths among U. S. women. For women, tobacco use has been documented to increase the risk of cancers of the cervix and vulva as well as complications including menstrual problems, reduced fertility, and premature menopause[180] in addition to the commonly known risks of cancers of the lungs, esophagus, stomach, bladder, kidneys, and pancreas that affect both men and women. The report also points out women are at higher risk and also experiences more complications than men for most sexual transmitted diseases resulting in infertility, ectopic pregnancy, and chronic pelvic pain. On pregnancy, it poses physical and psychological health concerns as well as financial burden on women. These findings indicate women's health cannot be overlooked.

2. Protecting the Religious Identity of Organizations.

Catholic tradition promotes the provision of health care services to all people. However, one provision in ACA contradicts the Catholic teaching. This section discusses the issue of contraceptive mandate.

a. The Reaction Regarding the Contraceptives Mandate

The response to contraceptives mandate includes a strong reaction from the

leadership of the Catholic Church.

i. Contraceptives Mandate Violates Religious Liberty

The contraceptive mandate received forceful opposition from US bishops and the Catholic Health Association. Their arguments were based on that the mandate violated their religious freedom and conscience rights. On the same day of the announcement of contraceptive mandate, Bishop Timothy M. Dolan, a soon-to-be Cardinal, responded by saying the new mandate is unconscionable; for it would force Americans to either violate their consciences or forsake health care.[181] He continued stating that the mandate was an attack on religious freedom and on access to health care. The mandate would pose a challenge to religious liberty and require American citizens to compromise with their religious conviction. His response came after the knowledge of contraceptive mandate also involved the demand of providing sterilization and abortifacients. These measures are directly against the Catholic faith and the Catholic teaching. When including contraception, sterilization, and abortifacients in preventive services, pregnancy is viewed as a disease to be prevented. The government responded swiftly by allowing religious organizations to decline contraceptive coverage but demands the insurance companies to provide contraceptives without cost.[182]

ii. Upholding the Catholic Faith

The historical Catholic teaching on contraception has been consistent for the past centuries. The church position on the issue had a distinctive contribution to moral theology in the second half of the twentieth century.[183] The official teaching disallows

deliberate actions taken to prevent conception. That includes contraceptive devices and oral drugs. It further concludes the deliberate avoidance of sexual intercourse during a woman's ovulation time is also wrong.[184] Beginning with Augustine, the conception of a child was the sole reason for sexual intercourse. Any other reason (sexual pleasure) to engage in sexual act was deemed as sin. His theological reason, thus, forbade any preventive measure for conceiving a child. Until 1951, Pope Pius XII declared permission for married couple to intentionally postpone conception due to serious reasons such as medical or financial.[185] However, he upheld the forbidden use of artificial contraception because they prevent sexual act from conceiving a child. Here, the strong value of procreation is explicitly expressed in the Catholic faith.

b. Permitting Abortion

There are exceptions to some forbidden practices in Catholic teaching. This section presents the reasons and conditions that allow such exceptions.

i. Catholic Faith in the Secular World

Direct abortion is deemed intrinsically evil and prohibited according to the Catholic teaching. However, it is seen that Catholic teaching allows voting for laws that also support abortion. This is a situation when the principle of cooperation can be used to explain how Catholic values are upheld in secular practices.[186] The Church mission, according to the US bishops, is to shape society, transform the world, and promote the common good.[187] The Church is to spread the message of God in the society, which

requires taking an active role in society and interact with secular organizations without forsaking the Catholic conviction.

ii. Voting for Laws that Support Forbidden Practices

In the matter of justifying legislators who vote for laws that also support abortion, Pope John Paul II explains that the attempt to completely overturn the abortion law will not succeed. Rather, the effort should be put on reducing harm by improving protection for unborn human life resulting in decreasing the negative impact of the abortion law.[188] When a legislator has a personal ambition to oppose abortion; voting for him will help support his proposal that aims at reducing the harm from the abortion law. The principle of cooperation can apply in this scenario so long as the pro-life legislator who votes for a law that permits abortion has the intention to limit the harm done by legislation regarding abortion.[189] It allows Catholics to vote for legislators who advocate many good services and, at the same time, support abortion.

3. The Principle of Cooperation

This section discusses the right to preventive care without violating religious conviction.

a. Categories of the Principle of Cooperation

Allowing forbidden services involves the use of cooperation. The following discussion includes categories of the Principle of Cooperation.

i. Settling the Conflict

Catholic teaching advocates health care services for all people; yet abortion, assisted suicide, sterilization, and artificial contraception are forbidden. However, United States is a pluralistic society that allows these religiously forbidden services. The issue is whether the Catholic organizations can work with the government that provides forbidden services. Seeking to live with convictions among secular practices, the Catholic tradition approves specific compromise justifying certain proscribed practices. For example, the Catholic tradition allows killing in some circumstances based on the ethical theory of just war. The action of killing is justified in a specific circumstance while the ethical principle of violence is upheld. Cooperation is a possible way to settle the conflict between Catholic values and secular practice.[190]

ii. Distinctions of Cooperation

The principle of cooperation is used as a guide for allowing secular actions without forsaking the Catholic conviction. Two distinctions in this principle are formal and material cooperation. Formal cooperation is to permit and participate in the wrongdoing of another. Mediate material cooperation involves participating in what is morally good which is also connected to perceived wrongdoing of another. It requires the cooperator not to take actual action of the perceived evil and to keep a distance from the perceived wrongdoing. This form of cooperation allows compromise when dealing with conflict between Catholic values and secular practices.[191]

b. Cooperation Justifies Health Policies that Provide Forbidden Services

The following discussion involves the conditions in which the support for forbidden services is allowed.

i. Support without Violation

When HHS first made the announcement, the mandate of providing contraception to all employees applied to Catholic organizations. The Catholic Health Association and the US bishops strongly opposed the policy. Following the revision of the policy in which Catholic organizations are exempted from providing contraception, the Catholic Health Association supported the policy.[192] The principle of cooperation played a part in the compromise. The support of the Catholic Health Association after the exemption of contraceptives provision indicates the principle of cooperation justifies the legislation. Their initial opposition demonstrated the mandate was a perceived wrongdoing and no participation was intended satisfying the crucial component in the use of the principle of cooperation.

ii. Considering the Greater Good

There are conditions in the mandate of forbidden practices actually justify the use of the principle of material cooperation. As the government, an external force, poses mandate of contraceptive coverage, Catholic organizations are forced to cooperate with services that against their conviction. Even with having to comply with the mandate, the provision of health plans to employees results in greater good. In consideration of the greater good, cooperating with the contraceptive mandate would have been justified. For

the Catholic organizations that provide health insurance through outside sources, remote material cooperation is justified based on the coverage of contraceptives is provided through other companies. For Catholic organizations that self-insure their employees, proximate material cooperation is applied due to provision of contraceptives through insurance component of the Catholic organization. To a lesser controversial end, Catholic organizations, whether insured by other insurance companies or self-insured, are now exempted from the mandate.[193]

Section Six. Conclusion.

The health care law of Patient Protection and Affordable Care Act is justified by the four moral principles of beneficence, autonomy, non-maleficence, and justice based on its promotion of human rights. The passing of ACA reflects the value of human rights exceeds the value of individualism and political pressure. Beneficence is seen in ACA when health care provision protects each person's basic right, each person from harm, each person from getting sicker, and each person's opportunity to pursue life goals and happiness. Personal autonomy is satisfied when members in society are allowed to freely choose health through health services under the provision of ACA including preventive care as well as disease treatments. Nonmaleficence supports the end of life care by ethically defining "killing" and "letting die." It demands patient self-determination regarding end of life care and open discussion which are included in ACA polices. Justice is also seen in ACA as the policy decreases health equity by providing equal health services to sustain living as a way to protect fair share of opportunities enabling the pursuit of life goals. In regards to the conflict between the Catholic value and government

mandate on contraception, compromise can be made by applying the principle of cooperation which allows the support of forbidden procedure without violating the Catholic conviction for the sake of producing greater good to others. As presented in this essay, ethical principles justify the right to basic health care based on human rights, which in turn support ACA.

References

11 Norman Daniels. *Just Health Care.* Oxford, NY: Oxford University Press, 1985.

2 Ezekiel J. Emanuel, Christine Grady, Robert A. Crouch, et al. *The Oxford Textbook of Clinical Research Ethics.* Oxford, NY: Oxford University Press, Inc., 2008, p. 149.

3 Dan Brock. "Public Policy and Bioethics," In *Encyclopedia of Bioethics,* edited by W. T. Reich. New York, NY: Macmillan Reference, 1995, pp. 2181-8.

4 Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 6th Ed. Oxford, NY: Oxford University Press, 2009.

5 Norman Daniels. *Just Health.* Cambridge, NY: Cambridge University Press, 2008.

6 Daniels, Norman. *Reading Rawls: Critical Studies on Rawls' 'A Theory of Justice.'* Stanford, CA: Stanford University Press, 1989, p. xlviii.

7 Norman Daniels. *Am I Parents' Keeper?: An Essay on Justice Between the Young and the Old.* Oxford, NY: Oxford University Press, 1988, p. 69.

8 Norman Daniels. *Setting Limits Fairly: Can We learn to Share Medical Resources?* Oxford, NY: Oxford University Press, 2002, p. 15.

9 The White House President Barack Obama. "Health Care that Works for Americans," http://www.whitehouse.gov/healthreform/healthcare-overview [accessed March 7, 2015].

10 Carolyn Ann Conti. "American Health Care: Justice, Policy, Reform," (PhD diss., Duquesne University, 2010.)

11 National Health Interview Survey Early Release Program. "Early Release of Selected Estimates Based on Data from the 2013 National Health Interview Survey." http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201406.pdf. [accessed March 7, 2015].

[12] Marc A. Rodwin. *Medicine, Money, & Morals: Physicians' conflicts of Interest.* Oxford, NY: Oxford University Press, 1993.

[13] Arthur Feldman. *Understanding Health Care Reform: Bridging the Gap between Myth and Reality*. Boca Raton, FL: CRC Press, 2012.

[14] Lisa I. Lezzoni. "*Public health goals for persons with disabilities: Looking ahead to 2020,"Institute for Health Policies* 2 (2009a): 111-115.

[15] Paul Starr, *The Social Transformation of American Medicine.* New York, NY: Basic Books, Inc., 1982, p. 243.

[16] Joseph S. Ross, "The Committee on the Costs of Medical Care and the History of Health Insurance in the United States," *The Einstein Quarterly Journal of Biology and Medicine* 19 (2002): 130.

[17] U.S. Department of Health & Human Services. "The Affordable Care Act, Section by Section," http://www.hhs.gov/healthcare/rights/law/. [accessed on March 11, 2015]

[18] Nick J. Tate. *ObamaCare Survival Guide: The Affordable Care Act and What it Means for You and Your Healthcare.* West Palm Beach, FL: Humanix Books, 2012. Kindle Edition.

[19] Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone system.* New York, NY: Public Affairs, 2014.

[20] The Staff of the Washington Post. *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All.* New York, NY: Public Affairs Books, 2010.

[21] U.S. Department of Health & Human Services. "The Affordable Care Act, Section by Section," http://www.hhs.gov/healthcare/rights/law/. [accessed on March 14, 2015]

[22] Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone system.* New York, NY: Public Affairs, 2014.

[23] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3025.

[24] Minnesota Association for Children's Mental Health. "Key Features of the Affordable Healthcare Act Law," http://www.macmh.org/2012/08/key-features-of-the-affordable-healthcare-act-law/. [accessed March 14,2015]

[25] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 10408.

[26] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5301.

[27] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5308.

[28] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5303.

[29] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5306.

[30] Democratic Policy & Communications Center. "Affordable Care Act: Section-by-Section Analysis with Changes Made by Title X and Reconciliation," http://www.dpc.senate.gov/healthreformbill/healthbill96.pdf. [accessed March 14,2015]

[31] Democratic Policy& Communications Center. "The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act Detailed Summary," http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. [accessed March 14, 2015]

[32] Democratic Policy& Communications Center. "The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act Detailed Summary," http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. [accessed March 15, 2015]

[33] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 8002.

[34] Arthur Daemmrich. "U.S. Healthcare Reform and the Pharmaceutical Industry," Harvard Business School. Harvard Business School, 2011. http://www.hbs.edu/faculty/Publication%20Files/12-015.pdf. [accessed March 15, 2015]

[35] Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone system.* New York, NY: Public Affairs, 2014.

[36] Democratic Policy& Communications Center. "The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act Detailed Summary," http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. [accessed March 15, 2015]

[37] National Conference of States Legislatures. "States Implement Health Reform: Medicaid and the Affordable Care Act," http://www.ncsl.org/documents/health/HRMedicaid.pdf. [accessed March 17, 2015]

[38] A.P. Wilper, S. Woolhandler, K.E. Lasser. "Health Insurance and Mortality in U.S. Adults," *American Journal of Public Health.* 2009; 99:2289-2295.

[39] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, et al. "Medical Bankruptcy in the United States, 2007: results of a National Study," *The American Journal of Medicine.* 2009; 122:741-746.

[40] Executive Office of the President Council of Economic Advisers. *The Economic Case for Health Care Reform.* Washington, D.C: Government Printing Office, June, 2009, 3.

[41] The Staff of the Washington Post. *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All.* New York, NY: PublicAffairs Books, 2010.

[42] U.S. Department of Health & Human Services. Affordable Care Act Rules on Expanding Access to Preventive Services for Women," http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html. [access March 21 , 2015]

[43] C.L. Ogden, L.R. Carroll, M.A. Curtin, et al. "Prevalence of overweight and obesity in the United States, 1999-200*4,*" *JAMA* 295, no 13 [2006]: 1549-55.

[44] A. Must, J. Spadnao, E. H. Coakley, et al. "The disease burden associated with overweight and obesity," *JAMA* 282, no 16 [1999]:1523-9.

[45] E. E. Calle, M. J. Thun, J. M. Petrelli, et al. "Body-mass index and mortality in a prospective cohort of U.S. adults," *New England Journal Medicine* 341, no 15 [1999]: 1097-105.

[46] Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2010.

[47] David L. Katz and Ather Ali. *Preventive Medicine, Integrative Medicine & the Health of the Public.* Commissioned for the Institute of Medicine, February, 2009. http://www.iom.edu/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf. [accessed March 21, 2015]

[48] Stephen Schimpff, MD. *The Future of Health-Care Delivery.* Dulles, VA: Potomac Books, 2012.

[49] H. R. Leavell and E. G. Clark. *Preventive Medicine for the Doctor in His Community.* New York: McGraw-Hill Book Company, 1965.

[50] Colleen M. Grogan. "*Political-Economic Factors Influencing State Medicaid Policy*." *Political Research Quarterly* 47 [1994]:589-622.

[51] K. Kronebusch. *Medicaid Politics:* "Policymaking Contexts and the Politics of Group Differences in the American States," (PhD. diss, Harvard University, 1993.)

[52] J. Berry, L. Caplan, S. Davis, et al. "A black-white comparison of the quality of stage-specific colon cancer treatment," *Cancer* 116, no 3 [2010]:713-722.

[53] K. L. Foley, E. Y. Song, H. Klepin, et al. "Screening colonoscopy among colorectal cancer survivors insured by Medicaid," *American Journal of Clinical Oncology* 35, no 3 [2012]: 205-211.

[54] Stephen Schimpff, MD. *The Future of Health-Care Delivery.* Dulles, VA: Potomac Books, 2012.

[55] Medicare Prescription Drug Coverage. "Closing the Coverage Gap-Medicare Prescription Drugs are Becoming More Affordable," https://www.medicare.gov/Pubs/pdf/11493.pdf. [accessed March 29, 2015]

[56] T. Bodenheimer and R. Berry-Millett. *Care Management of Patients with Complex Health Care Needs: Research Synthesis Report No 19.* Princeton, NJ: Robert Wood Johnson Foundation, 2009.

[57] R. S. Brown, S. Peikes, G. Peterson, et al. "Six features of Medicare Coordinated Care Demonstration programs that cut hospital admissions of high-risk patients," *Health Affairs (Project Hope)* 31, no. 6 [2012]: 1156-1166.

[58] R. D. McDevitt and J. Savan. "Prospects for account-based health plans under the patent protection and affordable care act," *Benefits Quarterly* 27, no. 1 [2011]: 21-25.

[59] J. Winkler. "Reconsidering employer-sponsored health care: Four paths to long-term strategic change," *Benefits Quarterly* 29, no. 2 [2013]: 8-15.

[60] Executive Office of the President Council of Economic Advisers. *The Economic Case for Health Care Reform.* Washington, D.C.: Government Printing Office, June 2009.

[61] Jon Gabel, R. McDevitt, L. Gandolfo, et al. "Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down," *Health Affairs* 25, no. 3 [2006]:832-43.

[62] A. Galbraith, A. Sinaiko, S. Soumerai, et al. "Some families who purchased health coverage through the Massachusetts connector wound up with high financial burdens," *Health Affairs* 32, no. 5 [2013]: 974-983.

[63] National Association of Social Workers. "Reproductive health disparities for women of color," *Health Disparities Practice Update.* December 2004.

[64] Institute of Medicine. “Clinical Preventive Services for Women: Closing the Gaps,” http://iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. [assessed April, 6 ,2015]

[65] U.S. Department of Health & Human Services. ”Affordable Care Act Rules on Expanding Access Preventive Services for Women,” http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html. [assessed April 6, 2015]

[66] Medicaid.Gov Keeping America Healthy. "Health Homes," http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/health-homes/health-homes.html. [accessed April 11, 2015]

[67] Department of Health & Human Services/Centers for Medicare & Medicaid Services. "Re: Health Homes for Enrollees with Chronic Conditions, November 16, 2010," http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf. [accessed April 11, 2015]

[68] Centers for Medicare & Medicaid Services. "Community-based Care Transitions Program," http://innovation.cms.gov/index.html. [accessed on April 11, 2015]

[69] U.S Department of Health & Human Services. "Key Features of the Affordable Care Act by Year," http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html. [accessed April 11, 2011]

[70] U.S Department of Health & Human Services. "Key Features of the Affordable Care Act by Year," http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html. [accessed April 11, 2011]

[71] Roberto Andorno. "Article 3: Human dignity and Human Rights," Eds. Henk A.M.J. ten Have and Michele S. Jean, *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles, and Application.* Paris, France: UNESCO, 2007.

[72] Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010, pp. 133-134.

[73] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, p.350.

[74] Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010, pp. 133-134.

[75] Alain Enthoven. *Health Plan: The Practical Solution to the Soaring Cost of Medical Care.* Reading, MA: Addison-Wesley Publishing Company, 1980.

[76] Daivd Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.* Washington, D.C.: Georgetown University Press, 2013.

[77] Benedict M. Ashley. "Reactions of Various Scholars and Their Comments on the Working Paper, No. 1," In *A Report to the Congregation for the Faith* "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," Braintree, MA: Pope John XXIII Medical-Moral Research and Education Center, 1988, 34-36.

[78] Aristotle. *Nicomachean Ethics.* Translated by Martin Ostwald. Englewood Cliffs, NJ: Prentice Hall, 1962.

[79] Immanuel Kant. *The Conflict of the Faculties.* In I. Kant, *Religion and Rational Theology,* ed. A. W. Wood and G. di Giovanni, trans. M.J. Gregor and R. Anchor. Cambridge, MA: Cambridge University Press, [1798] 1996, 239-327.

[80] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[81] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[82] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[83] Norman Daniels. *Seeking Fair Treatment: From the AIDS Epidemic to National Health Care Reform.* Oxford, NY: Oxford University Press, 1995, p. 85.

[84] Leon. R. Kass. "Practicing Ethics: Where's the action?," *Hastings Center Report* 20, no. 1 [1990]: 5-12.

[85] Jay Katz. *The Silent World of Doctor and Patient.* New York: Free Press, 1984.

[86] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[87] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[88] Tom L. Beauchamp and James F. Childress. *Principles of Bioethical Ethics*. Oxford, NY: Oxford University Press, Inc., 2009.

[89] Norman Daniel. *Just Health Care.* New York, NY: Cambridge University Press, 1985

[90] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, 2009.

[91] Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010

[92] The Library of Congress Thomas. *Patient Self Determination Act of 1990*. H.R..4449. Sec. 2.

[93] U.S. General Accounting Office. "Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain, 1995," http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed April 21, 2015]

[94] U.S. General Accounting Office. "Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain," 1995, pp.2-3. http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed April 21, 2015]

[95] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[96] U.S. House. *To Provide Affordable, Quality Health Care for All Americans and Reduce the Growth in Health Care Spending, and for Other Purposes.* 2009, H.R. 3200, section 1233.

[97] Jennifer Prah Ruger. *Health and Social Justice.* Oxford, NY: Oxford University Press, 2010.

[98] United Nations Treaty Collection. "Treaty Series: Treaties and international agreements registered or filed and recorded with the Secretariat of the United Nations," New York: United Nations vol. 993, 1983.

[99] Norman Daniel. *Just Health Care.* New York, NY: Cambridge University Press, 1985.

[100] Jennifer Prah Ruger. *Health and Social Justice.* Oxford, NY: Oxford University Press, 2010.

[101] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2711.

[102] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2713.

[103] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2716.

[104] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2717.

[105] A.S. Relman and U. Reinhardt. "An exchange on for-profit healthcare," In *For-Profit Enterprise in Health Care,* ed. B.H. Gray. Washington: National Academy Press, 1986, pp. 209-23.

[106] L.C. Thurow. "Learning to say 'No'," *The New England Journal of Medicine* 311, [1985]: 611-14.

[107] Daniel. Callahan. "*Adequate Health care and an aging society: Are they morally compatible?*"*Daedalus* 115 [1982]:247-67

[108] E. Haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics.*1995, pp. 9-11.

[109] The Catholic Health association of the United States. *With Justice for All?: The Ethics ofHealthcare Rationing.* Lt. Louis, MO: The Catholic Health Association of the United States, 1991, p. 18.

[110] Mark. A. Hall. "The malpractice standard under health care cost containment," *Law, Medicine and Health Care* 17 [1989]: 347-355.

[111] E. Haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics.*Washington DC: Georgetown University Press, 1995, pp. 1-2.

[112] Brian W. Ward, Jeannine S. Schiller, Richard A. Goodman. "Multiple chronic conditions among US adults: A 2012 update," *Prev Chronic Dis* 2014; 11:130389. http://dx.doi.org/10.5888/pcd11.130389. [accessed May 23, 2015]

[113] Mark D. Eisner, Paul D. Blanc, Edward H. Yelin, et al. "COPD as a Systemic Disease: Impact on Physical Functional Limitations," *American Journal of Medicine* 121, no, 9 [September 2008]: 789-796. http://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=18724969. [accessed May 23, 2015].

[114] Thomas Stedman. *Stedman's Medical Dictionary.* New York, NY: Lippincott, Williams, and Wilkins, 2000, p. 509.

[115] W. Brooks, J. Jordan, G. Divine, et al. "The impact of psychologic factors on measurement of functional status: Assessment of the sickness impact profile," *Medical Care* 28, no. 9 [1990]: 793-804.

[116] David Seedhouse. *Health Promotion: Philosophy, Prejudice, and Practice.* Chichester West Sussex, England: John Wiley and Sons, 2004.

[117] Matthew W. Brault. "Americans with disability: 2010," United States Census Bureau. https://www.census.gov/prod/2012pubs/p70-131.pdf. [accessed May 23, 2015].

[118] Norman Daniels. *Just Health Care.* 1985, pp.33-34.

[119] Margaret W. Linn, Richard Sandifer, and Shayna Stein. "Effects of Unemployment on Mental and Physical Health," *Am J Public Health* 75, no. 5 [1985]: 502-506.

[120] M. H. Brenner. "Mortality and the National Economy," *Lancet* 2 [1979]: 568-573.

[121] Margaret W. Linn, Richard Sandifer, and Shayna Stein. "Effects of Unemployment on Mental and Physical Health," 1985.

[122] Jennifer R. Pharr, Sheniz Moonie, and Timothy J. Bungum. "The Impact of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors," *International Scholarly Research Network Public Health* [2012]. doi:10.5402/2012/483432.

[123] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith. "Income, Poverty, and Health Insurance coverage in the United States: 2012," U. S. Census Bureau. https://www.census.gov/prod/2013pubs/p60-245.pdf. [accessed May 24, 2015].

[124] Alex Russell. "Ensuring Access to a Healthy Life," Center for Poverty Research. Spring 2014 Issue," http://poverty.ucdavis.edu/sites/main/files/file-attachments/poverty_research_now-poverty_and_health_2014.pdf. [accessed May 24, 2015].

[125] Sigurd R. Nilsen. "Poverty in America: Consequences for individuals and the economy," Government Accountability Office. January 24, 2007. http://www.gao.gov/new.items/d07343t.pdf. [accssed May 26].

[126] Barbara Wolf, William Evans, and Nancy Adler. "The SES and Health Gradient- A Brief Review of the Literature," in *Biological Consequences of Socioeconomic Inequalities,* eds. Barbara Wolfe, William Evans, and Teresa Seeman. New York: Russell Sage Foundation, 2012.

[127] A. Case, D. Lubotsky, and C. Paxson, "Economic Status and Health in Childhood: The Origins of the Gradient," *The American Eco- nomic Review* 25, no. 4 [2002]: 1308–1334.

[128] Rita Paul-Sen Gupta, Margaret L. de Wit, and David McKeown. "The Impact of Poverty on the Current and Future Health Status of Children," *Paediatr Child Health* 12, no. 8, [2007]: 667-672.

[129] M. E. J. Wadsworth and D. J. L. Kuh. "Childhood Influences on Adult Health: A review of Recent Work from the British 1946 National Birth Cohort Study, the MRC National Survey of Health and Development," *Paediatric and Perinatal Epidemiology* 11 no. 1 [1997]: 2-20.

[130] Avik Roy. *How Medicaid Fails The Poor.* New York, NY: Encounter Books, 2013, ebook version.

[131] D. Kuh, R. Hardy, C. Langenberg, et al. "Mortality in adults aged 26-54 years related to socioeconomic conditions in childhood and adulthood: post war birth cohort study," *BMJ* 325 no. 7372, [2002 Nov 9]: 1076-80.

[132] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith. "Income, Poverty, and Health Insurance coverage in the United States: 2012," U. S. Census Bureau. https://www.census.gov/prod/2013pubs/p60-245.pdf. [accessed May 24, 2015].

[133] Diane Rowland and Barbara Lyons. "Medicare, Medicaid, and the Elderly Poor," *Health Care Finances Review* 18 no. 2 [1996 Winter]: 61-85.

[134] W.G. Manning, J. R. Newhouse, and J. E. Ware. "The Status of Health in Demand Estimates: Beyond Good, Excellent, Fair, and Poor," in *Economic Aspects of Health,* ed. C. R. Fuchs. Chicago: Chicago University, 1981.

[135] M. McWilliams, E. Meara, M. Zaslavsky, et al. "Health of previously uninsured adults after acquiring Medicare coverage," *Journal of the American Medical Association* 298, no. 24 [2007]: 2886-2894.

[136] Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010, p.120.

[137] Madison Powers and Ruth Faden. *Social Justice: The Moral Foundations of Public Healthand Health Policy.* Oxford, NY: Oxford University Press, 2006, p.17.

[138] Charles J Dougherty. *American Health Care: Realities, Rights, and Reforms*. New York, NY: Oxford University Press, 1988, p. 119.

[139] Wikler, Daniel. "Philosophical Perspectives on Access to Health Care: An Introduction." In *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services; Volume Two: Appendices, Sociocultural and Philosophical Studies*, edited by President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 108-51. Washington, DC: U.S. Government Printing Office, 1983.

[140] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 242-245.

[141] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*. New York, NY: Oxford University Press, 2001, p. 234.

[142] Larry R. Churchhill. *Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone*. Cambridge, MA: Harvard University Press, 1994, p. 35.

[143] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 247.

[144] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[145] John Stuart, Mill. *Utilitarianism.* New York: Bobbs-Merrill, 1957.

[146] John Rawls. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

[147] Benjamin R. Barber. “Justifying Justice: Problem of Psychology, Politics, and Measurement in Rawls,” in *Reading Rawls.* ed. Norman Daniels. New York: Basic Books, n.d.,1989.

[148] Norman Daniels and James E. Sabin. *Setting Limits Fairly: Can We Learn to Share Medical Resources?* Oxford, NY: Oxford University Press, 2002, p. 17.

[149] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 241-243.

[150] Nicholas Rescher. *Distributive Justice.* Indianapolis, IN: Bobbs-Merill, 1966, ch. 4.

[151] Frank Lovett. *Rawls's a Theory of Justice: A Reader's Guide.* New York, NY: Bloomsbury, 2011. ebook.

[152] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 247-248.

[153] Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, pp. 47-48.

[154] Norman Daniels. *Just Health Care.* New York, NY: Cambridge University Press, 1985, pp.34-58.

[155] Norman Daniels. *Am I My Parents' Keepers?: An Essay on Justice Between the Young and the Old.* Oxford, NY: Oxford University Press, 1988, p. 64.

[156] Norman Daniels. *Just Health: Meeting Health Needs Fairly.* New York, NY: Cambridge University Press, 2008, pp. 161-162.

[157] J. N. Morgan. "The ethical basis of the economic claims of the elderly," in *Social Policy, Social Ethics, and the Aging Society,* ed. B. L. Neugarten and R. J. Havighurst. Washington D.C.: National Science Foundation, 1976, pp. 67-9.

[158] Albert Jonsen. "Principles for an ethics of health services," in *Social Policy, Social Ethics, and the Aging Society,* ed. B. L. Neugarten and R. J. Havighurst. Washington D.C.: National Science Foundation, 1976, pp.97-105.

[159] Sudhir Anand, Fabienne Peter, and Amartya Sen. *Public Health, Ethics, and Equity.* Oxford, NY: Oxford University Press, 2004, p. 208.

[160] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3021.

[161] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3201.

[162] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3301.

[163] Madison Powers and Ruth Faden. *Social Justice: The Moral Foundations of Public Health and Health Policy.* Oxford, NY: Oxford University Press, 2006, p. 87.

[164] American Public Health Association. "People With Disability in National Health Care Reform," Policy Statement no. 9307. Washington D.C.: APHA, 1994.

[165] T. Pogge. "A global resources dividend," in *Ethics of Consumption: The Good Life, Justice and Global Stewardship,* ed. D. A. Crocker and T. Linden. Lanham, MD: Rowman and Littlefield, 1998.

[166] D. Gillespie, M. Gleason, H. Mshinda, et al. "Knowledge into Action for Child Survival," *The Lancet,* 362 [2003]:323-27.

[167] Ronald Dworkin. "What is equality? Part 1: Equality of Welfare," *Philosophy and Public Affairs* 10, no. 3 [1981]:185-246

[168] A. Buchanan, D. Brock, N. Daniels, et al. *From Chance to Choice: Genetics and Justice.* Cambridge, MA: Cambridge University Press, 2000, p. 74.

[169] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 2001.

[170] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 2101.

[171] Carol Zimmermann. "U. S. Bishops Want to Give 'careful analysis' to HHS Final Rules,"

Catholic News Service. http://www.catholicnews.com/data/stories/cns/1302837.htm. [accessed June 8, 2015].

172 U.S. Department of Health & Human Services. "Administration Takes Steps to Ensure Women's Continued Access to Contraception Coverage, While Respecting Religious-based Objections," News release August 22, 2014. http://www.hhs.gov/news/press/2014pres/08/20140822a.html. [accessed June 8, 2015].

173 Center for Medicare & Medicaid Services. "Women's Preventive Services Coverage and Non-Profit Religious Organizations," http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html. [accessed September 9, 2015]

174 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.* Washington D.C.: Georgetown University Press, 2013, p 282.

175 US Conference of Catholics Bishops (USCCB). "U.S. Bishops Vow to fight HHS Edict," United States Conference of Catholic Bishops. http://www.usccb.org/news/2012/12-012.cfm. [accessed August 18, 2013]

176 Institute of Medicine. "Clinical Preventive Services for Women: Closing the Gaps," July 19, 2011. http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. [accessed June 15, 2015].

177 Ann Gerhart. "First Lady Pushes Cause of Reform," The Washington Post, September 19, 2009. http://www.washingtonpost.com/wp-dyn/content/article/2009/09/18/AR2009091802059.html. [accessed June 14, 2015]

178 United States Census Bureau. "2010 Census Shows Nation's Population is Aging,"

https://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn147.html. [accessed June 19, 2015].

179 The National Academies. *Women's Health Research: Progress, Pitfalls, and Promise.* Washington, D.C.: The National Academies Press Openbook, 2010, p.15.

180 J. L. Luborsky, P. Meyer, M. F. Sowers, et al. "Premature menopause in a multi-ethnic population study of the menopause transition," *Human Reproduction* 18 no. 1, [2003]: 199-206.

181 United States Conference of Catholic Bishops. "U.S. Bishops Vow to fight HHS Edict," http://www.usccb.org/news/2012/12-012.cfm. [accessed June 8, 2015].

182 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.* Washington D.C.: Georgetown University Press, 2013, pp. 282-283.

183 Richard McCormick. *Corrective Vision.* Kansas City, MO: Sheed & Ward, 1994, p.11.

184 Kelly et al. *Contemporary Catholic Health Care Ethics.* Washington D. C.: Georgetown University Press, 2013, p.95.

185 Charles J. McFadden. *Medical Ethics.* Philadelphia, PA: F. A. Davis, 1955, p. 128.

186 Gerard Magill. "A Moral Compass for Cooperation with Wrongdoing*,"* In *Voting and Holiness. Catholic Perspectives on Political Participation,* ed. Nicholas P. Cafardi. New York: Paulist Press, 2012, pp. 135-57.

187 US Conference of Catholic Bishops (USCCB). *Forming Consciences for Faithful Citizenship. A Call to Political Responsibility from the Catholic Bishops of the United States.* Washington, DC: USCCB, 2009b, nos. 9 and 14.

188 US Conference of Catholic Bishops (USCCB). *Forming Consciences for Faithful Citizenship. A Call to Political Responsibility from the Catholic Bishops of the United States.* Washington, DC: USCCB, 2009b, no. 31.

[189] US Conference of Catholic Bishops (USCCB). *Forming Consciences for Faithful Citizenship. A Call to Political Responsibility from the Catholic Bishops of the United States.* Washington, DC: USCCB, 2009b, no. 73.

[190] David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics,* 2013, p 278.

[191] David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.,*2013, pp. 278-279.

[192] David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.,*2013, pp. 280-282.

[193] David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics,* 2013, pp. 283-284.

Chapter Two

The Affordable Care Act (ACA): Patients, Populations, & Organizations

Section One. Introduction

The need for wider health care coverage has been noted and pursued in the United States since the time of Theodore Roosevelt. The efforts that spent in the early 1900s reflected the awareness and need for making health care services available to all. A look into the early work of advocating health care provision not only helps to understand that the need for affordable health care is not a contemporary trend, but also to justify the benefits included in the ten titles of the ACA. Roosevelt was the Progressive Party candidate in 1912, who held the view that a country could not be strong when its people were sick and poor.[194] To build up the United States was to provide sources for society to maintain health. He supported the idea of health insurance which, at the time, was advocated by the American Association for Labor Legislation (AALL). Roosevelt did not win the presidential race, and his health care agenda was not promoted from the political platform. The outlook of the non-governmental involvement accentuated the work of the health care reformers outside of political arena.[195] As early as in 1927, an independently funded investigation by the Committee on the Costs of Medical Care was initiated to understand the cost and distribution of medical care.[196] The committee was consisted of a total of 49 members including physicians, dentists, hospital administrators, public health officials, and economists, and others.[197] The research-based investigation was conducted in five years time with 27 reports generated. The conclusions of the investigation were divided into the opinions of the majority and minority. The majority recommended

expansion of basic public health services and using insurance, taxation, or both to cover healthcare costs. It was intended to promote healthcare provision to all members of society. On the other hand, the minority recommended governmental involvement be restricted to providing healthcare to the indigent and military servicemen.

It was noted the alarming negative effects in society when diseases were unattended. The advancement of industrialization accompanied by an expansion of urban communities was the cause of health problems during the late 1800s and early 1900s.[198] The more the condition of the poorer classes in the community was investigated, the more unsatisfactory their health and social situation was found to be. Health problem found among the poorer classes of the community include, but limited to, malnutrition, tuberculosis, and pellagra. In addition, maternal and infant mortality rate was high; which could threaten the overall population rate. Unfortunately, that was not the concern at the time. Men who engaged in industry and commerce for profit had little concerns about the consequences of their actions and considered that sacrifice of several generations of workers and their families in return for the innovation of industrial machines as part of the natural order of things, and not necessary evil.

The health problems were recognized by pioneer, Edward T. Devine, who attempted to reform social welfare. He described working condition, “We find the dire consequences of death and disease, of unemployment and underemployment, of overwork and nervous strain, of dark and ill ventilated and overcrowded rooms, of ignorance and maladjustment.”[199] Soon, socially minded citizen, physicians, clergymen, social workers, and government officials found a common ground for action to prevent tuberculosis, reduce health hazards in factories, lower infant mortality, and improve the

health of school children. Not until health problems had direct negative effects on politics did government actually took action. During the First World War, many young men were found to be unfit for military service during physical examination. The reduced number of abled men to fight in the war was a great concern for the U.S. government.

It was realized that in order to increase the number of physically fit people for military tasks, the attention had to turn to reserving the life of a child. High value was placed on child life and the causes of infant mortality. Experts recognized infant mortality was caused by malnourishment, parental ignorance, contaminated food, and other factors that related to poverty. One of the learned causes of babies who died before age two was diarrhea caused by highly contaminated milk. Mothers were then encouraged to breast-feed their infants, and milk stations were established to provide pasteurized milk to children. In addition, health visitors were used to instruct mothers on how to care for children. The efforts made by the U.S. government to keep infants alive reaped positive results. From the movement of keeping children alive came the awakening of that governmental involvement in health care services save lives.

Despite the recommendation of the majority from the Committee on the Costs of Medical Care and the health issues in society, the government-funded health care system did not develop into law. However, the idea of providing affordable health services continued. One can consider the long term pursuit of affordable health care has an indication of importance to society. The unceasing effort, in the end, bore a historic result as manifested in the passage of Affordable Care Act.

Section Two. ACA Overview: Key features of Affordable Care Act

This section explores the new health care features of ACA, the analysis examines the basic Titles of ACA and their impact on expanding coverage.

a. Ten Titles of the Affordable Care Act

There is a dramatic expansion of health coverage in the ACA.[200] This expansion is manifest in the ten titles used to explain the new system.

Title I. Quality, Affordable Health Care for All Americans. This act includes the benefits of cutting out-of-pocket cost, coverage of preexisting condition, full coverage of preventive care, coverage up to age 26, creating insurance exchanges,[201] providing tax subsidies, and penalties for individuals and employers who are non-complaint.[202]

Title II. The Role of Public Programs. This act increases Medicaid eligibility to 133 % of the poverty level allowing $29,300 for a family of four or $14,400 for a single person.[203]

Title III. Improving the Quality and Efficiency of Health Care. This act aims at improving the reporting system for physicians and skill facilities,[204] closing the "donut hole" in Medicare D,[205] creating the Independent Payment Advisory Board, establishing penalties for hospital-acquired infections , and establishing programs to reduce hospital readmission.[206]

Title IV. Prevention of Chronic Disease and Improving Public Health. A designated health council is responsible for promoting prevention and wellness such as smoking cessation and reducing obesity.[207] There are grants for small businesses to set up wellness programs.[208] Restaurant menus now must reveal calorie counts.

Title V. Health Care Workforce. This act provides scholarships and loan repayment programs to increase the supply of primary care physicians[209] and nurses[210] public health dentists,[211] and mental health practitioners.[212]

Title VI. Transparency and Program Integrity. This act requires transparency reports from pharmaceutical and health device manufacturers.[213] Nursing homes must disclose expenditures and errors.[214] Physicians are to report financial interests in relation to referrals.

Title VII. Improving Access to Innovative Medical Therapies. The FDA now has improved access to license a biological product that is biosimilar to one that has been on the market for 12 years. This act also includes providing affordable medications in hospitals particularly to certain children's hospitals and underserved communities.[215]

Title VIII. Community Living Assistance Services and Supports (CLASS). CLASS is a voluntary and self-funded public long-term care insurance program for individuals with functional limitation to purchase community living assistance services.[216]

Title IX. Revenue Provisions. New taxes are added on expensive health insurance plans provided by employers, indoor tanning services, elective cosmetic surgery, pharmaceutical manufacturers,[217] high-wage workers, and on employers regarding Part D subsidies.[218]

Title X. Strengthening Quality, Affordable Health Care for All Americans. This act amends the previous nine titles. In addition, it extends the Indian Health Care Improvement Act by improving health care delivery for American Indians and Alaska Natives.[219]

b. Expanding Insurance Coverage

The discussion of expanding insurance coverage involves the need to set priority and to remove obstacles to obtain insurance. The ACA benefits are constructed based on these areas.

i. Setting the Priority.

The central goal of ACA is to provide affordable and adequate health coverage for Americans. Wider health coverage is achieved by extending to young adults up to age 26, individuals with income up to 133% of federal poverty line,[220] Medicare recipients, and private insurance purchasers. Individuals who are previously without health care coverage now have the option to choose and buy a health plan in exchange. The foundational approach is to make health care affordable to all Americans by targeting cost reduction. The projected outcomes are healthier population, decreased premature

mortality due to lack of health insurance,[221] and decreased medical bankruptcy results from high out-of-pocket costs.[222]

1. Expanding Health Coverage to Young Adults

Historically, young adults between the ages of 19 and 25 encountered challenges in obtaining health insurance. According to the report from the White House posted on January 29, 2015, in 2009, 32.7 percent of young adults between ages of 19 and 25 were uninsured.[223] The uninsured rate reflected nearly one-third of the young adult population. The uninsured percentage was twice as high as the uninsured rate in the general public. For young adults in this age group, the challenges in obtaining health insurance were mainly due to full-time schooling and part-time work. Most of their part-time jobs do not offer health insurance. Even if they do, the monthly premium is not affordable based on part-time wages. These young adults are less likely to qualify for public assistance such as Medicaid. The situation is particularly grave for those who have pre-existing health conditions when health insurance coverage is unavailable to them. Although there is the option of getting coverage under their parents' plan, individuals who are non-students and older students are not eligible for dependent coverage. There is no doubt that health is affected without health care access.

The story of Monique A. White who was diagnosed with lupus erythematosus around the time of her college graduation demonstrates the need to extend health coverage to young adults.[224] Once she became sick, she was unable to get health insurance. She fell into one of the common scenarios shared by millions of Americans in that she made too much money to qualify for healthcare under welfare but not enough to

pay for the cost of doctors' services and medications on her own. She died at the age of 32. The months prior to Monique's death, she spent time writing letters and filling out applications to plead for help. Her physician, Dr. Amylyn Crawford stated that Monique would be alive if she had health insurance. What makes her case morally wrong is that she lived in one of the richest countries in the world, where treatments and medications are advanced.

Since ACA permits individuals up to age 26 to stay under their parents' plan, as many as 4 million uninsured young adults are now with coverage. There is strong evidence to show that increased access to health care links to the decreased rate of delaying to seek care as well as the reduced number of young adults who did not receive needed medical care.[225] One study shows dependent coverage links to improved health among young adults between ages 19 and 25.[226] Another study indicates having health care coverage provides peace of mind resulted in improved perception of health.[227] The provision for dependent coverage is also found to be a strategy for improving mental health among young adults.[228]

2. Medicaid Expansion

Medicaid was signed into law in 1965 as an effect of the successful approval of Medicare.[229] The program was intended to provide health care needs to the poor using the same reasoning that applied for the elderly under Medicare. It was agreed that Medicaid would be financed by both the federal government and state. For that reason, the state has been allowed to set its own guidelines regarding eligibility and services. Although it is understood that a core group of poor population must qualify to receive Medicaid

benefits, each state sets its own rules on coverage. It means that coverage varies from state to state, and it is not mandatory to cover individuals, say, who are pregnant, blind, disabled, or low-income level.[230] For instance, in 17 states, eligibility for Medicaid requires parents' income at the level of $11,000 for a family of four while 8 states and the District of Columbia qualify parents with income level at $33,000 for a family of four.[231] The variability resulted in a coverage gap as demonstrated in only two out of five poor people receive health care.[232] It is also noted the largest uninsured group of poor people is the single adults without dependent children. This group of population accounts for 55 percent of all non-senior people. [233] They are eligible for Medicaid only if they are pregnant or severely and permanently disabled.

ACA narrows the coverage gap by increasing the federal poverty level to 133 percent as means to expand eligibility for adults under age 65.[234] Enrollment data shows that between summer 2013 and January 2015, there was an increase of approximately 11.2 million enrollments in Medicaid and CHIP.[235] Under the new healthcare law, Medicaid eligibility is now based on the federal poverty level. The single measure approach eliminates the variations regarding eligibility from state to state. The new law also allows childcare expenses to be deducted from income raising the level of eligibility. The new Medicaid guidelines qualify a family of four with a total income of $29,327 and a one-person household of $14,404.[236] This coverage includes preventive services and no cost sharing. In addition, it will also increase physician reimbursement to Medicare level promoting larger physician service groups.

3. Improve Medicare Benefits

Medicare was signed into law in 1965 to serve as a provision of health insurance to people over age 65.[237] It covers hospitalization (Part A), physician services (Part B), and medications (Part D). Since the uprising of the cost of drugs, medications coverage has been an ongoing problem. Part D contains an annual drug coverage limit. When the medication spending reaches the annual designated limit, Medicare then denies drug coverage. However, drug coverage will resume when the patient exhausts his out-of-pocket contribution. Those who fill their prescriptions receive monthly report "Explanation of Benefits" notifying their spending on covered drugs. By that they know if they have reached the coverage gap.[238] In cases of high out-of-pocket spending, it becomes a burden to seniors who do not have employment to support medication use. Some are forced to discontinue their medications, which can be detrimental to health conditions particularly in cases of chronic diseases.

The new healthcare law aims at closing the coverage gap by the year 2020.[239] In the meantime, seniors pay 45% in 2016, 40% in 2017, 35% in 2018, 30% in 2019, and 25% in 2020 when buying Part D-covered brand name medications during the coverage gap.[240] As seen here, out-of-pocket cost decreases each year for the next five years. The contribution expressed in percentage is higher for generic drugs due to the overall cost for generic medications are lower.

ii. Removing Obstacles to Obtain Health Insurance.

ACA policies aim at removing the major obstacles that prevent one from getting health insurance. It reduces the overall health care premium resulting in access to all

Americans to obtain health care coverage. More importantly, it eliminates the restriction of only getting health insurance through employment.[241] The Ten Titles strategically include benefits that cover almost all levels of needs. New policy poses mandates on individual and business owners. In all, each American falls into one of the categories that allows him to get health insurance. It is projected 95 percent of U.S. citizens and legal residents will have health insurance within six years of the passage of ACA.[242]

1. A Chance to Get Care

Before the enactment of ACA, many adults in the United States were not getting care due to lacking health insurance. As a result, health issues could not be tended resulting in more serious conditions. Illnesses, as we know it, affect personal psychiatric health, decrease work performance, and increase healthcare costs. Under the provision of ACA, all health plans are required to cover preventive services without out-of-pocket costs.[243] These services are extended to adults, women including pregnant women, and children based on health risks, recommended ages, and recommended population. The goal is to provide what it needs to stay healthy, avoid, or delay the onset of disease. That in turn will promote productive lives. The projecting goal is to have a society with better health and less illness.

There are specific areas of preventive coverage that aim at promoting and improving health in the general population. The significant change in health care law is noted in adult health coverage. For example, adults age 19 and older are now eligible to receive free-of-charge vaccines recommended by Advisory Committee on Immunization Practices (ACIP) and approved by Center for Disease Control (CDC) including, but not

limited to, herpes zoster, seasonal influenza vaccine, and Quadrivalent Human Papillomavirus vaccine for females.[244] The benefit of screening for high blood pressure, high cholesterol, type II diabetes, alcohol misuse, obesity, tobacco use, sexually transmitted infection, and depression is early detection and treatment that reduce the advancement of these medical conditions.

2. “I can’t afford health insurance.”

The main focus of ACA is to reduce the number of uninsured individuals in the United States. The policy offers various options to optimize the possibility to be insured under one of the health programs. Individuals or families have low income can enroll in Medicaid. Those who do not qualify for Medicaid can receive subsidized insurance plan through states’ healthcare exchange. If the individual’s state does not offer health exchange, he can choose from the federal government exchange. These exchanges offer a selection of health plans with various pricing. The goal is to provide options that fit each individual’s budget and needs. The health exchange provision also allows individuals with higher income that is within the guideline to compare pricing between plans in the exchange and private insurance and purchase a plan that is more affordable. It is very likely that the plans in the exchange are cheaper than private insurance because of their set up as a large group of insurance plan.

The nation’s younger group of individuals is recognized as mostly healthy with the lowest health risk. Under the ACA individual mandate, all legal Americans are required to obtain health insurance through various options in the policy. For individuals who are between the ages of 26 and 29, there are two ways to get health coverage.

Individuals should visit the Health Insurance Marketplace to compare health plans that meet their needs.[245] They may get lower cost on monthly premium and may also qualify for lower out-of-pocket costs. If their income levels are within federal guidelines, they can qualify for Medicaid. In cases when family incomes are too high to qualify for Medicaid, the Children's Health Insurance Program (CHIP) in some states provides coverage for parents and pregnant women. The cost of CHIP varies from state to state, however, it will not cost more than 5% of family income. The CHIP coverage works closely with state Medicaid.[246] The second way is the option of purchasing the catastrophic plans that protects high medical expenses. These plans usually have low premiums but very high deductible at the cost of $6,850 in 2016.[247] Once the deductible is satisfied, the plans will cover 100% of the services. They will provide three primary care visits each year and certain preventive services are without out-of-pocket costs.

3. Coverage for Pre-existing Condition

According to U.S. Department of Health & Human Services, 19 to 50 percent of non-elderly Americans have some kind of pre-existing health conditions ranging from heart disease, asthma, diabetes, and cancer.[248] The percentage is translated into 50 to129 million people meaning one in five non-elderly people in the United States carry a pre-existing health condition. 25 million of these people are uninsured. Among those who are insured by employer-based coverage, 82 million of them have pre-existing health conditions. However, workers can lose their employer-based coverage health insurance when they become unemployed, self-employed, experience life events such as divorce or retirement, or relocation. They will then face major obstacles to continue to get treatment

for their chronic conditions. One study shows that 36 percent of individuals with pre-existing conditions were rejected when attempting to purchase health insurance.[249] It happened to Michael, a retiree, who lives Mississippi. Michael was rejected health insurance due to a pre-existing condition that involved a cardiac pacemaker.[250] He was without health coverage for nearly three years until he was accepted in the program Pre-Existing Condition Insurance Plan. He saw a cardiologist two days after the coverage began and was told the battery of the pacemaker was running out. He was scheduled to have surgery the following month. As for those who own individual market health insurance policy, one survey finds that 54 percent of them worry about denial of health coverage by their insurers if they become seriously ill.[251] Understanding the risk, high portion of individuals with chronic illness will less likely to leave their job once they obtain employer-based coverage resulting job lock.[252] This is particularly true among older workers who might not be able to choose the option to work part time or retirement in fear of losing health coverage.

Adding to the issue of pre-existing condition is the annual and lifetime limit that poses significant risks for high-out-of-pocket-cost care once the benefits run out. This unfortunate situation happened to Amy who lived in Iowa. Amy was sick and nearly killed by a rare form of infection.[253] During her treatment and recovery, she was on ventilators and dialysis. In addition, she needed medications that cost up to $1,600 per dose. The cost of her medical treatment rose quickly. Although Amy's health policy included $1 million lifetime dollar limit, she exceeded her coverage limit within months. This is the burden that many Americans encounter during their sick trial and recovery from illness.

Under ACA policy, all marketplace insurance plans are mandated to cover pre-existing health conditions. The policy further demands that no insurance plans can refuse to insure patients, raise the premium, or refuse to pay for treatment for pre-existing conditions.[254] That eliminates the burden of not getting needed treatment and medical debt. Once the policy begins, insurance plans are not allowed to deny coverage or increase premium based on health condition.

Section Three. Patients and Populations

The connection between patients and populations in the ACA focuses upon preventive care for all and increased benefit to target populations.

a. Emphasis on Preventive Care for All

The aim to decrease the rate of chronic diseases places the emphasis on preventive care. It also raises the issues of free preventive care and different levels of preventive care.

i. Free Preventive Care Services.

According to Department of Health & Human Services, chronic diseases amount to 75% of health care spending in the United States, and they are responsible for 7of 10 deaths each year.[255] For instance, more than two-thirds of American adults are obese.[256] Obesity is linked to hypertension, dyslipidemia, diabetes,[257] and early mortality.[258] Most of these diseases can be avoided if Americans are given preventive care services without out-of-pocket cost. It is often seen that copayments and deductibles are the reasons

people do not seek preventive care. Considering the benefit of mammograms or Pap smears, copayments reduce the likelihood for women to use these services.

Health prevention aims at maintaining and improving physical health of the general public. It is believed that less disease results in more wellness.[259] According to Holland, this goal can be achieved by keeping public health in focus. He presents various concepts in his arguments in support of the effort to establish policies that promote a healthier society. Practically, implementing free preventive care services is the only way to reach a larger population moving towards the goal of increasing wellness in society.

1. Emphasis on Prevention

One of the main focuses of ACA is to provide patients with free-of-charge preventive services that aim at reducing the risk for disease advancement. The areas of preventive care are put in categories based on age group and gender,[260] and the recommendations are based on evidence that proven to have health benefits. As seen in adult group, these specific preventive screening tests carry the potential to prevent health conditions from developing into more severe illnesses if detect early: abdominal aortic aneurysm for male smokers, alcohol misuse, blood pressure, cholesterol, colorectal cancer screening, depression, type II diabetes, HIV, immunization, obesity, and sexual transmitted diseases.[261] These conditions are now commonly seen in adult population in the United States. In fact, many adults suffer some of these conditions chronically resulted in decreased functioning. The economic loss is seen in absentee at work due to sick days. These negative effects disrupt personal advancement and impact the financial aspect on the individual and national level. Take obesity as an example, it is now

acknowledged by the media and public the increase risk for type II diabetes, heart disease, and cancer.[262] Screening and weight loss counseling can help to slow the epidemic of obesity. As seen so far, the main reason for most people not to get recommended screening is the cost.[263] ACA policy requires Medicare, Medicaid, and all health insurance companies to cover preventive care without out-of-pocket cost. The provision of free preventive services will encourage people to seek early detection that ultimately reduces the risk for advance disease process.

Beginning on September 23, 2010, ACA required insurance plans to provide certain recommended preventive care without charge.[264] Under ACA provision, 76 million more Americans are now eligible for expanded preventive services coverage.[265] The statistics reflects and support the notion that there is a need for preventive care.

2. Wellness Program

The concept of wellness programs stems from modification of behaviors to prevent illness.[266] It commonly includes changing diet and behavioral habits to improve health. The outcome of improved health is decrease risk of illness and reduce absentee at work. Health allows people to have better physical and mental ability to pursue life opportunities. ACA allows insurance plans to offer rewards as an incentive to motivate people to move towards healthy living.[267] One way of encouraging people to get recommended screening, vaccines, and engage in healthy behaviors is by reducing insurance premiums. This approach can motivate people to persevere through the difficult behavior changing process as seen in smoking cessation and weight loss. The method of offering incentive has been used in other promotions such as auto insurance that reduces

rate with good driving record. The incentive motivates people to drive more defensively and avoid reckless driving behaviors. The following illustration demonstrates how motivating incentive program in practice. Health Insurance Portability and Accountability Act of 1996 permitted financial incentive up to 20% of the health insurance cost.[268] It means for the annual healthcare cost of $12,000, the saving is $2,400.[269] People are willing to take up the effort to live healthier when the incentive is tangible.

Another wellness approach takes place in the physician's office. Beginning in January, 2011, Medicare members receive annual wellness visit with their physician.[270] The purpose is to update and develop a personalized preventive plan to avoid illness and disability based on health risks. It reviews risk factors of the following areas: family health history, vital signs, cognitive function, history of immunization, fall risks, hearing, home and fire safety, and screenings.[271] During the interview, the physician reviews the health risk assessment questionnaire and recommends prevention plan to promote healthy behaviors. Education and preventive counseling include nutrition, physical activity, tobacco cessation, and weight loss. These measures aim at health promotion and disease prevention.

The goal of prevention has an increase rate of success through public health. In 2010, the Prevention and Public Health Fund (PPHF) was established under ACA policy. It is the first mandatory system funded by the government to improve public health in the United States.[272] This is not an entirely new concept. In 1908, a Division of Child Hygiene in the New York City Health Department was established to initiate a program to require newborn babies who were born in the congested section of New York's lower East Side to be registered the day after their births.[273] A public health nurse would visit

the mother and teach her what needed to be done to keep the baby well. Two months after the program was initiated, it was found that there were 1200 fewer deaths in the district compared to the summer before. Later in 1921, Federal funded was used in health services for school children such as using school nurses and physicians for sanitation inspection and prevention of communicable diseases. Free clinics included general medical clinic, skin clinic, eye clinic, tonsil clinic, and a dental clinic was set up for school children.[274] These public services reaped noted success as seen in improved health in children. The outcome certainly was a reflection of the utility of public health services.

The newly established PPHF under ACA was allotted funding specifically for use towards expanding and sustaining national prevention and public health programs. The aim is to launch a wide spread national effort to improve public health and ultimately reduce health costs. The prevention strategy is done through various programs targeting the reduction of disability and the causes of death. The primary avocation is early detection and appropriate treatment to eliminate health threats. A wide range of programs is developed aiming at benefiting the general public of all ages. For example, home visitation for pregnant women and at-risk infants and toddlers to prevent injuries that might delay learning readiness.[275] Other plans focus on nutritious diet, smoking cessation, and building playgrounds to promote healthier living.

3. Lifestyle Modification

Extending from Let's Move Initiative that focuses on reversing childhood obesity, ACA established major health promotions that target healthier diet. There is a need to have a transformation in today's sedentary lifestyle. Take a look at the increase in body

mass index (BMI) between 1970 and 2000, average BMI was about 25 in the mid 1970s and rose to 28 in 2000s.[276] The understanding is that normal range for BMI is 18-24.9, obesity is above 30,[277] and morbidly obese is above 35. The increase of BMI is an indication of weight gain as a result of unhealthy diet and lack of exercise. Looking at the current trend, a national program is needed for promoting healthy diet habit leading to a healthy weight. Good eating habits should include whole grains, lean meat, and vegetables with strong warning to avoid fatty and processed foods. There should be a promotion to advocate family dinners made with wholesome ingredients and discourage frequent fast food consumption. This is precisely the focus of ACA prevention programs- to encourage and educate people to modify their lifestyle.

One of the major health promotion initiatives is menu labeling. ACA requires restaurants and fast food chains (with more than 20 locations) to list calories information on menus and drive-through boards.[278] Operators of vending machines (20 or more machines) are required to disclose calorie information on items sold.[279] Other nutritional information such as fat, cholesterol, sodium, carbohydrates, and sugar, should also be made aware. This is to educate people about the calorie content in food items leading to better food choices. On a larger scale, the requirement for the nutritional labeling will encourage food manufacturers to reformulate their products that contain reduced calories. Since Americans consume 1/3 of their calories outside of home setting, nutritional labeling will enable them to make informed diet choices.

ii. Three Levels of Preventive Care

The ACA policies, as described in the Ten Titles, cover the three levels of

preventive care aiming at improving overall health and wellness. According to Katz and Ali, preventive care and public health can decrease specific diseases and promote general health.[280] Stephen Schimpff, MD, also suggests health maintenance, disease prevention, and wellness programs are needed to improve health quality and decrease overall cost.[281] Preventive care involves primary, secondary, and tertiary prevention levels,[282] and these three levels actually benefit all people regardless of their level of health. Primary prevention promotes exercise and dietary practices, smoking avoidance or cessation, and immunization. Secondary prevention refers to screening such as colonoscopy and lipid testing. Tertiary prevention encompasses rehabilitation to restore functional ability and prevent degeneration.

1. Primary Prevention

ACA prevention targets the goal of improving health and reducing the onset of illness. Primary prevention focuses on protection from exposing to disease and decreasing risk factors that lead to illness,[283] disability, and premature death. It also includes the idea of increasing resistance to disease.[284] Practical steps towards promoting prevention include physical activity, healthy diet, smoking avoidance or cessation, and stress management.[285] This approach is effective in early stage when causal factors produce physiologic abnormalities without the manifestation of symptoms. For example, elevated cholesterol levels without atherosclerosis can be treated with lifestyle modification including healthy diet (low fat), exercise, and smoking cessation.[286] The other health prevention approach is via immunization that provides protection against disease. To reach the goal of wide spread promotion of prevention, the effort is extended

to involve changing the environment as well as changing the life styles and behaviors in the community, family, and individuals. One of the successful community-based programs for healthy diet was seen in community gardening that grows vegetables and fruits. The result of the study shows that community gardeners eat more vegetables than those who do not take up gardening.[287] Another report from Scotland states the positive outcome of introducing healthy food items in convenient stores raising higher awareness of healthy diet.[288]

Cooperating with ACA, National Prevention Strategy includes recommendations that public and private organizations can take part in helping Americans to stay healthy. The development of the strategy is based on the recognition that good health does not solely come from good medical care. Rather, good health is a result of stopping the disease before the onset, consuming healthy food, using clean air and water, engaging in physical activity, working in a safe environment, and living in healthy homes.[289] The new Community Transformation Grants are designated to improve the following areas: nutrition, physical activity, emotional wellness, smoking cessation, and health disparity.[290] The use of prevention can apply in these aspects of daily living to promote healthy lives. Rather than putting the attention on treating disease and illness, it is believed the approach of wellness and prevention has greater effect on achieving health.

2. Secondary Prevention

Secondary prevention focuses on detection and decreases disease complication.[291] Its purpose is to manage pre-symptomatic disease and prevent the progression to actual symptoms.[292] The effective tool is through screening and early diagnosis follows by

necessary treatment. This is referred to as a second line of defense against disease with the intention to avoid the progression to symptomatic condition. In 2014, 29.2 percent of U.S. population was obese and 9.6 percent had diabetes.[293] The report continues to point out that obesity alone contributes to diseases including heart disease, stoke, hypertension, liver disease, Alzheimer's disease, dementia, respiratory conditions and osteoarthritis. The special attention is on those who are at risk for health problems because of age, family health history, health behaviors, and lifestyle. Samples of recommendations for secondary prevention include blood work to check cholesterol, and diabetes, referral for treatment, nutrition guidelines, and physical programs. For example, mammography and colonoscopy are recommended for those who have family history of cancer. Another common concern is cardiac risk that can be detected using screening of cholesterol level and blood pressure. Early treatment show efficacy in improving both lipid profile[294] and reducing blood pressure.[295] The results are even better when combining with lifestyle change.

Provision from ACA that supports secondary prevention includes screening, counseling, and monitoring risk factors. Some of the recommendations on the list include screening for obesity, blood pressure, cholesterol, type 2 diabetes, tobacco, depression, sexual transmitted diseases, and diet. These are the commonly seen risk factors that can potentially develop into serious diseases that disrupt functioning and increase healthcare cost. With no out-of-pocket cost to these preventive screenings, people are prone to participate in early detection and receive treatment if needed. It is likely that early physiologic abnormalities are interrupted from progressing into symptomatic diseases.

3. Tertiary Prevention

Tertiary prevention takes place after the occurrence of a health condition. It also aims at managing chronic diseases and permanent impairments.[296] The main purpose is to manage the health condition through rehabilitation to reduce further complications such as disability.[297] The attention is placed on improving health resulting in better quality of life, and ultimately extends the years of productivity. The approach is to control symptoms and stall the disease progression so as to restore functional capacity.[298] For example, cardiac rehabilitation is recommended after coronary heart disease. These programs aim at reducing causal factors and cardiac mortality, and also increase left ventricular ejection fraction,[299] cholesterol level, and blood pressure.[300] In addition, depression is documented to have experienced by some post cardiac surgery patients. It increases the risk of mortality, however, those who complete cardiac rehabilitation have shown improvement in depressive symptoms.[301] Other tertiary prevention programs are designed to manage chronic diseases such as diabetes and arthritis. The goal is to improve both the ability to function and quality of life.

In addition to rehab and long-term management programs, the focus is also on decreasing preventable hospital readmission. Under the new healthcare policy, programs are developed to manage patients' post-discharge health condition to avoid hospital readmission.[302] This includes, but limited to, improving the quality of hospital inpatient care, timely discharge, adequate discharge planning, follow-up care, and transitional care. The purpose is to help patients returning as much as possible to their physical state prior to illness.

b. Increased Benefit for Target Populations

The increased benefit for target populations involves focus in on the poor and uninsured as well as the old and weak.

i. The Poor and the Uninsured.

It is noted that states with larger non-white population tend to spend less money on welfare programs.[303] It also reflects that minority groups in those states often receive less health care service through Medicaid.[304] Although some efforts have been made to improve health, disparities continue among medically underserved populations.[305] For example, African Americans have a high risk for developing colorectal cancer, and early detection has been seen in decreasing the overall deaths in new cases.[306] ACA intends to change the condition by raising Medicaid eligibility and removes out-of-pocket cost for preventive care. This is a new provision for people with low income and uninsured.

1. Low-income Population

Low-income individuals faced serious challenge in obtaining healthcare access. Among the 50 million uninsured Americans, approximately 70 percent are low-income individuals.[307] Based on 2012 data, families that experienced the highest level of financial burden of medical care were those with incomes at or below 250% of the federal poverty level.[308] Many of these individuals would go without healthcare due to unaffordability. Even in cases with insurance coverage, cost remains a major barrier to getting needed care.[309] The health care burden affects all members of the family, even for one member of the family can result in decreasing financial means to afford necessities causing increased

family stress.[310][311] Studies have shown that low-income people often delay needed care when out-of-pocket cost is high relative to their small income.[312] The cost of insurance took up a sizable portion of their income that forced them to forgo healthcare. To them, it would be a decision between affording food and healthcare. For low-income adults, most would choose the former. In the situation without health insurance, uninsured individuals are less likely to have regular care, are less likely to participate in preventive services, and are more likely to not seek treatment due to costs.[313] The effect is significant in situation of serious health condition such as asthma. Research studies find that the condition of asthma among low-income people tend to be more intense and more likely to require hospitalization.[314] Because it is not managed and monitored, asthma flare-up occurs more frequently posing serious health problem.

Public insurance coverage lessens the financial burden for low-income families. The benefits are even greater for the very low-income families. It reduces the likelihood to give up treatment to pay for food and housing.[315] The new healthcare policies under ACA expand Medicaid eligibility to cover incomes up to 133 percent of the federal poverty line by 2014, regardless of children. Insurance subsidies will be provided to incomes up to 400 percent of the federal poverty line. Also, tax credits are provided to small businesses that employ low-wage workers. These measures intentionally aim at providing healthcare coverage to individuals who cannot afford medical care. The provision allows greater coverage of preventive care that promotes higher wellness and better health in society.

2.Minority Groups

Studies have shown that racial and ethnic minorities experience medical disparity.[316] The Institute of Medicine (IOM) research committee stated in their findings that minorities tend not to receive needed health services even necessary procedures and routine treatment.[317] They also receive less attention in preventive care services. One study concludes that African Americans receive less preventive care services as well as life-saving treatment than Caucasians.[318] The outcome of decrease availability to health services prevents people from seeking care resulting in serious illness that lowers functioning. This should be of a concern from the health care perspective. Various reasons have been suggested based on research findings. The obvious barriers are related to conditions of culture and language. The lack of translation decreases the quality of health services and the possibly leads to cancellation of services all together. Then, it is noted a greater number of minorities are enrolled in lower-cost health plans that purposely limit healthcare expenditures resulting in limited services. The intention to contain cost motivates the use of incentives to physicians to limit services and access to private physician's office. The healthcare services that are available to these groups of population are noted as poor quality.[319] Other factors are concerned with physicians' uncertainty towards minority patients' health behaviors and beliefs.[320] How do these factors affect healthcare among minorities? The overall decrease service of health care to minority stirs a sentiment of mistrust of healthcare providers based on negative clinical experience and a perception that healthcare providers do not want to invest care in them. Receiving less healthcare attention regularly posts greater risks for serious illness that potentially effects societal health outcome and higher cost of advanced disease stages.

An example of the life-saving benefit of ACA policies is the provision of colorectal cancer screening (blood stool test, flex-sigmodoscopy, and colonoscopy) that is provided for all persons age 50 and over. The new healthcare law requires all health insurance plans to cover preventive services without out-of-pocket cost, and colorectal cancer screening is recommended in category A reflecting high certainty that the net benefit is substantial.[321] Studies have shown that African Americans have higher risk for developing colorectal cancer[322] and likely die from it.[323] Due to lack of access to health services, many African Americans could not participate in cancer screening. However, since increasing coverage through ACA, minority groups such as Hispanic and Blacks show greater decline in uninsured rate.[324] The new healthcare policies provide free access to preventive care removes the barriers for early detection and potentially saves lives.

3. Uninsured Population

The cause of uninsured of healthcare is mainly due to decreasing employer sponsored insurance coverage, rising healthcare costs, and job loss.[325] The common source of access to healthcare coverage is through employment. However, many workers do not obtain health insurance through their jobs. For some who are being offered health insurance through work, the contribution of premium is high relative to their income resulting in opting out of coverage. Also, low economy is a significant cause of increased uninsured rate. Weak economy often leads to recession that subsequently results in widespread job loss. What follows is the decrease of employer-sponsored health insurance, and the declining family incomes pose unaffordability. From the state, as of September 2015, 31 states have expanded Medicaid eligibility. However, people who live

in states that have not yet expanded Medicaid coverage still face the challenge to obtain healthcare coverage. According to CMS guidance, there is no deadline for states to implement the Medicaid expansion.[326] Reports also show that uninsured individuals have greater risks of remaining uninsured. Data shows that 29% of those individuals had been uninsured for one to five years, 24% reported to have been uninsured for greater than five years, and 10% reported to have never been insured.[327] The long periods of uninsured was initiated when they could not obtain coverage. After a time, it becomes difficult for them to seek coverage resulted in remaining uninsured.

ACA lowers the number of uninsured Americans by making health insurance affordable. The new policies provide all Americans accessibility to healthcare. From employer-mandate coverage provision to Medicaid to market exchange, the aim is to insure Americans who can then utilize preventive care and avoid serious illnesses. It is now understood that going without healthcare coverage leads to forgoing or delaying preventive care resulting in requiring advanced treatment later. The consequence affects both the patient (decrease functioning) and the healthcare system (financial burden). The coverage expansion is still at its early stage of implementation. However, it is noted that many people have taken advantage of the provision by applying for healthcare coverage since the passage of ACA.

ii. The Old and the Weak.

New change in Medicare aims at improving Medicare prescription drug coverage. Medicare is meant to be a source to provide health care to the elderly who may have passed their employment years and no longer able to obtain health care coverage from

employers. The problem is that the full cost of health services is not fully reimbursed resulting in out-of-pocket costs.[328] Because Part A and Part B do not cover all medical expenses, seniors have to purchase supplemental policies. For Part D, seniors and the government each share a portion of the cost. The total out-of-pocket cost can reach $6,000 per year. Adding on to the financial burden is the problem of "donut hole." The ACA policies help to reduce expenses in “donut hole” by providing seniors additional savings on prescription drugs until it is eliminated by 2020.[329]

Under ACA, care management for Medicare patients who are high risk for hospitalization is conducted by visiting nurses. This is arranged as an ongoing help to educate and train these patients on self-management skills.[330] These visiting nurses monitor patients’ health status and report changes to providers. This intervention has the potential to improve patient health. One study shows care management reduced hospitalization by 8 to 33 percent among patients who were at high risk of hospitalization.[331] The reduction of hospitalization also means decrease Medicare spending.

1. Medicare Recipients

The implementation of ACA does not affect Medicare coverage. The Medicare Program continues to be funded by Hospital Insurance program (Medicare Part A) and the Supplementary Medical Insurance program (Medicare Part B and Prescription Drug Coverage).[332] According to Centers on Budget and Policy Priorities, ACA has improved the outlook of Medicare’s finances.[333] The life of the Medicare Trust Fund is extended to at least 2029 reflecting a 12-year extension as a result of reductions in waste, fraud, and

Medicare costs.[334] Medicare program is able to preserve guaranteed health coverage and without raising the eligibility of age.

ACA policies set a focus on keeping elderly population healthy. Not only does the new healthcare law protect Medicare coverage but also improve benefits as well. Seniors do not need to purchase more health insurance to comply with ACA.[335] Medicare recipients now receive increased services such as preventive screening like colonoscopy and mammograms without out-of-pocket fee for the Part B coinsurance or deductible.[336] Drug benefit is improved through offering discounts and by closing the "donut hole". Other measures to improve quality of care are to hold hospital accountable for hospital-acquired conditions such as infection or bedsores and provide annual wellness visit. By penalizing hospitals for these conditions, it will prompt hospital administrators to set up a system to schedule following up visits and coordinate transitional care that promotes recovery.[337] The new law makes changes to the way healthcare was practiced for the purpose of improving health among the elderly and avoid unnecessary health expenses.

Home health services are covered under Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).[338] These services include the utilization of intermittent skilled nursing care, physical therapy, speech-language pathology services, and continued occupational services. There is no cost for home health care services that are used for a reasonable and predictable period of time. Medicare patients who are under the care of a physician are eligible for these services. A home care agency usually coordinates these services under the physician's order. An explanation is provided before the initiation regarding service and supplies coverage. This is to make known to Medicare

recipients what is covered in the plan and extend options for them to pay for service and supplies that are beyond allowance.

2. Improving Quality in Hospital and Skilled Facility

One of the target improvements of Medicare program is better management that involves hospital care. The aim is to deliver high quality care without the spending that is not warranted.[339] When most of post-acute care takes place in the intensive care unit, the total cost of treatment is higher. One option that provides continuous care and, at the same time, containing cost is to utilize skilled nursing facilities. Skilled nursing facilities are used for the purpose of continuing therapy as post-acute care after an inpatient hospital stay. Other settings that serve the same purpose include inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and in the patient's home by home health agencies (HHAs). Another noted reason for utilizing post-acute care facilities is to decrease the length of hospital stay.[340] This will help keep hospital beds available for acute sickness.

Hospital readmission is identified as another concern in the effort of making quality improvement. High rate of readmission is a reflection of lower quality care that costs higher healthcare expense. Prior to ACA, it was noted approximately19 percent of Medicare beneficiaries were readmitted within 30 days.[341] It is now learned that Repeat hospitalization has another negative effect. Studies have shown that cognitive functioning of the elderly patients tend to decline after hospitalization even when their condition is stabilized.[342, 343] Clearly, there needs to be improvement in the process within

the hospital or skilled nursing facilities to reduce complications that result in readmission.[344]

To promote improvement in patient care and quality outcome, ACA requires payment adjustment for inpatient hospital readmission. This is an aim at preventing unnecessary hospital readmission. According to MedPAC, hospital readmission for Medicare beneficiaries decreased by approximately 100,000 in 2013 as compared to the year 2012.[345] Increased reduction rate of hospital readmission is noted after the establishment of the hospital readmission reduction program (HRRP) under ACA in 2010.[346] The policy provides incentive to hospital to reduce readmission and make penalties for high rate readmission. The current policy also corrects the former questionable practice that involved avoiding necessary admission as a measure to reduce readmissions. Skilled nursing facilities are also impacted by payment adjustments in cases that are admitted to the facility after hospital discharge and readmitted to hospital for conditions that could have been avoided.[347] Hospitals are now making efforts to reduce readmission by taking steps to reduce complications, schedule follow-up visits, reconcile medications before discharge, utilize case managers, and educate patients with self-management.[348] Efforts are also made to coordinate patient care between discharge hospital and skilled nursing facilities, post-acute care providers, pharmacists, and home health nurses to prevent unnecessary hospital readmission.[349]

Section Four. Organizations and New Mandates

Changing the way to obtain health care insurance involves implementing new policies in health care organizations and new mandates in firms.

a. Insurance Provision with Inclusion of Contraception

The priority of expanding health care requires the involvement of employers and their participation in full preventive care to women.

i. Making Health Insurance a Priority

Under ACA policies, employer with 50 or more full-time employees must now offer health insurance. Health plan benefits must satisfy the specified criteria stated in the ACA policies.[350] Employers who do not comply will pay a penalty per each unsponsored employee.[351] This is to intentionally increase the insured population. In the United States, about 43 percent of small companies that employ fewer than 50 workers offer health insurance.[352] These small companies pay much higher premiums than large companies.[353] For low-income families, their out-of-pocket costs are higher.[354] That leads to some of these families opting out of purchasing insurance all together. This condition is projected to change once the ACA is fully implemented.

1. Working but No Health Insurance

In the United States, it was seen as an apparent trend of increase enrollment in private health insurance with increase income. The ability to purchase insurance was closely tied to the level of income. In reality, low-wage workers faced a serious challenge of buying health insurance even though they were a part of the labor force. It was noted fewer that half of those whose incomes were below 200 percent of the poverty purchased private insurance.[355] The main reason was due to employers in small firms did not offer insurance, and those workers could not afford the full cost of health insurance on their

own. It is learned that approximately a third of those small firms with fewer than 50 workers offered health insurance.[356] Some of those workers would turn down the offer to remain uninsured due to high cost of premium in proportion to their wages.[357] Interestingly, according to Gallup in 2015, the most important financial problems facing American families were healthcare costs and low wages/lack of money.[358] Both problems took the top two places for six years consecutively. These two problems have significant effects on workers with low-wages. It is now understood that earning low wages reduces the ability to purchase health insurance, and healthcare cost effects ability to pay.

Take a look at the example of a server who works at a family restaurant. Clarissa Morris is a 47-year-old woman who earns $2.13 an hour plus gratuity.[359] Her daily take-home pay is about $90 including $70 tips. Her husband earns $9 an hours as a part-time worker. Their combine monthly income barely affords the rent and essentials. What is left in their paychecks is spent on food. That leaves them with no sufficient fund for health insurance. In their situation, they cannot purchase health insurance even though they both have a job. Their low monthly earning forces them to forgo health insurance. Another scenario, according to Brad Mete who manages a staffing agency, his workers who earn about $300 a week are reluctant to buy insurance that cost $30 weekly.[360]

A study conducted in 2012 by ADP, the payroll processing company, found the relationship between workers participated in purchasing health insurance and their income. This study examined the behavior of 310,000 full-time nonunion employees who identified themselves as single.[361] According to the study, only 37% of the workers who earned between $15,000 and $20,000 purchased health insurance. The percentage reached 82% for workers who earned between $40,000 and $45,000 and leveled off at

81% for income greater than $45,000. It is noted in the 2012 guideline, 400% of the Federal Poverty Level (FPL) was roughly $45,000 for a single individual.

Under ACA policies, legal residents of the United States can obtain health insurance through work or the insurance exchange. The new health policy provides subsidies to help low-income individuals pay for their health insurance through state market exchanges. Based on the 2015 FPL guidelines, applicants are first needed to rule out eligibility for Medicaid prior to qualifying for subsidy. Those who qualify for Medicaid cannot apply for subsidy. Eligibility for premium subsidies in the exchange requires incomes are at least 100 percent of the FPL but not more than 400 percent.[362] For plans effective in 2016, 100 percent of the FPL is $11,770 for a single person and $24,250 for a family of four. The 400 percent of the FPL is $47,080 for a single person and $113,640 for a family of five. Raising the percentage of the Federal Poverty Level expands the eligibility for low-income individuals to purchase health insurance.

2. Employer Responsibility Under ACA

Under ACA, employers with 50 or more full time employees are required to offer health insurance within 90 days.[363] Businesses that fail to comply with the new healthcare law will be subjected to penalty. The new reporting requirements from the U.S. Department of Labor demand employers, whether or not they offer health insurance, to provide information regarding the Marketplace. For employers who offer health insurance, they are responsible to explain plan coverage and costs using a standard Summary of Benefits and Coverage (SBC) form.[364] The SBC form is used to help

workers understand their insurance options. There is a risk for a penalty for non-compliant employers who fail to disclose benefits and coverage.

To support the proper spending of health premium, ACA policies limit insurance companies' spending on administrative costs, marketing, and non-healthcare-related expense. For large employer plans, the law requires at least 85% of all premium be spent on direct healthcare services and the requirement of 80% for small employer plans. Insurance companies that fail the requirement must provide rebates to employers who then must allocate the rebate properly.[365] Also, there are benefits for employers who choose to promote health at work. It is consistent with the ACA that incentives are rewarded to employers who create a wellness program at work to promote health.[366] The regulation requires that the wellness program be offered in connection to a group health plan. The maximum permissible reward is 20 to 30 percent of the cost of coverage. The incentive is raised to 50 percent for wellness programs that intend to prevent or decrease tobacco use.

As for the employers with 25 or fewer workers, there are also provisions for them. Tax credits for offering health insurance are key provisions under ACA for small businesses. Qualifying criteria specify that these small businesses employ fewer than 25 full-time workers, pay annual wages below $50,000, and contribute 50% or more towards their health insurance premium.[367] This credit can be worth up to 50% of the employer's premium costs and 35% for tax-exempt employers. Employers can offer health insurance through Small Business Health Options Program (SHOP) on Marketplaces. The benefit of using SHOP is increasing purchasing power for small businesses to obtain better health insurance coverage. The program pools small businesses together and reduce

administrative complexity resulting in reducing costs. This will enable small businesses to provide health insurance to employees.

ACA requires employers and insurers to report information on health coverage. The reporting requirement mandates certain organizations to report to the Internal Revenue Service (IRS) that they provide health coverage.[368] These organizations are companies with 50 or more full-time employees and health insurance issuers self-insuring employers of any size. This reporting requirement also applies to employers of any size that sponsor self-insured plans.[369] The reporting system is served as a measure to assure health coverage is provided to workers.

ii. Women's Preventive Services Including Contraception.

ACA added additional preventive health benefits for women. Many women in the United States are without routine reproductive health services, particularly in racial and ethnic groups, resulting in health complications.[370] In July 2011, the independent Institute of Medicine recommended preventive health services to include medications, procedures, devices, tests, education, and counseling to improve health and delay the onset of diseases.[371] Based on that report, ACA includes the following services without out-of-pocket cost: well-woman visits, gestational diabetes screening, HPV/DNA testing, STI counseling, HIV screening and counseling, contraception and contraceptive counseling, breastfeeding support, and interpersonal and domestic violence screening and counseling.[372] It is believed that these preventive measures carry the potential to reduce health care costs.

1. Seeking Better Health for Women

It is noted women have longer life expectancies than men.[373] They also have different healthcare needs than men because of reproductive differences. For example, pregnancy and childbirth carry health risks that can lead to maternal mortality. Women's health condition is affected by biology, behaviors, social, and environmental factors. A study shows that women, in general, need more preventive care than men.[374] These extra services rendered greater out-of-pocket spending in health care creating a burden on them financially.[375] The extra healthcare spending became a barrier to participate in preventive services. Even moderate cost of co-payment could discourage women from undergoing Pap smear, mammogram, or cancer screening.[376] As it is now understood, these preventive services provide early detection and can save life. For women who had experienced social disadvantage, obtaining preventive services were more challenging. That put them at greater risks for conditions such as depression, asthma, heart disease, and sexual transmitted infections.[377]

In 2009, Mrs. Michelle Obama spoke about discrimination of health coverage in the United States because of gender.[378] She mentioned many women lacked healthcare services due to working part-time or working for small companies. It was also due to pre-existing health conditions such as history of pregnancy and caesarean section. Insurance companies used these conditions as grounds for denial of health care coverage. This is supported by CDC report stating the year (2009) prior to the passage of ACA approximately 20 percent of women aged 18-64 was without health insurance.[379] In the same report, it was also noted 31.1 percent of women in 2009 experienced lost of health insurance coverage around the time of pregnancy. Lacking health coverage was

concluded as a barrier to receiving preventive health services and treatment. The concern of lacking health coverage was that the unattended health problems could affect the pregnancy and the health of the newborn.[380] For women of reproductive age, no health coverage limits the opportunities to prevent, identify, manage, or treat health conditions leading to possible risk for poor health during pregnancy. This is particularly concerning with certain chronic conditions such as diabetes, hypertension, thyroid problem, obesity, and sexual transmitted diseases. When maternal health is at risk, the health of the infant is jeopardized.

It is noted ethnic and racial groups are less likely to receive adequate reproductive health care such as annual gynecological exams, contraceptives, and prenatal care. Let's examine the effect of annual Pap smear, it was recorded 13,000 women diagnosed with cervical cancer and 4,100 died in 2002.[381] Cervical cancer is 100 percent preventable through detection and early treatment. Studies show that early detection of cervical cancer, such as Pap smear, saves lives.[382] However, it is often under used particularly among women who are in poverty.

Infant mortality is the other commonly seen incident that links to failure or delay prenatal care. Initial prenatal care is believed to bring positive birth outcome.[383] This is because the early identification of risks or complications, such as hypertension and placental abruption,[384] allows physicians to begin management that can reduce the risk of infant mortality.[385] However, it is noted some women do not begin prenatal care during the first trimester of pregnancy. The delay in prenatal care may also pose a late start on taking prenatal vitamins.

ACA requires insurance plans and all Marketplace health plans to cover specific preventive services for women without copayment or coinsurance. These preventive care benefits for women are to be provided even when yearly deductible has not met.[386] Services are specifically designed based on women's needs as well as those that for pregnant women or women who may become pregnant. In addition, ACA also includes measures that help to improve infant mortality rate. The new health policies provide post-natal home nurse visits.[387] This is a strategy of a comprehensive, high-quality early childhood system aims at promoting maternal, infant, and early childhood health.[388] It also serves the purpose of monitoring and stabilizing the condition of the infant after they are discharged from the hospital.

2. Contraceptive Measure

On July 10, 2015, the Administration released the final ruling to assure women have access to obtain contraceptive services without cost sharing.[389]This announcement is also meant to include access to all recommended preventive services for women's care. It is now confirmed that women across the United States can obtain preventive services including contraception under the ACA. Beginning in 2012, ACA required insurance plans to provide female enrollees recommended preventive care as well as FDA-approved contraceptive services without cost sharing.[390] The provision of contraception is important to many women in the United States. Nearly 99 percent of women need contraception at some point during their lives, and more than more of these women between the ages of 18 and 34 cannot afford it. Hence, the provision of contraception is significant to women's health needs.

Preventive measures that are included in ACA are recommendations by the Institute of Medicine (IOM) committee. IOM's recommendations are based on the satisfactory of three main criteria.[391] First, the health-related condition affects a broad population. Second, the preventing health-related condition has a large impact on health and well-being. Third, the preventing health condition is supported by quality evidence. The committee specifically studied whether certain disease or condition affects women more than men. It found sufficient evidence to recommend eight preventive services including several recommendations for women's reproductive health.

Recommendation by IOM includes a fuller range of contraceptive education, counseling, methods, and services to prevent pregnancy.[392] These services allow women to have better control over their health and birth outcome. IOM recommends FDA-approved contraceptive services and supplies as prescribed by physicians. These approved contraceptives include barrier methods such as diaphragm and female condoms, hormonal methods such as oral contraceptives, birth control patch, and birth control shot, emergency contraception such as Plan B One Step, and implanted devices such as intrauterine device (IUD).[393]

To ensure the above services can reach all the women without interruption caused by financial obstacles, ACA removes the cost-sharing requirement. Now insurance has to provide contraception without out-of-pocket contribution. All new private insurance plans, individual policies, and employer plans have to provide contraception services without cost sharing. The fine for non-compliance is $100 per day for each enrolled person.[394] The exception is granted for plans that are under the grandfather clause. The requirement to cover contraception applies to employers with 50 or more workers.

Employers with fewer than 50 workers are not penalized for not providing health insurance. However, if they choose to offer health insurance; contraception for women must be included in the plan.

Some employers claim that the requirement to provide contraception violates their religious rights. These organizations include for-profit businesses and corporations and religious affiliated nonprofit corporations. Their claims present either the objection to the coverage of all contraceptive services or the focus on emergency contraceptives. A significant number of lawsuits were filed based on the reason of Religious Freedom Restoration Act of 1993 citing "The Religious Freedom Restoration Act of 1993 (RFRA) provides that the government "shall not substantially burden a person's exercise of religion" unless that burden is the least restrictive means to further a compelling governmental interest."[395] A compromise was made and the announcement of the final ruling was released on July 10, 2015.

The final ruling is with respect to religious beliefs. Eligible organizations that object to contraceptive provision may seek an accommodation from contracting or referring for these services. The ACA policies allow these organizations to submit in writing of their religious objection to Health and Human Services.[396] The Department of Labor and Health and Human Services will then notify the insurers and third party administrators of the organization's objection to provide contraception. This is for the purpose that the enrollees in these insurance plans to receive separate payments for contraceptive services without out-of-pocket cost.

Adding the coverage of contraception without out-of-pocket cost has shown favorable reception among women in the United States. According to data from

Intercontinental Marketing Services (IMS Health), the number of filled prescriptions for oral contraceptives increased from 1.2 million in 2012 to 5.1 million in 2013.[397] IMS estimated the reduction in out-of-pocket costs at 483.3 million in 2013 for the dispensed oral contraceptives. Without cost sharing, women are more ready to utilize contraceptive services.

b. Quality of Care

One of the new health care goals is to produce better health outcomes at lower costs. New measures are put in place to improve health care quality and delivery.

i. Taking Care of the Vulnerable Population.

The ACA section 2730 indicates Health Home service for people with chronic conditions including mental health, substance abuse, asthma, diabetes, heart disease, HIV/AIDS, and obesity.[398] Using the approach of treating the whole person, Health Home coordinates care including primary, acute, behavioral health, and long-term services for chronically ill people. The effort is to improve health by providing comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow up, patient and family support, and referral to community and social support services.[399]

The Community-based Care Transitions Program (CCTP) is created to reduce hospital readmission for high-risk Medicare beneficiaries. It is estimated approximately one in five Medicare patients being discharged from a hospital are readmitted within 30 days totaling the cost over $26 billion every year.[400] The goal is to correct preventable

errors in hospital and improve the components along the care continuum. Care transition services are carried out by community-based organizations to manage patient's transition and improve their care.[401]

1. Health Homes Services and Medical Homes Services

The section 2730 of the Affordable Care Act titled "State option to provide health homes for enrollees with chronic conditions." The Medical Home Model designs its services around patient's needs and access to care to enhance quality. The principles establish the following characteristics: should have a personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, enhanced access, and adequate payment.[402] This is a physician-led care team, and the individual decides who is to be a part of the care team. The primary care physician ensures team members work together to provide patient care. The patient-centered approach offers extended office hours and utilizes email and telephone to increase communication between provider and patients.[403] Similar to Health Home Model, the Medical Home model also has designated providers including physicians, nurses, nutritionists, pharmacists, and social workers to coordinate all aspects of health care. This will offer the potential of improving physical and behavioral health, accessing community-based social services, and management of chronic conditions. The strategy to focus on health quality rather than volume of services prompts the offers of financial incentives for providers who focus on quality of patient outcomes.

Health Homes service delivery model builds on the expertise and experience of medical home model. It utilizes the "whole person" approach to facilitate access to

medical care, behavioral health care, and community-based social services and supports for Medicaid individuals with chronic conditions.[404] These services are provided by designated health professionals including physicians, behavioral health professionals, nutritionists, and social workers.[405] Providers are required to report quality measures to the state to maintain service standard. The criteria for the eligibility for health home services must fall into one of the following three conditions: 1) on e chronic condition and is at risk for a second; 2) two or more chronic conditions; or 3) a serious and persistent mental health condition. Chronic conditions include mental health, substance abuse, asthma, diabetes, heart disease, and overweight. By implementing health home services, patients with chronic conditions receive continuous care resulting in reduce visits to the emergency room. Provision of health home services to Medicaid beneficiaries with chronic conditions took effect on January 1, 2011.

2. Community-based Care Transitions Program

The Community-based Care Transitions Program is mandated under ACA policies.[406] The goal for this program is to improve transition care for high risk Medicare patients. More specifically, it is to provide transition care to other care settings when the patient is being discharged from the hospital. The program utilizes community-based organizations to provide transition care services that satisfy the continuum of care. The primary target population is Medicare beneficiaries with multiple chronic conditions, depression, and cognitive impairment.

To ensure the program operates efficiently, the transition care services are provided through community-based organizations (CBOs). Selection preference is given

to Administration on Aging, an organization that provides services and programs to help the elderly to live independently in their homes and communities.[407] This mission is in line with the purpose of transition care. Consideration is also given to organizations that operate similar transition interventions with Medicaid programs and health services at home.[408] This focus selection is aimed at satisfying the intention of recovery and returning to functioning after hospitalization.

Favoring Administration of Aging organizations for transition care is due to its evidence-based care transition interventions. There are five interventions models that support transition care. 1) The Care Transitions Intervention (CTI) is a hospital-based model for the duration of four weeks. It requires a Transition Coach[409] to make hospital visit, help the patient with discharge checklist, and explain self-management, medication management, as well as the importance of following-up appointment with primary care physician. The Transition Coach is also required to make three follow-up phone calls to the patient. 2) The Transitional Care Model (TCM)[410] is a 1 to 3-month hospital-based model. The assigned Transitional Care Nurse makes hospital visit then home visits once a week for a month, assesses and patient's ability to perform activities of daily living, explains medication management and the need to follow-up with primary care physician, and calls patient when home visit is not conducted. 3) Project BOOST (Better Outcomes by Optimizing Safe Transitions) suggests specific approaches to optimize discharge process, identify risk for readmission or poor post-discharge outcomes, ensure patient understanding of care plans including self-care instructions and follow-up appointments, and teach patient how to communicate key information with physicians.[411] 4) Re-engineered Discharge (RED) promotes patient safety and reduces hospitalization rates by

utilizing standardized discharge intervention to explain patient education, discharge planning, and post-discharge telephone reinforcement.[412] 5) Transforming Care at the Bedside (TCAB) model applies the philosophy of safety and reliability, care team vitality, patient-centeredness, and increased value to construct the following interventions: enhancing admission assessment for post-discharge needs, enhancing teaching and learning, providing patient and family-centered communication, and early post-acute care follow-up.[413] It is clearly seen here that all five models promote and emphasize on improving patient outcomes and avoiding future hospital admission which are the primary purposes for establishing transition care.

Center for Medicare and Medicaid Service will evaluate these community-based organizations (CBO) for their effectiveness by reviewing readmission rates, mortality rates, observation services, and emergency department visits in 30 days, 90 days, and 180 days. The evaluation also assesses the result of the program with consideration of any unintended adverse outcome. This is to ensure the program is functioning as it is intended.

ii. Improve Quality of Patient Care

To intentionally improve the quality of care, hospitals receive financial incentives on performance.[414] Hospitals are required to report publicly on their performance regarding heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. A national pilot program is established to reimburse hospital with a bundle payment for providing efficient services while improving quality of care. Physicians who join the Accountable Care Organization also

receive financial incentives through preventing disease and illness and reducing unnecessary hospital admissions. To further promote quality of care, physicians who provide higher value care will receive higher payment.

1. Quality Health Care for Americans

Implication from the White House spokesperson, quality patient care requires a healthcare system that avoids wasteful spending and increases efficiency. It was announced that 50,000 fewer people died between 2010 and 2013 as a result of hospital preventable errors and infections.[415] The longer hospital stay poses a risk of exposing to infection that complicates existing conditions and increases spending. An effort has been made to improve this condition. A program of financial incentives was initiated intending to improve care quality.

ACA aims at correcting inefficiencies by limiting exposure to hospital-based infection, keeping health record between primary care and specialists, and monitoring prescriptions. Since October 2012, hospitals have been penalized for high-than-expected rates of 30 days readmissions of Medicare patients. As a result, the readmission rates declined from 19% to 18% reflecting approximately 150,000 fewer Medicare patients readmitted annually.[416] Hospitals that have high rates of hospital-acquired conditions such as avoidable infections, adverse drug events, pressure ulcers, and fall may receive penalty of losing 1% of Medicare payments. According to data from Department of Health and Human Services (DHHS), it estimated the ACA-related initiatives prevented 50,000 deaths and saved $12 billion between 2010 and 2013.[417] The payment incentives program for hospitals and physicians took effect in 2013 for hospitals and in 2015 for

physician practices. It began with redistributing 1% of total Medicare payments to good health care performance. By 2017, the redistributing rate will increase to 2% under the program. The Bundled Payment for Care Improvement (BPCI) provides a single payment for enrolled hospitals, physicians, and post-acute care facilities.[418] The goal is that these initiatives will encourage the effort of good health care performance.

2. Comprehensive Primary Care Initiative

For years, primary care has been underfunded and faced challenges to undergo needed changes. ACA supports programs that improve and strengthen primary care quality. The Comprehensive Primary Care (CPC) Initiative is a project emphasizes care coordination, improves chronic disease management, increases access to primary care, and simplifies administrative work.[419] This program involves 30 payers and 492 primary care providers providing service to 2.5 million patients in designated seven regions. These seven geographic regions include Arkansas, Colorado, New Jersey, New York, Ohio and Kentucky, Oklahoma, and Oregon.[420] They were chosen after consideration of market penetration of payers and their agreement to support the CPC functions.[421] An early report conducted after one year indicates monthly reduction Medicare expenditures by $14, or 2%, per patient using the program.[422] So far, the report shows reduction in emergency room visits and hospitalization. However, it is still early to make conclusion on quality care improvement.

There are a set of five core functions in the CPC project specifically aim at strengthening primary care quality.[423] 1) Access and Continuity: extending office operating hours to 24/7 to optimize continuous access to care; 2) Planned Care for

Chronic Condition and Preventive Care: Primary care providers actively monitor patients' needs so as to integrate necessary services if needed. They also provide timely chronic care as well as preventive care measures; 3) Risk-Stratified Care Management: Implementing extra care and support to patients with serious or multiple conditions to ensure their needs are met; 4) Patients and Caregiver Engagement: Integrating cultural competent to involve patients and their families in all medical care decisions; and 5) Coordination of Care Across the Medical Neighborhood: Coordinating all medical care including managing care transitions, referrals, and information exchange. CPC participants/practices are to report their progress regularly via a web portal. Centers for Medicare and Medicaid Services provides national and regional learning network to support practices in attaining good progress.

Summary

The Central goal of ACA is to provide affordable and adequate health coverage for Americans. The history of illnesses and diseases in the past makes awareness of how decreased health can negatively affect the functioning of the society and the country as well as creating a financial burden. The passage of ACA reflects the need to develop a government-support system that provides health care to all Americans. The Ten Titles of ACA contain significant changes in how healthcare is delivered. The plan is to provide coverage for all ages regardless of their financial status and health conditions. A mandate was initiated to require employers to provide health coverage to their workers. Employees who are left out of the mandate can purchase affordable plans through Market Exchange where plans and pricing are designed to meet everyone's needs and budget. A

variety of programs including health prevention are initiated aiming at improving or promoting health through designated channels. These services cover the health needs for people from young to old and the disabled. Among the new healthcare changes and additions, the mandatory provision for contraception created a conflict between the government and the religious groups. The issue was resolved through using compromise and specific regulations. All this effort is to secure a policy that provides healthcare.

References

[194] Paul Starr. *The Social Transformation of American Medicine.* New York, NY: Basic Books, Inc., 1982, p.243.

[195] Daniel S. Hirshifield. *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943*. Cambridge, MA: Harvard University Press, 1970, p. 1.

[196] Joseph S. Ross, "*The Committee on the Costs of Medical Care and the History of Health Insurance in the United States*," *The Einstein Quarterly Journal of Biology and Medicine* 19 (2002): 130.

[197] Charles C. Smith. "The Committee on the Costs of Medical Care." Presented to the Innominate Society for the Study of Medical History. April 10,1984. http://innominatesociety.com/Articles/The%20Committee%20%20On%20The%20Costs%20Of%20Medical%20Care.htm. [accessed on 12/27/2015]

[198] George Rosen. *A History of Public Health.* The Johns Hopkins University Press, Baltimore and London, 1993, p. 320.

[199] George Rosen. *A History of Public Health.* The Johns Hopkins University Press, Baltimore and London, 1993, p.325.

[200] U.S. Department of Health & Human Services. "The Affordable Care Act, Section by Section," http://www.hhs.gov/healthcare/rights/law/. [accessed on March 11, 2015]

[201] Nick J. Tate. *ObamaCare Survival Guide: The Affordable Care Act and What it Means for You and Your Healthcare.* West Palm Beach, FL: Humanix Books, 2012. Kindle Edition.

[202] Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone system.* New York, NY: Public Affairs, 2014, p.242.

[203] The Staff of the Washington Post. *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All.* New York, NY: Public Affairs Books, 2010.

[204] U.S. Department of Health & Human Services. "The Affordable Care Act, Section by Section," http://www.hhs.gov/healthcare/rights/law/. [accessed on March 14, 2015]

[205] Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone system.* New York, NY: Public Affairs, 2014.

[206] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3025.

[207] Minnesota Association for Children's Mental Health. "Key Features of the Affordable Healthcare Act Law," http://www.macmh.org/2012/08/key-features-of-the-affordable-healthcare-act-law/. [accessed March 14,2015]

[208] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 10408.

[209] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5301.

[210] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5308.

[211] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5303.

[212] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 5306.

[213] Democratic Policy & Communications Center. "Affordable Care Act: Section-by-Section Analysis with Changes Made by Title X and Reconciliation," http://www.dpc.senate.gov/healthreformbill/healthbill96.pdf. [accessed March 14,2015].

[214] Democratic Policy& Communications Center. "The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act Detailed Summary," http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. [accessed March 14, 2015].

[215] Democratic Policy& Communications Center. "The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act Detailed Summary," http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. [accessed March 15, 2015].

[216] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 8002.

[217] Arthur Daemmrich. "U.S. Healthcare Reform and the Pharmaceutical Industry," Harvard Business School. Harvard Business School, 2011. http://www.hbs.edu/faculty/Publication%20Files/12-015.pdf. [accessed March 15, 2015]

[218] Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone system.* New York, NY: Public Affairs, 2014.

[219] Democratic Policy& Communications Center. "The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act Detailed Summary," http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. [accessed March 15, 2015]

[220] National Conference of States Legislatures. "States Implement Health Reform: Medicaid and the Affordable Care Act," http://www.ncsl.org/documents/health/HRMedicaid.pdf. [accessed March 17, 2015].

[221] A.P. Wilper, S. Woolhandler, K.E. Lasser. "*Health Insurance and Mortality in U.S. Adults*," *American Journal of Public Health.* 2009; 99:2289-2295.

[222] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, et al. "*Medical Bankruptcy in the United States, 2007: results of a National Study*," *The American Journal of Medicine.* 2009; 122:741-746.

[223] Jason Furman and Matt Fiedler. "4.5 Million Young Adults Have Gained Coverage Since 2010, Improving Access to Care and Benefitting Our Economy," January 29, 2015. https://www.whitehouse.gov/blog/2015/01/29/45-million-young-adults-have-gained-coverage-2010-improving-access-care-and-benefitt. [accessed 12/30/2015].

[224] T.R. Reid. *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care.* New York, NY: Penguin Books, 2010, e-book version.

[225] Benjamin D. Sommers, Thomas Buchmueller, Sandra L. Decker, et al. "*The Affordable Care Act has Led to Significant Gains in Health Insurance and Access to Care for Young Adults," Health Aff* 32, no 1 [January 2013]:165-174.

[226] Kao-Ping Chua and Benjamin D. Sommers. "*Changes in Health and Medical Spending Among Young Adults Under Health Reform,"* JAMA 311, no. 23 [2014]: 2437-2439.

[227] Amy Finkelstein, Sarah Taubman, Bill Wright, et al. and Oregon Health Study Group. "The Oregon Health Insurance Experiment: Evidence from the First Year," *Q J Econ* 127, no. 3 [2012]: 1057-1106.

[228] Brendan Saloner and Benjamin Le Cook. "An ACA Provision Increased Treatment for Young Adults with Possible Mental Illnesses Relative to Comparison Group," *Health Aff* 33, no. 8 [2014]: 1425-1434.

[229] Irwin Unger. *The Best of Intentions: The Triumphs and Failures of the Great Society Under Kennedy, Johnson, and Nixon.* New York, NY: Doubleday, 1996, p. 40.

[230] John Iglehart. "*Medicaid Expansion Offers Solutions, Challenges*," *Health Aff* 29, no. 2 [2010]: 2230-2232.

[231] The Henry J. Kaiser Family Foundation. "Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women," (April 13, 2015) http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/ [accessed 12/31/2015].

[232] John Iglehart. "*Medicaid Expansion Offers Solutions, Challenges*," *Health Aff* 29, no. 2 [2010]: 2230-2232.

[233] The Henry J. Kaiser Family Foundation. "Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women," (April 13, 2015) http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/ [accessed 12/31/2015].

[234] Alison Mitchell, Congressional Research Service Report for Congress. "Medicaid Financing and Expenditures," (July 30, 2012) https://www.fas.org/sgp/crs/misc/R42640.pdf. [accessed 12/31/2015].

[235] Samantha Artiga, Robin Rudowitz, and Alexandra Gates, et al. "Recent Trends in Medicaid and CHIP Enrollment as of January 2015: Early Findings from the CMS Performance Indicator Project," (March 31, 2015). http://kff.org/medicaid/issue-brief/recent-trends-in-medicaid-and-

chip-enrollment-as-of-january-2015-early-findings-from-the-cms-performance-indicator-project/. [accessed 2/15/2016].

236 John Iglehart. "*Medicaid Expansion Offers Solutions, Challenges*," *Health Aff* 29, no. 2 [2010]: 2230-2232.

237 Dan Brooks. *The Ultimate Medicare Decision-Making Formula: consumer guide to Medicare Supplement, Medicare Advantage, and Part D Plans.* eBooks version, 2013.

238 Medicare.gov. "Closing the Coverage Gap- Medicare Prescription Drugs Are Becoming more Affordable," (revised January, 2015). https://www.medicare.gov/Pubs/pdf/11493.pdf. [accessed 1//9/2016]

239 Medicare.gov. "The Affordable Care Act & Medicare," http://www.medicare.gov/part-d/costs/coverage-gap/more-drug-savings-in-2020.html. [accessed 12/31/2015].

240 Medicare.gov. "Closing the Coverage Gap- Medicare Prescription Drugs Are Becoming more Affordable," (revised January, 2015). https://www.medicare.gov/Pubs/pdf/11493.pdf. [accessed 1//9/2016]

241 Executive Office of the President Council of Economic Advisers. *The Economic Case for Health Care Reform.* Washington, D.C: Government Printing Office, June, 2009, 3.

242 The Staff of the Washington Post. *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All.* New York, NY: PublicAffairs Books, 2010.

243 U.S. Department of Health & Human Services. "Preventive Services Covered Under the Affordable Care Act," (September 23, 2010) http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/#CoveredPreventiveServicesforAdults. [accessed 1/1/2016].

[244] U.S. Department of Health & Human Services. "The Affordable Care Act and Immunization," (September 14, 2010). http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-and-immunization/index.html. [accessed 1/2/2016].

[245] HealthCare.gov. "Introducing the Health Insurance Marketplace," (June 21, 2013) https://www.healthcare.gov/blog/introducing-the-health-insurance-marketplace/. [accessed 1/6/2016].

[246] HealthCare.gov. The Children's Health Insurance Program (CHIP). https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/. [accessed 1/6/2016].

[247] HealthCare.gov. "The 'metal' Categories: Bronze, Silver, Gold & Platinum," https://www.healthcare.gov/choose-a-plan/plans-categories/#catastrophic. [accessed 1/6/2016]

[248] U. S Department of Health & Human Services. "At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could be Denied Affordable Coverage Without Health Reform," https://aspe.hhs.gov/sites/default/files/pdf/76376/index.pdf. [accessed 1/11/2016]

[249] Michelle M Doty, Sara R.Collins, Jennifer. L Nicholson. et. al. "Failure to Protect: Why the Individual Insurance Market is Not a Viable Option for Most US Family," The Commonwealth Fund, July 2009. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf. {accessed 1/11/2016]

[250] The White House. "Affordable Care Act: The New Health Care Law at Two Years,"

https://www.whitehouse.gov/sites/default/files/uploads/careact.pdf. [accessed 1/15/2016]

251 The Henry J. Kaiser family Foundation. "Survey of People who Purchase Their Own Insurance," (June 2010). https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8077-r.pdf. [accessed 1/12/2016].

252 Kevin T. Stroupe, Eleanor D. Kinney, and Thomas J.J. Kniesner. "*Chronic Illness and Health Insurance-Related Job Lock," Journal of Policy Analysis and Management* 20, no. 3 [summer 2001]: 525-544.

253 The White House. "Affordable Care Act: The New Health Care Law at Two Years," https://www.whitehouse.gov/sites/default/files/uploads/careact.pdf. [accessed 1/15/2016]

254 HealthCare.gov. "Coverage for pre-existing conditions," https://www.healthcare.gov/coverage/pre-existing-conditions/. [accessed 1/15/2016].

255 U.S. Department of Health & Human Services. Affordable Care Act Rules on Expanding Access to Preventive Services for Women," http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html. [access March 21 , 2015].

256 C.L. Ogden, L.R. Carroll, M.A. Curtin, et al. "*Prevalence of overweight and obesity in the United States, 1999-2004,*" *JAMA* 295, no 13 [2006]: 1549-55.

257 A. Must, J. Spadnao, E. H. Coakley, et al. "*The disease burden associated with overweight and obesity," JAMA* 282, no 16 [1999]:1523-9.

258 E. E. Calle, M. J. Thun, J. M. Petrelli, et al. "*Body-mass index and mortality in a prospective cohort of U.S. adults*," *New England Journal Medicine* 341, no 15 [1999]: 1097-105.

259 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2010.

[260] Sue Ter Maat, "Preventive Care Coverage a Mystery to Many Patients," American Medical News, March 18, 2013. http://www.amednews.com/article/20130318/business/130319953/6/. [accessed 1/18/2016].

[261] National Conference of State Legislatures. "Preventive Services Covered Under the Affordable Care Act," (June 30, 2014). http://www.ncsl.org/research/health/american-health-benefit-exchanges-b.aspx. [accessed 1/18/2016]

[262] Nanci Hellmich. "Obamacare Requires Most Insurers to Tackle Obesity," USA Today, July 4, 2013. http://www.usatoday.com/story/news/nation/2013/07/04/obesity-disease-insurance-coverage/2447217/. [accessed 1/18/2016].

[263] Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act Will Improve our Terrible Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone System.* New York, NY: Public Affairs, 2014, p.242.

[264] U.S. Department of Treasury, Labor, and Health and Human Services. "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the patient Protection and Affordable Care Act," *Federal Register* 75, no. 137 [July 19, 2010]: 41726-41760.

[265] Amy Burke and Adelle Simmons. "Increased Coverage of Preventive Services with Zero Cost Sharing Under the Affordable Care Act," *ASPE Issue Brief,* June 27, 2014. https://aspe.hhs.gov/sites/default/files/pdf/76901/ib_PreventiveServices.pdf. [accessed 1/18/2016]

[266] Stephen C. Schimpff. *The Future of Health-Care Delivery: Why It Must Change and How It will Affect You.* Dulles, VA: Potomac Books, 2012, p.108.

[267] Stephen C. Schimpff. *The Future of Health-Care Delivery: Why It Must Change and How It will Affect You.* p. 241.

[268] *Health Insurance portability and Accountability Act of 1996.* HR 3103. Public Law 104-191. 104th Cong. [August 21, 2996].

[269] Ezekiel J. Emanuel. *Reinventing American Health Care,* 2012, p. 241.

[270] Medicare.gov. "Preventive Visit & Yearly Wellness Exams," https://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html#. [accessed 1/18/2016].

[271] Department of Health and Human Services. Centers for Medicare & Medicaid Services. "The ABCs of the Annual Wellness Visit (AWV)," (January 2015) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf. [accessed 1/18/2016].

[272] Centers for Disease Control and Prevention. "Prevention and Public Health Fund," (page last reviewed September 29, 2015). http://www.cdc.gov/funding/pphf/index.html. [accessed 1/19/2016].

[273] George Rosen. *A History of public Health.* Baltimore, MD: The Johns Hopkins University Press, 1993, p. 333.

[274] George Rosen. *A History of public Health.* 1993, p. 342-344.

[275] Ezekiel J. Emanuel. *Reinventing American Health Care,* 2012, p. 243.

[276] Stephen Schimpff, MD. *The Future of Health-Care Delivery,* 2012, p.109.

[277] Center for disease control and Prevention. "About Adult BMI," (Page last updated on May 15, 2015). http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/#trends. [accessed 1/21/2016].

[278] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 4205.

[279] U.S. Food and Drug Administration. "Menu and Vending Machines Labeling Requirements," (Page last updated on 11/13/2015). http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm217762.htm. [accessed on 1/22/2016].

[280] David L. Katz and Ather Ali. *Preventive Medicine, Integrative Medicine & the Health of the Public.* Commissioned for the Institute of Medicine, February, 2009. http://www.iom.edu/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf. [accessed March 21, 2015]

[281] Stephen Schimpff, MD. *The Future of Health-Care Delivery.* Dulles, VA: Potomac Books, 2012.

[282] H. R. Leavell and E. G. Clark. *Preventive Medicine for the Doctor in His Community.* New York: McGraw-Hill Book Company, 1965.

[283] LET (Leadership, Education & Training Program in Maternal & child Nutrition). "Focus on Prevention: Strategies for Affecting Nutritional Health," (University of Minnesota, Last Modified in August 2012). http://www.epi.umn.edu/let/nutri/principles/prevent.shtm. [accessed on 1/23/2016].

[284] James. F. Jekel and Joann G. Elmore. *Epidemiology, Biostatistics, and Preventive Medicine.* Philadelphia, PA: Elsevier Saunders, 2007.

[285] David Katz and Ather Ali. "Preventive Medicine, Integrative Medicine & the Health of the Public," (Institution of Medicine, 2009).

https://iom.nationalacademies.org/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf. [accessed 1/23/2016].

[286] Panupong Jiamsripong, Martina Mookadam, Tadaaki Honda, et al. "The Metabolic Syndrome and Cardiovascular Disease: Part I," *Prev Cardiol* 11, no. 3 [2008]: 155-61.

[287] Partnership for Prevention. "Health Policy Priorities," (summer 2005). https://www.prevent.org/data/files/topics/health_policy_priorities.pdf. [accessed 1/23/2016].

[288] The Scottish government. "Healthy Food at Corner Shops," (7/2/2015). http://www.gov.scot/News/Releases/2005/02/07095154. [accessed 1/23/2016].

[289] Center for Disease Control and Prevention. "National Prevention Strategy: America's Plan for Better Health and Wellness," (page last updated on January 17,2014). http://www.cdc.gov/Features/PreventionStrategy/. [accessed on 1/24/2016].

[290] Howard K. Koh and Kathleen G. Sebelius. "Promoting Prevention through the Affordable Care Act," *New England Journal of Medicine* 363 [2010]: 1296-1299.

[291] LET (Leadership, Education & Training Program in Maternal & child Nutrition). "Focus on Prevention: Strategies for Affecting Nutritional Health," (University of Minnesota, Last Modified in August 2012). http://www.epi.umn.edu/let/nutri/principles/prevent.shtm. [accessed on 1/23/2016].

[292] David Katz and Ather Ali. "Preventive Medicine, Integrative Medicine & the Health of the Public," (Institution of Medicine, 2009). https://iom.nationalacademies.org/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf. [accessed 1/24/2016].

[293] Americas Health Rankings (United Health Foundation). "A Call to Action for Individuals and Their Communities," (25th Anniversary Edition 2014). https://www.apha.org/~/media/files/pdf/pubs/ahr_2014.ashx. [accessed on 1/24/2016].

[294] Leslie. K. Nies, Alicia A. Cymbala, Sheila Kasten, et al. "*Complementary and Alternative therapies for the Management of dyslipidemia," Ann. Pharmacotherapy* 40, no. 11 [2006]: 1984-92.

[295] G. Y. Yeh, R. B. Davis, and R.S. Phillips. "*Use of Complementary Therapies in Patients with Cardiovascular Disesae," Am J Cardiol* 98, no. 5 [2006]: 673-80.

[296] Institution for Work & Health. "What Researchers mean by…Primary, Secondary and Tertiary prevention," (2006). http://www.iwh.on.ca/wrmb/primary-secondary-and-tertiary-prevention. [accessed on 2/1/2016].

[297] LET (Leadership, Education & Training Program in Maternal & child Nutrition). "Focus on Prevention: Strategies for Affecting Nutritional Health," (University of Minnesota, Last Modified in August 2012). http://www.epi.umn.edu/let/nutri/principles/prevent.shtm. [accessed on 1/23/2016].

[298] David Katz and Ather Ali. "Preventive Medicine, Integrative Medicine & the Health of the Public," (Institution of Medicine, 2009). https://iom.nationalacademies.org/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf. [accessed 1/28/2016].

[299] Pantaleo Giannuzzi, Pier Luigi Temporelli, Ugo corra, et al. "Attenuation of Unfavorable Remodeling by Exercise Training in Postinfarction Patients with Left Ventricular Dysfunction:

Results of the Exercise in Left Ventricular Dysfunction (ELVD) Trial," *Circulation* 96, no. 6 [1997]: 1790-7.

[300] Rod. S. Taylor, Allan Brown, Shah Ebrahim, et al. "Exercise-based Rehabilitation for Patients with Coronary Heart Disease: Systematic Review and Meta-analysis of Randomized Controlled Trials," *AM J Med* 116, no. 10 [2004]: 682-92.

[301] R. V. Milani and C. J. Lavie. "Impact of Cardiac Rehabilitation on Depression and its Associated Mortality," *Am J Med* 120, no. 9 [2007]: 799-806.

[302] R. P. Kocher & E. Y. Adashi. "*Hospital Readmissions and the Affordable Care Act Paying for Coordinated Quality Care," JAMA* 306, no. 16 [2011]: 1794- 1795.

[303] Colleen M. Grogan. "*Political-Economic Factors Influencing State Medicaid Policy*." *Political Research Quarterly* 47 [1994]:589-622.

[304] K. Kronebusch. *Medicaid Politics:* "Policymaking Contexts and the Politics of Group Differences in the American States," (PhD. diss, Harvard University, 1993.)

[305] J. Berry, L. Caplan, S. Davis, et al. "*A black-white comparison of the quality of stage-specific colon cancer treatment,*" *Cancer* 116, no 3 [2010]:713-722.

[306] K. L. Foley, E. Y. Song, H. Klepin, et al. "*Screening colonoscopy among colorectal cancer survivors insured by Medicaid*," *American Journal of Clinical Oncology* 35, no 3 [2012]: 205-211.

[307] Barbara Wolfe. "Poverty and Poor Health: Can Health Care Reform Narrow the rich-poor Gap?," *Focus* 28, no.2[2011]: 25-30.

[308] Robin A. Cohen, and Whitney K. Kirzinger. "Financial Burden of medical Care: A Family Perspective," (January 2014). http://www.cdc.gov/nchs/data/databriefs/db142.pdf. [accessed 2/13/2016].

[309] A. Davidoff. "Insurance for Children with Special Health Care Needs: Patterns of Coverage and Burden on Families to Provide Adequate Insurance," *Pediatrics* 114 [2004]:394-403.

[310] P.C. Damiano, J.C. Willard, E.T. Momany, et al. *"The Impact of the Iowa S-SCHIP Program on Access, Health Status, and the Family Environment*," *Ambulatory Pediatrics* 3, no. 5 [2003]: 63–9.

[311] J. H. May and P. Cunningham. "Tough Trade-offs: Medecial Bills, Family finances and Access to Care," (2004). http://www.hschange.org/CONTENT/689/689.pdf. [accessed 2/12/2016].

[312] A. N. Trivedi, W. Rakowski, and J. Z. Ayanian. "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans," *New England Journal of Medicine* 358, no. 4 [2008]: 375-83.

[313] Sara. R. Collins, Michelle M. Doty, Ruth Robertson, et al. "Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief- Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010," (March 2011). http://www.commonwealthfund.org/publications/fund-reports/2011/mar/help-on-the-horizon. [accessed 2/8/2016].

[314] Edith Chen, Robert C. Strunk, Alexandra Trethewey, et al. "Socioeconomic Status and Inflammatory Processes in Childhood Asthma: The Role of Psychological Stress," *Journal of Allergy and Clinical Immunology* 117, no. 5 [2006]: 1014-1020.

[315] Alison A. Galbraith, Sabrina T. Wong, Sue E. Kim, et al. "Out-of-pocket Financial Burden for Low-income Families with Children: Socioeconomic Disparities and Effects of Insurance," *Health Serv Res* 40, no. 6 [2005]: 1722-1736.

[316] C. D. Mullins, L. Blatt, C. M. Gbarayor, et al. "*Health Disparities: A Barrier to High-quality Care," Am J Health Syst. Pharm* 62, no. 18 [2005]: 1873-1882.

[317] Institute of Medicine. "Unequal Treatment: What Healthcare providers Need to Know About Racial and Ethnic Disparities in Healthcare," (March 2002). https://iom.nationalacademies.org/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitieshcproviders8pgFINAL.pdf. [accessed 2/2/2016].

[318] Ashish. K. Jha, Paul D. Varosy, Alka M, Kanaya et al. "Differences in Medical Care and Disease Outcomes Among Black and White Women with Heart Disease," *Circulation* 108, no. 9 [2003]: 1089-94.

[319] P. B. Bach, H. H. Pham, D. Schrag et al. "Primary Care Physicians Who Treat Blacks and Whites," *New England Journal of Medicine* 351, no. 6 [2004]: 575-84.

[320] M. van Ryn and J. Burke. "The Effect of Patient Race and Socio-economic Status on Physician's Perceptions of Patients," *Social Science and Medicine* 50, no. 6 [2000]:813-828.

[321] U. S. Preventive Services Task Force. "USPSTF A and B Recommendations," (February 2016). http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. [accessed 2/8/2016].

[322] S. Agrawal, A. Bhupinderjit, M. S. Bhutani, et al. "Colorectal Cancer in African Americans," *Am J Gastroenterol* 100 no. 3 [2005]: 515-523.

[323] Jamillah Berry, Lee Caplan, Sharon Davis, et al. "A Black-white Comparison of the Quality of Stage-specific Colon Cancer Treatment," *Cancer* 116 no. 3 [2010]: 713-722.

[324] Robin A. Cohen and Michael E. Martinez. "Health Insurance coverage: Early Release of Estimates from the National Health Interview Survey," (Division of Health Interview Statistics,

National Center for Health Statistics, January-March 2015). http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf. [accessed 2/15/2016].

325 The Henry J. Kaiser Family Foundation. "Key Facts About the Uninsured Population," (October 5, 2015). http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/. [accessed 2/13/2016].

326 The Henry J. Kaiser Family Foundation. "Status of State Acton on the Medicaid Expansion Decision," (January 2016). http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. [accessed 2/15/2016].

327 The Henry J. Kaiser Family Foundation. "Key Facts About the Uninsured Population," (October 5, 2015. http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/. [accessed 2/15/2016].

328 Stephen Schimpff, MD. *The Future of Health-Care Delivery.* Dulles, VA: Potomac Books, 2012.

329 Medicare Prescription Drug Coverage. “Closing the Coverage Gap-Medicare Prescription Drugs are Becoming More Affordable,” https://www.medicare.gov/Pubs/pdf/11493.pdf. [accessed March 29, 2015].

330 T. Bodenheimer and R. Berry-Millett. *Care Management of Patients with Complex Health Care Needs: Research Synthesis Report No 19.* Princeton, NJ: Robert Wood Johnson Foundation, 2009.

331 R. S. Brown, S. Peikes, G. Peterson, et al. "Six features of Medicare Coordinated Care Demonstration programs that cut hospital admissions of high-risk patients," *Health Affairs (Project Hope)* 31, no. 6 [2012]: 1156-1166.

[332] Centers for Medicare & Medicaid Services. "Trustees Report & Trust Funds," (last modified on 7/22/2015). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/. [accessed on 2/22/2016].

[333] Paul N. van de Water. "Medicare Is Not "Bankrupt"," (Centers on Budget and Policy Priorities, updated on July 30, 2015). http://www.cbpp.org/research/health/medicare-is-not-bankrupt. [accessed on 2/22/2016].

[334] Medicare.gov. "The Affordable Care Act & Medicare," https://www.medicare.gov/about-us/affordable-care-act/affordable-care-act.html. [accessed 2/20/2016].

[335] Andrea Adleman. "Will Obamacare Affect Medicare?: Myths and Facts," Health, U.S. News, November 14,2014. http://health.usnews.com/health-news/health-insurance/articles/2014/11/14/will-obamacare-affect-medicare-myths-and-facts. [accessed 2/22/2016].

[336] Medicare.gov. "The Affordable Care Act & Medicare," https://www.medicare.gov/about-us/affordable-care-act/affordable-care-act.html. [accessed 2/20/2016].

[337] Marsha Mercer. "Is Your Medicare Safe?," (AARP Bulletin, January/February 2014). http://www.aarp.org/health/medicare-insurance/info-12-2013/medicare-and-affordable-care-act.html. [accessed 2/21/2106].

[338] Medicare.gov. "Your Medicare coverage: Home Health Services," https://www.medicare.gov/coverage/home-health-services.html. [accessed 2/21/2016].

[339] The National Academies of Sciences Engineering Medicine. "Geographic Variation in Health Care Spending and Promotion of High-Value Care," (Interim Report, March 22, 2013).

http://iom.nationalacademies.org/Reports/2013/Geographic-Variation-in-Health-Care-Spending-and-Promotion-of-High-Care-Value-Interim-Report.aspx. [accessed 2/17/2016].

340 Jonathan Blum. "Post-acute Care in the Medicare Program," (Testimony before House Committee on Ways and Means Subcommittee on Health, June 14, 2013). http://www.hhs.gov/asl/testify/2013/06/4481.html. [accessed 2/17/2016].

341 S. F. Jencks, M. V. Williams, and E. A. Coleman "Rehospitalizations among Patients in the Medicare Fee-for-service Program," *New England journal of Medicine* 360, no.14 [2009]:1418-1428.

342 K. Rockwood. "Hospitalization and Effects on Cognition," *Neurology* 78, no. 13 [2012]: 86-87.

343 R. S. Wilson, L. E. Hebert, P. A. Scherr, et al. "Cognitive Decline After Hospitalization in a Community Population of Older Persons," *Neurology* 78, no. 13 [2012]: 950-956.

344 S. Silow-Carroll, J. Edwards, and A. Lashbrook. "Reducing Hospital Readmissions: Lessons from Top-performing Hospitals," (Commonwealth Fund, 2011). http://www.commonwealthfund.org/publications/case-studies/2011/apr/reducing-hospital-readmissions. [accessed 2/10/2016].

345 MedPAC Staff. "The Hospital Readmission Penalty: How Well is it Working?," (March 24, 2015). http://www.medpac.gov/blog/march-2015/march-2015/2015/03/24/the-hospital-readmission-penalty-how-well-is-it-working-. [accessed 2/20/2016].

346 MedPAC. "Refining the Hospital Readmissions Reduction Program," (Report to the Congress: Medicare and the Health Care Delivery System, June 2013). http://www.medpac.gov/documents/reports/jun13_ch04.pdf?sfvrsn=0. [accessed 2/10/2016].

[347] Jonathan Blum. "Post-acute Care in the Medicare Program," (Testimony before House Committee on Ways and Means Subcommittee on Health, June 14, 2013). http://www.hhs.gov/asl/testify/2013/06/4481.html. [accessed 2/20/2016].

[348] M. D. Naylor, L. H. Aiken, E. T. Kurtzman, et al. "The Care Span: The Importance of Transitional Care in Achieving Health Reform," *Health Affairs* 30, no. 4 [2011]: 746-754.

[349] J. M. Bellone, J. C. Barner, and D. A. Lopez. "Postdischarge interventions by Pharmacists and Impact on Hospital Readmission Rates," *Journal of the American Pharmacists Association* 52, no.3 [2012]: 358-362.

[350] R. D. McDevitt and J. Savan. "Prospects for account-based health plans under the patent protection and affordable care act," *Benefits Quarterly* 27, no. 1 [2011]: 21-25.

[351] J. Winkler. "Reconsidering employer-sponsored health care: Four paths to long-term strategic change," *Benefits Quarterly* 29, no. 2 [2013]: 8-15.

[352] Executive Office of the President Council of Economic Advisers. *The Economic Case for Health Care Reform.* Washington, D.C.: Government Printing Office, June 2009.

[353] Jon Gabel, R. McDevitt, L. Gandolfo, et al. "Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down," *Health Affairs* 25, no. 3 [2006]:832-43.

[354] A. Galbraith, A. Sinaiko, S. Soumerai, et al. "Some families who purchased health coverage through the Massachusetts connector wound up with high financial burdens," *Health Affairs* 32, no. 5 [2013]: 974-983.

[355] Katherine Swartz. "Health Are for the Poor: For Who, What Are, and Whose Responsibility," *Focus* 26, no. 2 [fall 2009]: 69-74.

[356] K. Swartz. *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do.* New York, NY: Russell Sage Foundation, 2006.

[357] J. Haas and K. Swartz. "The Relative Importance of Worker, Firm, and Market Characteristics for Racial/Ethnic Disparities in Employer-Sponsored Health Insurance," *Inquiry* 44, no. 3 [2007]: 280-302.

[358] Art Swift. "Americans See Healthcare, Low Wages as Top Financial Problems," (Economy, January 21, 2015). http://www.gallup.com/poll/181217/americans-healthcare-low-wages-top-financial-problems.aspx. [accessed 2/27/2016]

[359] Stacy Cowley. "Many Low-Income Workers Say 'No' to Health Insurance," *The New York Times*, October 19,2015, under "Business Day," http://www.nytimes.com/2015/10/20/business/many-low-income-workers-say-no-to-health-insurance.html?_r=0. [accessed 2/28/2016.].

[360] Stacy Cowley. "Many Low-Income Workers Say 'No' to Health Insurance," *The New York Times*, October 19,2015, under "Business Day," http://www.nytimes.com/2015/10/20/business/many-low-income-workers-say-no-to-health-insurance.html?_r=0. [accessed 2/28/2016.].

[361] ADP Research Institute. "Planning for Health Care Reform: How Income Impacts Employee Health Benefits Participation," http://www.adp.com/~/media/RI/pdf/Benefits%20Planning%20For%20Health%20Care%20Reform%20How%20Income%20Impacts%20Employee%20Health%20Benefits%20Participation%20White%20Paper.ashx. [accessed 2/29/2016].

[362] Louise Norris. "My Eligibility for Medicaid Depends on How My Income Compares to the Federal Poverty Level. Can You Spell Out What That Means in dollars," (Healthinsurance.org contributor, February 19, 2016). https://www.healthinsurance.org/faqs/my-eligibility-for-

medicaid-depends-on-whether-im-133-percent-of-the-federal-poverty-level-can-you-spell-out-what-that-means-in-dollars/. [accessed 2/29/2016].

[363] HealthCare.gov. "How the Affordable Care Act Affects Small Businesses," The Health Care Law & Business. https://www.healthcare.gov/small-businesses/health-care-law-and-business/how-aca-affects-businesses/. [accessed 3/2/2016].

[364] Federal Register. "Agency Information Collection Activities; Submission for OMB Review; Comment Request; Summary of Benefits and Coverage and Uniform glossary Required Under the Affordable Care Act," (A Notice by the Labor Department on 2/26/2016). https://www.federalregister.gov/articles/2016/02/26/2016-04314/agency-information-collection-activities-submission-for-omb-review-comment-request-summary-of. [accessed 3/2/2016].

[365] National Conference of State Legislatures. "Medical Loss Ratios for Health Insurance," http://www.ncsl.org/research/health/health-insurance-medical-loss-ratios.aspx. [accessed 3/6/2016].

[366] United States Department of Labor. "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans," (Federal Register, November 26, 2012). http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=26492&AgencyId=8&DocumentType=1. [accessed 3/5/2016].

[367] U. S. Small Business Administration. "Employers with Fewer Than 25 Employees," https://www.sba.gov/content/employers-with-fewer-25-employees. [accessed on 3/16/2016].

[368] Internal Revenue Service. "Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)," (Page last reviewed or Updated on 3/3/2016). https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055. [accessed on 3/11/2016].

[369] U.S. Small Business Administration. "Employers with Fewer Than 25 Employees," https://www.sba.gov/content/employers-with-fewer-25-employees. [accessed 3/17/2016].

[370] National Association of Social Workers. "Reproductive health disparities for women of color," Health Disparities Practice Update. December 2004. http://www.naswdc.org/diversity/Equity1204.pdf. [accessed 3/20/2016].

[371] Institute of Medicine. "Clinical Preventive Services for Women: Closing the Gaps," http://iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. [assessed April, 6 ,2015]

[372] U.S. Department of Health & Human Services. "Affordable Care Act Rules on Expanding Access Preventive Services for Women," http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html. [assessed April 6, 2015]

[373] S. F. Wood, A. Dor, R. E. Gee, et al. "Women's Health and Health Reform: The Economic Burden of Disease in women," Washington, D. C.: The Jacob's Institute of Women's Health, The George Washington University School of Public Health and Health Services, 2010.

[374] S. M. Asch, E. A. Kerr, J. Keesey, et al. "Who is at Greatest Risk for Receiving Poor-quality Health Care?," *New England Journal of Medicine* 354, no. 11 [2006]: 1147-1156.

[375] K. H. Kjerulff, K. D. Frick, J. A. Rhoades, et al. "The Cost of Being a Woman- A National Study of Health Care Utilization and Expenditure for Female-specific Conditions," *Womens Health Issues* 17, no. 1 [2007]: 13-21.

[376] A. N. Trivedi, H. Moloo, and V. Mor. "Increased Ambulatory Care Copayment and Hospitalizations among the Elderly," *New England Journal of Medicine* 362, no. 4 [2010]: 320-328.

[377] J. Campbell, A. S. Jones, J. Dienemann, et al. "Intimate Partner Violence and Physical Health Consequences," *Archives of Internal Medicine* 162 no. 10 [2002]: 1157-1163.

[378] Jeff Zeleny. "Michelle Obama: Health Care Overhaul is 'Next Step' for Women," *The New York Times,* September 18, 2009, under "Prescriptions," http://prescriptions.blogs.nytimes.com/2009/09/18/michelle-obama-health-care-overhaul-important-to-women/?_r=0. [accessed 3/6/2016].

[379] Denise D'Angelo. "Patterns of Health Insurance Coverage Around the Time of Pregnancy Among Women with Live-born Infants-Pregnancy Risk Assessment Monitoring System, 29 States, 2009," *Morbidity and Mortality Weekly Report (MMWR)* 64, no. SS04 [2015]: 1-19.

[380] KayJohnson, Samuel.F. Posner, Janis. Biermann, et al. "Recommendations to Improve Preconception Health and Health Care-United States. A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care," *MMWR* 55, no. RR06 [2006]:1-23.

[381] National Association of Social Workers. "Reproduction Health Disparities for Women of Color," Health Disparities Practice Update, December 2004. http://www.naswdc.org/diversity/Equity1204.pdf. [accessed 3/20/2016].

[382] Centers for Disease Control and Prevention. "Racial and Ethnic Approaches to Community Health (REACH 2010): Addressing Disparities in Health at a Glance 2004," http://www.cdc.gov/nccdphp/aag/aag_reach.htm. {accessed 3/20/2016].

[383] Janine A. Clayton, Claudette E. Brooks, and Susan G. Kornstein. "Toward More Individualized Medicine: Introducing the Women of Color Health Data Book, Fourth Edition,"

http://orwh.od.nih.gov/resources/policyreports/pdf/WoC-Databook-FINAL.pdf. [accessed 3/20/2016].

[384] The American College of Obstetricians and Gynecologists. "*Benefits to Women of Medicaid Expansion Through the Affordable Care Act," Committee Opinion* no. 552 [2013]. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Benefits-to-Women-of-Medicaid-Expansion-Affordable-Care-Act. [accessed 3/22/2016].

[385] Hawaii State Department of Health. 'Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) trend report 2000-2008. (Family Health Services Division, Maternal and Child Health Branch, 2010). http://health.Hawaii.gov/mchb/files/2013/05/pramstrendreport2010.pdf. [accessed 3/20/2016].

[386] Healthcare.gov. "Preventive Care Benefits for Women," https://www.healthcare.gov/preventive-care-women/. [accessed 3/7/2016].

[387] Christopher Ingraham. "Our Infant Mortality Rate is a National Embarrassment," *The Washington Post,* September 29, 2014*,* under "Wonkblog," https://www.washingtonpost.com/news/wonk/wp/2014/09/29/our-infant-mortality-rate-is-a-national-embarrassment/. [accessed 3/22/2016].

[388] Health Resources and Services Administration. "Affordable Care Act Maternal, Infant and Early Childhood Home Visiting program," http://www.hrsa.gov/grants/apply/assistance/homevisiting/homevisitingsupplemental.pdf. [accessed 3/22/2016].

[389] U.S. Department of Health & Human Services. "Administration Issues Final Rules on Coverage of Certain Recommended Preventive Services Without Cost Sharing," (For Immediate

Release July 10, 2015). http://www.hhs.gov/about/news/2015/07/10/administration-issues-final-rules-on-coverage-of-certain-recommended-preventive-services-without-cost-sharing.html. [accessed 3/9/2016].

390 Centers for Medicare & Medicaid Services. "Women's Preventive Services Coverage and Non-Profit Religious Organizations," https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html. [accessed 3/9/2016].

391 Institute of Medicine of the National Academies. "Clinical Preventive Services for Women: Closing the Gaps," (Report Brief, July 2011). http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the Gaps/Preventive%20Services%20Women%202011%20Report%20Brief.pdf. [accessed 3/27/2016].

392Institute of Medicine of the National Academies. "Clinical Preventive Services for Women: Closing the Gaps," (Report Brief, July 2011). http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-theGaps/Preventive%20Services%20Women%202011%20Report%20Brief.pdf. [accessed 3/27/2016].

393 The Henry J. Kaiser Family Foundation. "Overview of Contraceptive Coverage under the ACA and Legal Challenges to the Requirement," https://kaiserfamilyfoundation.files.wordpress.com/2014/02/slides-laurie_sobel-supreme-court-and-contraceptives2.pdf. [accessed 3/28/2016].

[394] The Henry J. Kaiser Family Foundation. "Overview of Contraceptive Coverage under the ACA and Legal Challenges to the Requirement," https://kaiserfamilyfoundation.files.wordpress.com/2014/02/slides-laurie_sobel-supreme-court-and-contraceptives2.pdf. [accessed 3/28/2016].

[395] *Religious Freedom Restoration Act of 1993*, Public Law 103-141, 103d Cong. [November 16, 1993], codified at *U.S.Code* 42[2000bb].

[396] Centers for Medicare & Medicaid Services. "Women's Preventive Services Coverage and Non-Profit Religious Organizations," https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html. [accessed 3/9/2016].

[397] Amy Burke and Adelle Simmons. "Increased Coverage of Preventive Services with Zero Cost Sharing Under the Affordable Care Act," *ASPE Issue Brief*, June 27, 2014. https://aspe.hhs.gov/sites/default/files/pdf/76901/ib_PreventiveServices.pdf. [accessed 3/30/2016].

[398] Medicaid.Gov Keeping America Healthy. "Health Homes," http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/health-homes/health-homes.html. [accessed April 11, 2015].

[399] Department of Health & Human Services/Centers for Medicare & Medicaid Services. "Re: Health Homes for Enrollees with Chronic Conditions, November 16, 2010," http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf. [accessed April 11, 2015].

[400] Centers for Medicare & Medicaid Services. "Community-based Care Transitions Program," http://innovation.cms.gov/index.html. [accessed on April 11, 2015].

[401] U.S Department of Health & Human Services. “Key Features of the Affordable Care Act by Year,” http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html. [accessed April 11, 2011]

[402] Department of Health & Human Services/Centers for Medicare & Medicaid Services. “Re: Health Homes for Enrollees with Chronic Conditions, November 16, 2010,” http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf. [accessed April 9, 2016].

[403] National Conference of State Legislatures. "The Medical Home Model of Care," Updated in September, 2012. http://www.ncsl.org/research/health/the-medical-home-model-of-care.aspx. [accessed on 4/4/2016].

[404] Medicaid.gov. "Health Homes (Section 2730) Frequently Asked Questions," Effective May, 2012. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-faq-5-3-12_2.pdf. [accessed on 4/4/2016].

[405] Medicaid.gov. "Health Homes," https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html. [accessed on 4/4/2016].

[406] Center for Medicare and Medicaid Services. "Solicitation for Applications: Community-based Care Transitions Program," https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CCTP_Solicitation.pdf. [accessed 3/20/2016].

[407] Administration on Aging. "Administration for Community Living," U. S. Department of Health and Human Services. http://www.aoa.gov. [accessed 4/2/2016].

[408] Center for Medicare and Medicaid Services. "Solicitation for Applications: Community-based Care Transitions Program," https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CCTP_Solicitation.pdf. [accessed 3/20/2016].

[409] The Care Transitions Intervention. "What is a Transitions Coach?," http://caretransitions.org/what-is-a-transitions-coach/. [accessed on 4/2/2016].

[410] Transitional Care Model. "About TCM," http://www.transitionalcare.info/about-tcm. [accessed 4/1/2016].

[411] Society of Hospital Medicine. "Overview Project BOOST Implementation Toolkit," http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/Overview.aspx. [accessed 4/3/2016].

[412] Boston Medical Center, Boston University School of Medicine. "Project RED (Re-engineered Discharge)," http://www.bu.edu/fammed/projectred/index.html. [accessed 4/3/2016].

[413] Institute for Healthcare Improvement. "Reducing Avoidable Readmissions by Improving Transitions in Care," http://www.ihi.org/education/InPersonTraining/ReduceReadmissions/Pages/default.aspx. [accessed 4/3/2016].

[414] U.S Department of Health & Human Services. "Key Features of the Affordable Care Act by Year," http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html. [accessed April 11, 2011]

[415] Tanya Somanader. "4 Ways the Affordable Care Act is Improving the Quality of Health Care in America," Home/Blog, March 25, 2015. https://www.whitehouse.gov/blog/2015/03/25/4-ways-affordable-care-act-improving-quality-health-care-america. [accessed April 9, 2016].

[416] Centers for Medicare and Medicaid Services. "Public Use File: New Data on Geographic Variation, 2015," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html. [accessed 4/9/2016].

[417] Agency for Healthcare Research and Quality. "Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimate of Cost Savings and Deaths Averted From 2010 to 2013," http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/interimhacrate2013.pdf. [accessed 4/9/2016].

[418] Data.CMS.gov. "BPCI Initiative Filtered View," https://data.cms.gov/dataset/BPCI-Initiative-Filtered-View/e5a5-c768. [accessed on 4/10/2016].

[419] David Blumenthal, Melinda Abrams, and Rachel Nuzum. "The Affordable Care Act at 5 Years," *New England Journal of Medicine* 372, [2015]: 2451-2458.

[420] Centers for Medicare & Medicaid Services. "Comprehensive Primary Care Initiative: Seven Regions," Last update on 3/22/2016. https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Seven-Regions.html. [accessed 4/11/2016].

[421] Center for Medicare & Medicaid Services. "Comprehensive Primary Care Initiative," Last update 3/22/2016. https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/. [accessed 4/11/2016].

[422] Erin Taylor, Stacy Dale, Deborah Peikes, et al. "Evaluation of the Comprehensive Primary Care Initiative: First Annual Report," Mathematica Policy Research, January 2015. https://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf. [accessed 4/11/2016].

[423] Centers for Medicare & Medicaid Services. "Comprehensive Primary Care Initiative," Last updated on 3/22/2016. https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/. [accessed 4/11/2016].

Chapter Three

Patients: Autonomy and the Right to Healthcare

Section One. Introduction

The horrific biomedical research misconduct that occurred in the 20th century sparked a strong advocacy for ethical standard that resulted in the emphasis on autonomy.[424] It became a relentless movement to correct unethical research and medical misconduct. To understand the severity of the issue, it is critical to examine the events that led to the realization of the importance of human rights and subsequently autonomy. The extensive work of study on human rights prompted the urgency to value human beings from an ethical perspective that later helped improve healthcare standards. In those cases of biomedical misconduct, human beings were exploited and used in research activities without their consent. It was further discovered that people in the human experiments conducted by the Nazi physicians were forced to endure experiences that were beyond a human body could handle. The inhumane approaches were outraged by many civilized countries, and an effort to change the conduct in research was indispensable. The focus was predominantly on setting up requirements that enforce human rights and the minimization of harm to participants. Responding to the urgency to create rules for research conduct, different agencies and organizations develop rules that based on how they interpret the problem of research conduct. Over the years, many perspectives and analysis were given to how rules should be written to protect human rights. Their efforts were undoubtedly brought some good to the new standard, but they also created complexity and, at times, confusion. That led to an examination to existing

rules and restrictions in attempt to seek the fundamental elements that would support the compliance with respecting human rights. When combining these thoughts and ideas, it points to the foundational principles of human conducts. These principles singly stress the beneficent behaviors towards human beings, and they become the sound guidelines for today's research conduct and medical behaviors.

One of the war crime cases described by U.S. prosecuting attorney, Telford Taylor, at the Doctors Trial (1946-1947) against the German physicians involved placing victims in stimulated altitude of 47,000 feet and deprived of oxygen, victims were described as "agonal convulsive breathing," "convulses arms and legs," and "grimaces, bites his tongue."[425] This is one of many horrific Nazi medical experiments during World War II. The documents of the Doctor Trial further revealed the intention of the German physicians whose ideology changed from dedicating to healing human beings to killing them via human experiments. That was the result of granting physicians with power and prestige that unfortunately led to the actions of dehumanization. Enticing by the privilege giving by the state, physicians no longer serving human beings, rather, they were servants of Germany.[426]

After reviewing the documents and evidence, the Nuremberg court recognized that all human beings, including medical professionals, could easily be enticed by power and social prestige to advance personal agenda.[427] As a result, the 10-point Nuremberg Code was developed in 1948. The Nuremberg Code strongly stresses the rights and welfare of study participants and the significance of informed consent prior to involvement in research. It was adopted by U.S. district court in Ohio[428] and Maryland as a common law standard.[429] Further analysis on the Nuremberg Code resulted in criticism

that directed at its emphasis on human consent to research studies when the crimes against human beings committed by the Nazi physicians were not related to research consent.[430] Robert Burt, a Yale law professor, asserts that the problem with Nazi crimes was not about human consent because the victims did not agree to participate in the first place.[431] Perhaps it was based on the knowledge of the Nazi physicians' excuse of "medical research", the Nuremberg judges focused on the rules that would guard against future recurrence of human experiment by enforcing the process of obtaining informed consent.

After the discovery of the horrific human experiment by Nazi physicians, there arose an international movement and awareness to seek after protecting human rights. The positive result of the movement was seen in the Declaration of Geneva in 1948 and International Code of Medical Ethics in 1949. Then in 1964, the Declaration of Helsinki was officially adopted by World Medical Association (WMA) after the initial discussion in 1953 and a draft in 1961.[432]

While the Nuremberg Code centers its theme on consent in research, the Declaration of Helsinki goes further to stress the need to protect the health and interests of active research participants. The shift began to lean towards the concern for the patients. This was seen in the specific language used in the stated principle: "Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject."[433] However, the meaning of proportion of risk and benefit became difficult to define; it seemingly was left to the physician to decide. More complication related to language use (such as patient psychology, physical, and legal incapacity) raised questions about the consistency on obtaining consent. That

led many to consider the Declaration was weak. After much discussion, the 1975 revisions added the involvement of an independent committee in the situation when a physician thinks that consent is not needed.[434]

Current content of the Declaration of Helsinki strongly focuses on the interests of human beings than the interests of science. It also makes clearer references for terms such as "economic vulnerability" and "economic and medical disadvantage." The statements about informed consent such as alternatives to obtaining consent when study participants are legally incompetent remain controversial. Many consider the guideline in the Declaration favors physicians' interests than the participants. Despite of the criticism, the Declaration of Helsinki is still a widely used guideline on medical research ethics.[435]

In 1974, the National Commission, established after the 30-year Tuskegee syphilis study, was given a task by Congress to develop guidelines for conduct that involves human in research. The Tuskegee incident undoubtedly challenged the discussion on treating patients according to their rights regardless of the state of their physical health. The guidelines are not meant to function as federal regulations, rather, they are written as statements of general moral principles that can be used to judge research conduct. Unlike the Nuremberg Code and the Declaration of Helsinki that stress the rules for recruiting study participants, the Belmont Report provides basic moral principles that serve as a framework for guiding conduct in research.[436]

The Belmont Report, also known as Belmont principles, contains three principles: respect for persons, beneficence, and justice. This is the beginning of a solid theory in addressing the standardized approach for acceptable ethical behaviors. Respect for persons is used to justify obtaining informed consent. It further requires the respect for

autonomous individual's choices which should not be overridden except in the case of clearly/legally/medically inadequate autonomy; then a third party may decide based on the best interest of the individual. This principle stresses the importance of informed consent and the full disclosure of information prior to the involvement in research. The principle of beneficence carries the message of "balance benefits against risks" which basically urges researchers to do risk-benefit assessment as a means to minimize possible harms to participants. The use of the principle of justice is in the distribution of burden and benefits of research. Thinking along that line, this principle is intended to avoid past practice of using disadvantaged (mentally ill or minority) people to carry the burden. The idea is that since the society shares the advantage of research benefit, the burden of science research should be fairly shared by the society.[437] These principles, according to Dan Brock, can be used to identify practical moral problems that involve in research. Christine Grady gave her support to Belmont principles by asserting, "probably the single most influential body in the United States involved with the protection of human research subjects was the National Commission."[438]

In as much as the influence Belmont Report has on a wide range of bioethics, it is not immune from criticism. The major criticism on using abstract principles to guide research problems is its lack of concrete solution to actual problems. An analysis on the issue sheds a different light. Before the Belmont Report, the rules for controlling research conduct were more of an idea of "Do this, and don't do that." However, the wide range of problems that related to research cannot be covered within the scope of rules. There is always a chance for cunning manipulation when interpreting the intension of the rules as

seen in obtaining consent from nonautonomous persons. In general, moral principles have the power to guide the motives of actions; particularly behaviors in human studies.[439]

The Belmont Report has undoubtedly established a framework for the conduct related to human research. The following eight principles further provide a comprehensive and systematic framework to guide ethical behaviors when using human beings in clinical research. Although the purpose is to respond and specify ethical problems and identify a possible solution, the content of each principle centers its focus on protecting human rights and benefiting healthcare. Interestingly, this theme is in line with the current effort made in the ACA.

Collaborative partnership promotes the agreement, respect, and equality between a community and research. Its purpose is to seek community involvement so as to avoid exploitation of a certain community[440] and to ensure that community receives fair benefit from the advantage of research.[441] To achieve this goal, designated representatives from the community will identify health issues to be studied and the results are aimed at health improvement. Recognizing the positive community effect on achieving health goals, ACA includes policies that specifically involve community services.

Social value is significant because of the wide spread of health benefit to society. Respecting social value leads to the consideration of who will be the beneficiary in research[442] as opposed to the idea of merely advancing science agenda. The focus is placed on seeking what is beneficial to the people as a whole rather than the interest of a special group. This will reduce the risk of exposing participants for no valid reason.[443,444,445,446] The idea of social value is one of the supporting beams in ACA.

Under ACA policies, various options are provided for all Americans to obtain health services. To avoid exposing participants to risk for no benefit, a research study must be scientifically valid as evidenced by justifiable objectives, reliable data, sound design and methods, a plausible sample size, and an unbiased outcome measures. Specifically, when involving humans in study, researchers must consider approaches with minimum risk. The objective of the study must focus on generating results that improve health care.[447] Similarly, The new healthcare policies are unbiased. ACA aims at improving health among all Americans with designated benefits for various needs regardless of the status of health.

Fair participation prevents the risk of recruiting disadvantaged persons such as poor, mentally ill, and uneducated.[448] Acceptable scientific reasons for choosing a certain group of individuals could be incidence of disease,[449] susceptibility to a disease, or high transmission rate of infections. The selection of participants should reflect the social value of the research.[450] It is critically important to make sure that the participants will receive the benefit from research.[451] ACA aims at distributing health services to all Americans without discriminating against vulnerable populations. In fact, ACA provides health benefits for every age group and health condition.

Favorable risk-benefit ratio requires researchers to identify probability and the intensity of the risk involve in research. It urges researchers to bear in mind the potential risks on participants, which should include psychological, social, and economic risks. In the case that the risks outweigh the benefits, it must be justified by the social value, the sound design, methods, and reliable data of the study.[452] Similarly, the ACA policies are designed after careful considerations in regards to the balance of benefits, risks, and

health outcomes.

Independent review is a third party committee that has no affiliation with the research. Its role is to provide a guard against conflicts of interest (obtain funding and advance career) that might potentially put participants in unfavorable positions. The independent reviewers make sure that the risk-benefit is considered and the study generates information that is valuable to society.[453] ACA also set up policies for accountability to restrict physicians and health institutes from seeking personal interests when providing health services.

An ethical study must include informed consent. The purpose of informed consent is to show respect and autonomy of people. A valid informed consent means that the consented person, who is competent, receives complete and accurate information[454] including potential risks and who will benefit from the study; it must also be voluntary without any coercion Moreover, the individuals should be told about their rights and the liberty to refuse and withdraw from participation without penalty.[455] ACA requires healthcare providers to disclose information and seek consent for treatments.

Showing respect to participants goes beyond informed consent. The principle of respect for participants requires researchers to prevent harm or adverse effects from treatment. The principle also includes requiring researchers to adjust treatment, withdraw participants from the study if necessary, and provide information on a continuous basis.[456] ACA requires healthcare professionals and health institutes to mitigate errors and provide quality health care.

These eight comprehensive principles were widely accepted and supported because of their power to judge issues that contain ethical values. The idea was to work

in accordance with these principles to avoid human exploitation and unfair distribution of risks and benefits.[457] This framework further provides practical and just research that reduces potential ethical problems.[458] Later, the greater effects of these principles were seen in healthcare policies and everyday healthcare practice.

The outcome of studying the issues of exploitation, access, and regulation involving in research was the rise of the focus on the value of human dignity and human rights. The fulfillment of human dignity demands the exercise of the principle of respect that involves treating others as one would like to be treated. Unarguably, every human being wants to be treated with autonomy and be given freedom to make decisions; likewise, each one should treat others in the same manner. Respect for autonomy is to consider the person's individual right in preference and decision making. It is to recognize each person has the right to choose what is best for him and has the liberty to decide on that action. Relating it to healthcare, if an autonomous person chooses healthcare to be the best for himself; he should be given the liberty to decide on healthcare coverage without resistance. At such end, ACA satisfies the individual right to autonomy.

Section Two. Autonomy and Human Rights

The discussion regarding the use of federal funding to expand healthcare coverage needs to include the fundamental reasons of dignity and human rights.

a. Human Dignity & Sanctity

Healthcare is designed for human to use and thus the explanation on the value of

human beings is essential to providing healthcare to all citizens.

i. The Intrinsic Value of Every Human Being.

Human dignity is generally known as the foundation of human rights. It is concerned with the respect for intrinsic value of every human being and the entire humanity. Human existence must also be perceived from the spiritual dimension in order to understand that dignity cannot simply rely on the interpretation from genetics.[459] It does not change its level or degree when a person becomes ill, disabled, or disfigured. Dignity is not earned or gained by labor or achievement; it is simply related to being humans.[460] It means humans naturally inherit rights to all necessities to sustain living. It then provides human rights with the protection of life, freedom, and property. It further extends to protect against oppression and unequal treatment.[461] These reasons justify equal access to health care for the purpose of eliminating diseases that disrupt health.[462] That means medical goods and services should be guaranteed to all members in society to sustain their existence regardless of race, socio-economics, and religion.[463]

1. Religious View on Human Dignity

Christian theology emphasizes human dignity for all mankind based on the biblical teaching that affirms humans are made in God's image.[464] The ontological status of man distinguishes humans from other species. The Catechism of the Catholic Church explains that man is the only creature can know and love God.[465] God has chosen man, the only earthly species, to share His characteristics of knowledge and love. It is God's purpose to create man with the ability to think, reason, and love specifying humans as

persons and not things. Man has the capability to govern himself and commune with another human being. This is the fundamental reason for human dignity. Advancing in the theory, the God-given ability to reason is seen only in human beings. In his famous oration in 1486, *On the Dignity of Man,* Pico della Mirandola asserts human dignity is manifested and affirmed in man's ability to make choices and to be as he desires.[466]

2. Philosophical View on Human Dignity

The basis of the philosophical view on human dignity stems from man's autonomy as manifested in his capacity to be the authority of his own life. The importance of man's capacity to reason and take control of his life substantiates contemporary claim on dignity. In *Metaphysics of Morals,* Immanuel Kant asserts human dignity is understood as that individuals should be treated as ends and not merely means to an end.[467] Kant ties this concept to the idea of dignity as autonomy. This is a non-religious-based conception of dignity. In this theory, people are recognized as autonomous individuals because they are able to choose their own destiny and determine their future;[468] as such, people deserve to be respected.[469] They should not be treated, in general or by law, as means to an end. The autonomous nature and human capability support the idea of dignity. Hence, autonomy requires people to treat others as autonomous individuals.

3. Historical View on Human Dignity

During the 17th and 18th century, the recognition of human rights instigated a variety of responses. The French tradition had long held dignity as the aristocratic

privilege. In the French Revolution of the 18th century, the Declaration of the Rights of Man and of the Citizen extended dignity to every citizen.[470] Various historical figures advocated human dignity in their arguments. Thomas Paine, in 1791, contended for human rights for the living in his response to Mr. Burke's attack on the French Revolution.[471] Such rights were not to be willed and controlled. He asserted, the living man had rights to be whoever he willed to be and choose his own wants. To Paine, these rights would exist among men for as long as they were living. Mary Wollstonecraft, in 1790, supported human rights in her writing *Vindication of the Rights of Man*.[472] She furthered her advocacy in *Vindication of the Rights of Women* by using dignity to explicate the appropriate state of women. In 1805, William Wordsworth, an English poet, wrote the value of man was not measured by or contingent on economic status.[473]

The interest in developing the concept of human dignity continued in the late 18th and onto the 19th century. Even the communitarian acknowledged human rights although with minimal emphasis on liberty. In the late 18th and early 19th century, Jean-Jacques Rousseau, a philosopher, justified human rights in a communitarian form by agreeing to equality and fraternity among men.[474] The rights were associated with duties and responsibilities, but nonetheless, he agreed that those duties are closely connected to individual rights. At its full value, the extent of the value of human dignity was seen in governmental rulings. As recorded, the result of the revolution of 1848 was the decrees of the French Republic that included abolition of slavery citing slavery was an affront to human dignity.[475] From the end of the 19th century to the 20th century, the Catholic Church saw the need to develop social teaching in response to the threat of socialism, communism, class war, and totalitarianism. The Catholic social teaching was centered on

the adoption of dignity written by Pope Leo XIII,[476] Pius XI,[477] Pope John XXIII[478] and Pope Paul VI,[479] and Pope John Paul II[480]. In their writings, the conception of human dignity was understood and formulated based on the creation of man in God's image. During the post Second World War period, it was Jacques Maritain, a philosopher, who secured the conception that dignity was metaphysical and ontological encompassing moral entitlement.[481] The realization of the horrors of the Holocaust helped shape the path of ethics that stressed the value of human dignity. Since that time, human dignity has been recognized globally and played a significant role in social and political policies.

ii. Life is Sacred.

Christian theory supports human life is sacred because of its dignity, destiny, and integrity.[482] Human beings are created in God's image and participate in God's holiness. Humans are the symbols of God, and the sacraments of God are revealed in them. God chooses his created beings as a people, a chosen race, and a society. Humans are commanded by God to keep charge of the earth, which strongly indicates the superior value of human beings. The recognition of sanctity of life brings the import of supporting a reasonable degree of quality of life. That implies the rightness to preserve life through using health care services. More clearly, it is the life preservation of the poor and the rich without partiality. It is not to advocate providing unlimited resources on each person. Rather, the quality of each life must be considered.[483]

1. Theological View on the Origin of Life

To Christians, theological principles are straightly the interpretation of the word

of God. Much focus has been put on the event surrounding creation. The Bible writes that man is created by God,[484] which clearly indicates the origin of human. At the completion of creating man, God saw all that He created was good.[485] That should give out a message that the design of human was well thought through, and the end product was good. Thus, God's wisdom is seen throughout the entire plan of creation. In particularly, God created all material things in the first five days and then created man so that he could enjoy the world. Clearly, the order and details of creation reveal God's careful and thoughtful workmanship. Based on that, man should come to respect His wisdom and accept what He gives however unpleasant to the human way.

Further discussion on the work of creation leads to the complete rest in God, which is signified by the Sabbath. The act of resting expresses man's response to accept God's invitation to enter the Sabbath's rest while contemplating on His creation. It also represents man's conviction of God's loving purpose in making human. The acceptance of God's choice and the understanding of the order of creation allow man to put away anxiety and fear of earthly living and, instead, learn to enjoy what God intends to give. It is the assurance of God's love and purpose for human that enables each person to perceive his genetic make-up as part of God's workmanship. Man is then able to see himself, the creation, is good as God sees him.

2. Selective Reproduction

Selective reproduction is an attempt to create a child who is more desirable than the alternative by natural reproduction.[486] It is an intervention to select specific characteristics or physical features for the future child so as to satisfy the desire of the

parents. The types of desirability vary from parent to parent. Notably, the widely accepted reason for selection is to avoid diseases that cause disability and shorten life. Other kinds of selection are also a worthwhile discussion for the understanding of selective reproduction. Advanced biotechnology allows preimplantation genetic diagnosis (PGD), sperm sorting to determine sex, and prenatal tests. These are the technologically sophisticated forms of selective reproduction. They are controversial and highly debatable in the realm of ethics. They are also the pressing issues for the governmental regulations and policy. However, these are not the only forms of selective reproduction. There are common forms of selective reproduction that have been used for a long time.

The use of contraception and sexual abstinence is also considered a form of selective reproduction. Their justification is based on the theory of "better off and worse off". It can be explained using the following example. Say a young woman who thinks that if she has a child now; her child will have a worse life than the future child in 10 years. For that, she decides to create a better-off child 10 years later. In this case, the woman chooses a better-off child over the one that is less well off. Undoubtedly, this form of selective reproduction is deemed to be morally acceptable and unproblematic among teenagers. Another kind of selective reproduction is through a sperm donor. In this case, a woman chooses a sperm donor who has the desirable characteristics such as high intelligence or physical appearance. She hopes that her future child will inherit some of the desirable traits of the sperm donor.[487] This idea is not new. During the 1980s, the Repository for Germinal Choice was set up to collect and store Nobel Prize-winners' sperms in hope to pass on their brilliant mind to future children.[488] Notably, this is a form of positive eugenics.

However, the idea of manipulating the creation of human leads to the scenario of choosing one possible future child over the other. In the process of PGD, several embryos are created outside of body using the technique of in vitro fertilization. Each of these embryos is screened for the presence of genetic diseases. The healthy ones will be used for implanting inside the prospective mother, and the others with genetic disease will be destroyed.[489] Thus, the chance of carrying a child with a genetic disease is avoided. So then, choosing different embryos is choosing between different possible future people.

Three scenarios can potentially be created using PGD to play out the idea of choosing possible future people. First scenario, let's say five tested healthy embryos are implanted in five different women, and they give birth to five children- Abigail, Barnabas, Caleb, David, Esther. Second scenario, if only the first three embryos are implanted and born and the last two are destroyed. That means out of the five possible future people, only Abigail, Barnabas, and Caleb will live and David and Esther do not come into existence. The idea of non-existence can also be applied to the scenario in which a pregnant woman suffers a miscarriage in an accident. The difference, in the case of miscarriage, is that the non-existence status of the child is not intentional (in the sense of selection). Third scenario, let's say the first two embryos carry genetic diseases, and by choice, the first one is implanted and born. The argument is against the decision of creating Abigail with disability. But by choosing to implant other healthy embryos will have resulted in creating Caleb, David, and Esther, and Abigail will be non-existed.[490]

The basic argument against selective reproduction is the rudimentary principle of unconditional love of the parents to their children. It affirms that parents ought to love their children with all the given characteristics whether they are short, deaf, tall, or blond.

Hales further explains that unconditional parental love is subdivided into best form of love, worst form of love, and the strongest form of love. The best form of love is the parental love that mainly depends on their children's essential features which is "being their children." The worst form of love is the one that depends on transient features (such as physical beauty) of their children. The strongest form of love refers to the kind that is conditional upon features that cannot change. Going further, unconditional love is also a commitment that enables parents to love their future children unconditionally when they arrive. In this case, although parents have not seen their future children, they can think affectionately about them because their features are a mix of both parents. All this communicates a message of the parental love to their children regardless of their features.[491]

b. Personal Autonomy

Justifying the right to health care involves personal autonomy and the freedom to self-rule.

i. The Right to Make Choices.

Personal autonomy is free from the control of others and from the limitation of making preferred choices. An autonomous person has the freedom to act on his own values and carry out his self-chosen plan without the interference by others. This is in line with Aristotle's perspective that humans act by choice generated from the inner personal will as opposed to outside force.[492] It indicates the natural free will to determine action for self. Immanuel Kant explains simply the logic of the right for human determination.

To be a moral agent is to take responsibility for one's own actions. To be a responsible agent is to be able to choose freely. To choose freely is to be autonomous.[493] This concept of human determination is significant in individuals' decision-making regarding healthcare choices. It reflects the state of independent self-governance as being able to consider the good of healthcare and make the decision to obtain it without the controlling interference of others.[494] This is the nature of autonomy applied in healthcare. In contrast, individuals, such as prisoners and persons with retardation, who cannot make decisions often are controlled by others. As seen in healthcare, these people often receive inadequate healthcare services. In these cases, it is said that their liberty in autonomy is denied.[495]

1. Respect for Autonomy

Personal autonomy is expressed through the meaning of self-rule and is further encompasses the idea of freedom in making choices. Some philosophers include abilities, skills, or capacities of self-governing, and reasoning as characteristics of autonomy.[496] It is intended to describe the rights of people to make choices concerning their health, lifestyle, purchases, and family. These are important aspect of human life, without them, life is less satisfactory.[497]

The basis for the principle of respect for autonomy is that all persons have unconditional worth[498] and the freedom to make choices.[499] Taking away a person's autonomy is, according to Kant, to treat him as a means.[500] This directly disrupts an individual's pursuit of his goal. The principle of respect for autonomy supports the idea that a person ought to be free to carry out his desire so long as the action does not cause

harm to others. In other words, all persons who wish to exercise their autonomy must have valid justification for their action. So the idea of respecting for autonomy does include the obligation to consider others. The kind of autonomy that is free from constraint by others is called negative obligation,[501]and positive obligation, which is in line with Kantian's belief, is referred to actions that foster autonomy[502] which is seen when healthcare professionals disclose relevant information to patients for adequate decision making.[503]

Some criticism asserts that the principle of respect for autonomy can actually cause harm by forcing people to make decision that they do not want to do,[504] such as in cases related to end-of-life medical decisions. This concern was identified in two studies in which Korean Americans, Mexican Americans, and Navajo Indians preferred the medical choices to be made by family members rather than the patients themselves. However, letting the patients choose not to make decision for themselves is an act of autonomy, which is an exercise of patients' rights.[505] Furthermore, the will to choose and the action that follows by that choice is also an act of consent. Thus, the principle of autonomy supports the concept of consent.

2. Choosing Healthcare

In his book, *Reinventing American Health Care*, Ezekiel Emanuel asserts that those individuals without healthcare insurance are neither lazy nor dependent on the government.[506] Majority of these people work for employers who do not provide health insurance or their low-income jobs cannot afford health insurance. These individuals realize they do get sick, and they want health care. In general, healthcare services are

rendered contingent on the proof of health insurance policy. It means that individuals who are without health insurance also without health services. It is an unsettling feeling to not have the assurance of health services knowing at some point in the life span sickness will strike. When they do get sick or notice early symptoms, it is against their choosing to not seek medical treatment. In a large number of cases, they suffer serious health problems because of lacking early treatment. It is particularly heart wrenching for individuals with a crippling disease and without needed healthcare. This is seen in the case of Alicia Facchino who suffers from Multiple Sclerosis.[507] Alicia has no health insurance and cannot afford homecare. She is confined to the wheelchair and unable to leave her house. Her two children, ages 10 and 12, take care of her at home. It is a difficult task to care for a patient with multiple sclerosis and is no doubt a harder task for young children. Here is the ethical dilemma, Alicia chooses to have home care to provide needed assistance for better physical mobility and for achieving daily activities. Her choice to maintain everyday physical function was not honored because she does not have health insurance. She is an autonomous individual who knows what is needed to sustain everyday life. Hence, her right to make decision for herself particularly in regards to daily living must be honored.

ii. Self-governance.

Self-governance allows people to manage their own life including the decision on healthcare. The principle of respect for autonomy demands the acknowledgement of people's right to self-rule and make choices based on their personal values.[508] Daniels claims in the *strong assumption* that individuals should be given the freedom to pursue

economic advantage from their physical condition even when they are ill and disabled.[509] Relating it to healthcare, the emphasis is on respecting one's freedom to have healthcare services as he wants[510] to the extent that physicians have an obligation to help patients make sound medical decisions by overcoming their obstacles such as medical impediments.[511] Even autonomous persons who have self-governing capacities of their health might have constraints caused by illness, depression, coercion, or other conditions that restrict their options.[512] Not receiving healthcare service during illness is one of the times that restrict people's options. In most people, illness prompts the desire to seek treatment for relief of physical suffering. Respect for autonomy involves maintaining people's autonomous choice and eliminate conditions that destroy autonomous action. In contrast, disrespect of autonomy involves actions that ignore and inattentive to autonomous choice.[513] The case of not providing health treatment when needed falls in the latter condition.

1. Moral Authority to Self-Rule

Moral authority is revealed in an autonomous person who possesses specific characteristics. Gerald Dworkin provides the formulation of moral autonomy.[514] It begins with that an autonomous person who holds his own moral principles, and his will is the ultimate authority of his moral principles. He applies the principles he accepts and bears the responsibility for those moral principles. He does not accept others as moral authority without independently judge their moral correctness. Dworkin clearly describes each individual is to be his own authority and decision maker. And that his will is the

determinant of what is right and wrong. An autonomous person speaks for himself as to what is right according to his own principles. It then concludes that he should and must exercise his will to make decisions for himself according his moral principles.

For many years, a large group of people in the United States was without healthcare services.[515] Among the millions without healthcare, most of them would prefer to have it. Take a look at the example of the Oregon Health Insurance Experiment.[516] There were approximately 10,000 uninsured people selected out of 90,000 people on the waiting list to apply for public health insurance in 2008. It was evident their judgment to want healthcare did not change by their unfortunate circumstances or the standard healthcare policy. It is a fair assumption that there are similar situations in other cities across the United States in that uninsured people want to have healthcare. These are autonomous individuals who know it is right to have healthcare, and their decision should be honored. With ACA, all uninsured people in the United States have a chance to have healthcare coverage.

2. Choosing Personal Integrity

The word integrity is noted in the Declaration of Helsinki. It was originally intended to use as a safeguard of research participants' physical and mental condition.[517] It holds the meaning of "totality" and "untouched" pointing to promoting the health of the human body. However, the intention to keep the health of the human body cannot be achieved unless the right to protect health is respected. The scenario in clinical research is good for elucidating this point. In research, keeping integrity means that study participants are not to be touched, and they are to be kept intact both physically and

psychologically. It signifies the importance of the unaltered state of human beings, which also seems to relate to the protection of human dignity and human rights. The Convention of Human Rights and Biomedicine supports this notion in its first article declaring that dignity and identity of all human beings should be protected. It further indicates that all human beings should be respected for their integrity, rights, and freedoms relating to biology and medicine.[518]

In the wake of the development of bioethics, the conception of personal identity exceeded the traditional perspective. It is now believed that a lived body is a sum of all parts that includes physical, psychological, social, intellectual, and spiritual dimensions. The combination of these parts creates a person. It is further understood that the loss of any of these parts will result in defect – a loss of totality. A loss of totality is like losing part of the person's identity. Following the heels of this thought, since a person is comprised of the multidimensional character, losing one part of the dimensions is a loss of part of one's life. Hence, from the perspective of caring for a human life and respect for dignity, study participants should be kept intact and "untouched".[519] This is to satisfy the preservation of human dignity and human rights.

The story of Wayne[520] illustrates the agony of wanting to keep personal integrity when healthcare is not available. He is a 40-year-old divorced father of one child. He works as a hairstylist, and his job does not provide health insurance or any other benefits. Without insurance coverage, he avoids seeking medical attention and, in fact, has gone 10 years without a visit to the doctor. In one incident he noticed he had a cavity; he had to do without seeing a dentist even though keeping the cavity can have a serious consequence. He has no dental coverage and cannot afford the cost. What he can do is to maintain the

daily habit of carefully brushing his teeth and flossing which does not restore his totality as advocates in personal integrity. Again it happened two years later when Wayne seriously injured his elbow and noted obvious bruising. He did not seek medical help because of the lack of insurance coverage and went on his daily responsibilities as usual. Soon it was clear to him the injury was serious. He went to the emergency room where x-ray was taken and fracture was confirmed. The treatment plan included putting him in a cast and referring him to orthopedic surgeon. However, the surgeon explained to him the cast would result in poor outcome. The cast was then removed, but Wayne could not return to see the surgeon for further treatment or follow up. In his case, his autonomous choice to choose health clearly was not honored and his personal integrity was not protected. ACA aims at eliminating situations such as this by setting up various channels for applying healthcare coverage.

Section Three. Beneficence & Non-Maleficence

The topics of the right to treatment and the right to forgo treatment are discussed using the principles of beneficence and non-maleficence.

a. Right to Treatment

Using tax money to provide health care for members of society raises the question whether each one is obligated to do good to others.

i. The Obligatory Actions to Give Benefit.

In the United States, the lack of coverage of health care to a large number of

people compels a discussion on the right to treatment. Morality requires people to do good to others, and beneficence demands taking actual actions to benefit others' welfare.[521] Beneficence is associated with acts of mercy, kindness, charity, and humanity. The principle of beneficence specifically stresses the moral obligations to act for the benefit of others. In a broader sense, these obligations can apply to support the provision of healthcare to everyone securing basic protection of treatment. The act of beneficence is particularly pronounced when giving healthcare access to those who cannot afford it. The core element of the moral theory demands obligatory actions to give benefit, to prevent and remove harms, and to consider the goods and harms of an action.

1. Give Them Healthcare

In the long tradition in the United States, some Americans had health insurance and others did not. It would make the impression that the value of life varies among people. But moral rules are against partiality. The basic concept of impartiality is the moral actions of all persons in the system are being judged impartially. That means no other respect should influence the decision of one's moral action regardless of who will benefit from the action. It is mostly used with regard to obeying the moral rules[522] such as "Do not cause pain," "Do not disable," "Do not deprive of freedom," and " Do your duty."[523] All persons in the group should understand and acknowledge the role of impartiality. In general, the exercise of morality does not require the presence of impartiality; it is needed when moral rules are infringed. Similar to the idea of public system, the use of impartiality only works when all persons in the group acknowledge the

moral rules. Therefore, the act of impartiality outside of protected group will need to be confirmed by the specificity of the moral rules of that group before acceptance.[524]

Acting impartially can be illustrated using the example of the basketball game. A referee is considered impartial when he does not favor any one particular team player when he calls fouls. He is not considered judging partially if he prefers less physical contact and calls more fouls, or, he might prefer more bodily contact and call fewer fouls as long as he does not benefit any team player when calling fouls. Here, the calling fouls impartially demonstrates the differences in exercising impartially; moral impartiality also allows for differences in the ranking of harms and benefits as long as one does not favor any particular member of the group.[525]

2. Healthcare without Partiality

Because the judgment of impartiality is based on the violation of moral rules, it leads to the questioning of its adequacy. Moral rules such as “Do not deceive” and “Do your duty” are always too general for normative guidance. They leave room for various interpretations as to what degree should one do his duty and what is considered satisfactorily “Do your duty.” The lack of specificity limits its adequate function for normative guidance.[526] The lack of specificity also allows for error in actions that appears to be impartial at first glance. Let’s use the basketball game as an example, if the referee calls more fouls based on his personal disliking in physical contact, there is a chance that the total foul call during the game might reveal that one team ends up getting more foul calls than the other team. The outcome of the referee’s judgment will cause pain to the team that receives more foul calls.

Similarly, setting up a healthcare practice that provides health insurance solely based on financial means is showing partiality that violates the moral rules of "Do not cause pain," "Do not disable," "Do not deprive of freedom," and " Do your duty." It is partial because favor is shown to those who have financial means, and the judgment causes pain to those who cannot afford it. The value of life and health should be respected in the same manner across all economic levels, and the exercise of freedom to choose health must be impartial. Providing healthcare for all Americans regardless of socioeconomic status is an act of judging impartially. This is reflected in ACA policy.

ii. Health Services for All Americans.

The moral right to healthcare advocates health for all members in society in support of fair opportunity. This is only possible through government-funded health services, which means a national health policy is needed.[527] With millions of people in the United States without health insurance coverage primarily due to unemployment, poverty, and limited government-funded health resources, national health policies that include equal distributions of health services are essential.[528] The policy should guarantee necessary care to prevent illness, diagnose and treat disease, injury, disability, or health conditions associated with avoidable morbidity and immature mortality.[529] This is the aim of ACA.

1. God Intends for the Continuation of Living

When biblical theology is properly understood, the religious perspective offers meaning to why man deserves healthcare. Based on what God has done for human, it is

understood that humans are intrinsically worthy in God's eyes. This is seen when the man and woman sinned by eating the forbidden fruit and broke the union with God.[530] Yet, God still purposed to save them so as to keep them in existence.[531] That means that humans are of great worth. It further indicates that God intends for the continuation of living, thus, the utilization of healthcare is necessary and justified.

Both traditions of Judaism and Catholicism agree that the world was created by God, and humans have the responsibility to be good stewards to nature's resources. It is further described to have included conserving, protecting, and perfecting God's creation as part of the stewardship.[532] When putting that into the context of health care, Jewish tradition believes that humans are naturally responsible for preserving and protecting their physical bodies for God's purposes.[533] It furthers includes the actions of providing food to the hunger and heal the sick. In doing so, one fulfills the obligation of preserving and protecting what is God's. Similarly, the Catholic tradition asserts that it is God's will for humans to take part in healing as it expresses love towards one's neighbor.[534'535] Catholic perspectives on the contradiction between healthcare and faith in God are the belief that sound medicine is God's providence. God is the only one who commands the whole world and causes all things to happen; thus, the invention of medical technology and medicine is a form of God's provision.[536] Based on that, humans are entitled to healthcare to preserve and protect God's creation, namely the human body.

Roman Catholicism based its ethical and moral standard on the theme of God's grace and love. This is supported by the act of Jesus Christ, the son of God, who died on the cross to provide salvation for mankind. Thus, the connection between man and God is forever tied to the divine saving grace. God's love allows humans to have a God-and-man

relationship that compels them to seek a God-centered value that address human well-being and specific moral actions.[537'538] Such perspectives must be in line with the faith of the church, its sacraments, and its magisterial teaching.[539] Often, Catholic ethics is related to moral theology which is developed using the combination of scripture, tradition, reason, and experience. The purpose of moral theology is to address human behavior with the concept of God's divine purpose in creation. In other words, the Catholic moral theology attempts to discern the proper standard of human actions by interpreting the meaning of the scriptures and the human experience. In situations where scripture is inconclusive, the use of reason, Catholic tradition, and magisterium's interpretation is supplemented.[540] These are the bases of how Roman Catholic arrives at their decision on ethical and moral standard, from there, decisions concerning life and death issues are made.

2. The Idea of Natural Law

The following two paragraphs examine the elements of the natural law which is fundamental to Catholic ethical decision. Human reason and experience has long been considered as elements of natural law in classical and contemporary Roman Catholic ethics. Thomas Aquinas asserts that it is God's divine purpose for his creation to flourish. For this reason, human fulfillment includes self-preservation, procreation, and communion with God. The ability to exercise these activities proves that God gives reasoning and discernment to humans but not to animals. This distinction between humans and animals indicates the God-given ability for humans to think, choose, and

make decision,[541] which leads to the outcome of human experience. Thus, both concepts have significant value in resolving issues within bioethics.

It is important to note that Catholic ethics are distinctly marked by physicalism which is the approach that solely focuses on physical actions without the consideration of other aspects of human experience. According to physicalism, judgment of every action is primarily based on physical properties.[542] For example, the physical structure is naturally designed for a man and a woman to complete the sexual act, therefore, any unnatural behavior, such as homosexuality, directly violates God's purpose of creation.[543'544] While acknowledging the significance of the physical aspect of a person, those who support personalism argue that the personal, spiritual, and social aspects should also be counted, After all, these elements are an integral part of human lives. In response, contemporary thinkers emphasizes that a human person is defined by his biological patterns which, and only which, can satisfy the fulfillment of human flourishing.

b. Right to Forgo Treatment

The concept of not to do harm to another individual is being considered in the context of the right to forgo treatment.

i. Medical Wishes.

The Patient's Self-Determination Act (PSDA) assures that individuals who receive services from Medicare and Medicaid are informed of their rights under state law to make decisions regarding medical care including the acceptance and refusal of

treatment.[545] This will ensure the autonomous right of the patient and protect the use of the principle of nonmaleficence for physicians. The policy applies to institutional providers and health plans that participate in Medicare or Medicaid. These include hospitals, nursing homes, home healthcare providers, hospices, and health maintenance organizations. The participated providers and institutions are required to provide enrollees written information on their rights to make decisions concerning medical care and the right to execute their advance directive.[546] However, the provision of care does not base upon whether the patient has an advance directive. The PSDA protects individual's preferences about treatments, and advance directive is a source of making his preferences known particularly in the case when he becomes unable to communicate his medical preferences. The advance directive is important in that it gives direction to healthcare professionals regarding withholding or withdrawing life-sustaining procedures.[547] The providers are to honor patients' medical wishes to treat if treatment is requested and not to treat when treatment is refused. The failure of executing both conditions violates moral principles.[548] This measure is to support personal right and autonomy specifically at end of life.

1. Caring for the Suffering Patients

In general, physicians operate on two presuppositions of treatment.[549] The first presupposition of treatment is that the patient will ultimately suffer from even a minimal disease. That begins even at the initial stage of diagnosis. The second presupposition is how the physicians' actions can influence the course of the event throughout the illness, however long that may last. Physicians are aware that they act on these presuppositions

when seeing patients at the initial diagnosing. They tend to think of the possibility of serious disease and the importance of their decisions. These are good thoughts in relation to treating illness. According to Hippocrates, an important aspect of the role of physicians is to cultivate prognosis; a step that would esteem them to be good physicians.[550] The act of foreseeing and announcing beforehand the outcome of the patient condition would earn the confidence and trust of the patients. However, physicians could have treated both the disease and suffering if they could expand these thoughts to consider the possibility of suffering.

Suffering is personal and subjective, which cannot be measured.[551] It has the characteristics of self-conflict and loneliness. It often accompanies physical illness and symptoms. Medical science does not have a full explanation for suffering because it is phenomenological. The diagnosis of suffering requires an appreciation of the patient as a whole. It also requires physicians to tune into their own feelings, intuition, and senses in order to detect the presence of suffering in patients. It is imperative for physicians to understand the involvement of individuals in their own illness and the personal expression of suffering. Treatment will be less effective without the understanding of the meaning of illness that assigns to each patient.[552]

Caring for patient requires more than medicine or medical procedures; it includes understanding the patient's perspectives, feelings, and emotions.[553] For example, the dreaded thoughts of being diagnosed with a life-threatening disease put fear in patients. It makes them feel different from everyone else leading to a sense of isolation from society. This is precisely the effect of suffering, the loss of something dear. Often, patient cannot articulate their feeling of dread about illness and simple reassurance may not be enough

to calm their fear.[554] Physicians need to know how patients think and feel about illness in order to truly help them.[555] It will be helpful to allow patients to express what is on their mind and provide them with details in the way they wish. In particular, physicians should be willing to listen to their patients' fear and try to mitigate it by explaining the course of illness and treatment in details in the way that they can best understand it. More importantly, the physicians need to assure patients of their support throughout the course of treatment. It further relieves patients' stress when they are introduced to all involved physicians who will be a part of the treating team.

2. Patient's Self-determination Regarding End of Life Care

The patients' rights movement in the 1970s began the concern with the patient's "right to die."[556] While medicine advances to keep people living longer, the Constitution guarantees individuals the right to direct their own medical care. Such right has come to view as part of a patient's right to self-determination including both the preferences of full treatment and the choice to die. However, in general, end of life decisions often raise the concern for possible harm. If the choice of care needs to be provided by healthcare professionals, the principle of nonmaleficence is just as important as the autonomous choice. The patient's choice and the physician's actions are often intertwined creating controversies.[557] This was seen in the Nancy Cruzan case[558] which was the major influence in the development of the national policy of Patient's Self-Determination Act (PSDA) that came into effect in December 1999.[559]

The U.S. Supreme court decision in *Cruzan v. Director, Missouri Department of Health* was a national precedence for addressing whether the U.S. Constitution could

grant a person a right to die. The case involved Nancy Beth Cruzan, a 25-year-old woman who severely injured in a single-car accident on January 11, 1983, in Missouri.[560] A heartbeat and breathing were restored after 15 minutes without oxygen. Doctors diagnosed her with a severe brain damage; she never regained consciousness, lapsed into a permanent vegetated state, became a spastic quadriplegic, and required a feeding tube. However, she was able to breathe without a ventilator. Since her medical care was paid for by the state hospital, she was a patient of Missouri State. When her parents requested to have her feeding tube removed after five years of being in permanent vegetated state, the hospital refused. There began the legal discourse between Cruzan's parents and the State. Initially, the lower court issued the order to remove the feeding tube, but the order was later overturned by Missouri Supreme Court influenced by the Missouri Living Will statute that favored the choice of life. Her roommate also testified stating that she heard Nancy's wishes not to live as a "vegetable;" the court firmly upheld its decision.[561]

When the case went to the U.S. Supreme Court, the government, for the first time, was involved in the issue of personal decision. It sided with the Missouri State's decision based on the ground of requiring "clear and convincing" evidence that Nancy would want to have life-sustaining equipment removed if she was competent. Up to that time, the U.S. Constitution protected the rights of competent individuals who wish to have treatment withdrawn or withheld.[562] There was no clear protection for incompetent persons. Along with announcing its decision on the case, the court addressed the need for states to enact policy that required clear and convincing evidence of incompetent persons' wishes regarding life-sustaining treatment and a surrogate should be appointed to confirm their preferences in the event when the individuals could not speak for themselves.

Furthermore, the court agreed that the state may weigh the interest of preserving human life greater than the protected interests of the individual.[563] Stating that once the patient had died, the erroneous decision to withdraw life support would not be correctible reflecting the concern for possible harm. No doubt, the court decision received national attention and prompted the government to consider a new policy that assures the rights of incompetent persons. Shortly after the Cruzan decision, Congress enacted the Self-Determination Act.[564] The clear description of the policy accomplishes two things: respects the patient's wishes and ensures physicians' practice of nonmaleficence.

ii. ACA Includes End-of-Life Services.

In 2009, Bill HR 3200, section 1233 states the need to have an advance care planning consultation between the patient and a medical practitioner regarding advance care planning. The practitioner is to explain end-of-life care planning and the patient should be given information regarding choosing a proxy to communicate his wishes in the case when he cannot speak for himself.

1. Advanced Directive

In the proposal of Patient Protection and Affordable Act, specific end-of-life planning was included in the discussion. However, a political uproar regarding advance care planning in Bill HR 3200, section 1233 caused Congress to reconsider the new policy. Bill HR 3200, section 1233 states the need to have an advance care planning consultation between the patient and a medical practitioner regarding advance care planning. The practitioner should explain the care planning including advance directive,

living wills, and durable powers of attorney along with explanation of the role and responsibilities of a healthcare proxy. The practitioner is also responsible for explaining end-of-life services including palliative care, hospice, and life-sustaining treatment. Regarding life-sustaining treatment, an explanation of its benefits shall be explained to the patient and his family. The practitioner, namely physician, nurse practitioner, or physician assistant, can order life-sustaining treatment according to state approved guidelines and regulations. The patient shall receive information from the practitioner regarding designating a legal surrogate for decision making on his behalf. This is to ensure patients are informed of their rights to make their final medical decisions and to avoid having physicians decide whether to treat or not to treat which can lead to moral concerns. Since the bill gives practitioners the responsibility to initiate the advance care plan and authority to sign orders for life sustaining treatment, it appears that providers have the authority to grant treatments.[565] The concern was raised regarding whether patients truly have the autonomy to determine his own medical care.

2. The Option to Live or Die

Under the Patient Self-Determination Act, participated institutions and providers are required to periodically inquire whether or not the individual has written an advanced directive with his wishes clearly stated. Staff members should also be provided with educational programs on ethical issues concerning patient self determination to enforce and respect patient rights.[566] The establishment of allowing patients to accept or refuse treatment has now become an important part of health care policy. The interpretation of government policy to determine one's option to live or die stirred an intense uproar

during the development of the Patient Protection and Affordable Care Act. The term "death panel" was used as part of the argument to oppose ACA. The opponents of ACA considered the advance care planning initiated by the practitioners along with guideline of the policy similar to facing a death panel that decides if the individual is to live or die. The argument implied that the policy encouraged practitioners to counsel elderly patients to choose less medical care leading to the option of death, which would indicate the violation of the principle of nonmaleficence. It further stirred up the speculation regarding rationing healthcare, and the elderly would make the sacrifice. The political and public uproar caused policy makers to reconsider the topic of advance care planning and subsequently not include this section in ACA.[567] However, the new policy does include the provision for end-of-life care.

Section Four. Patient Protection and Affordable Care Act

This section discusses the connection between the right to basic healthcare and responsibility and the Affordable Care Act.

a. Right to Basic Healthcare

Tying to the concept of the right to treatment is the right to basic healthcare. ACA policies aim at providing services that meet basic health needs.

i. The Right to Health

The ethical demand requires individuals, state, and non-state parties to implement and achieve compliance with a right to health according to human rights principle.[568] The

goal is more likely to achieve with individual and collective efforts in domestic social, political, and economic activities. Human rights supports the liberty to pursue life goal which can only be accomplished by having good health and good functioning which justifies the demand for the right to health. The right to health is understood as a right for every human being[569] to enjoy the highest attainable state of physical and mental health. In this sense, every person should entitle to the right to health through the demand for equality of access to health services.[570] This can only be made possible through government-financed policies, such as ACA, that guarantee health services to everyone. In this way, it requires every person in society to understand the obligation to help achieve the right to health by committing to tax contribution. This sense of societal contribution satisfies reciprocity-based beneficence. All these efforts work in reclaiming a concern for health for every member in society regardless of income level and health status.[571]

1. Good Health and Good Functioning

The reason for supporting healthcare for every member in society is because health ensures normal functioning which protects opportunity resulting in achieving life goals. It then can also be said that health is required for life based on this reason, and the need for normal functioning is worth supporting because it is the prerequisites for happiness. The impairment of normal functioning also directly impacts capabilities by reducing their potential resulting in unfulfilled life goals. Illness and disability threatens the hope of life plans and satisfaction and limits the exercise of one's capability resulting in an unfair share.[572] In sum, the ability to achieve life goals and happiness rests on

normal functioning that requires healthcare. It also means that the need for normal functioning is necessary for living.

Rawls' theory of justice as fairness addresses fair equality of opportunity so that each person will have a fair share of the normal opportunity range. He suggests to improve educational or job-training programs as a way to remove disadvantages so that individuals can have a fair opportunity range.[573] Since health is the essential element for opportunity, healthcare is necessary for people in society. The theory explains that an ideal society based on justice as fairness allows equal basic liberties[574] and exercisable political participation rights which are essential to the development of basic capabilities.[575] This principle stresses fair equality of opportunity by mitigating the effect of socioeconomic inequalities and factors that minimize opportunity. However, fair share of opportunity cannot be achieved without normal functioning, and normal functioning is through the provision of healthcare. Then the provision of public health is necessary. Clearly, there is the inter-connectedness among equal opportunity, normal functioning, and healthcare access.[576]

2. The Concept of Health Equity

Health Equity seeks equal access to healthcare for all members in society regardless of socioeconomic status, race, and gender. Based on distributive justice, healthcare as social goods is justified for fair distribution.[577] When acquiring health services is burdensome to some and not others, it is considered healthcare inequity. However, equal respect for persons requires treating everyone fairly, which should be applied in the form of equal distribution of reasonable set of health care amenities. This is

particularly beneficial to the vulnerable individuals with healthcare needs, who may feel affronted by the inequity of health services. Indeed, the moral right to healthcare advocates health for all members in society in support of fair opportunity. This is only possible through government-funded health services, which means a national health policy is needed.[578] With close to 50 million people in the United States are without health insurance coverage primarily due to unemployment, poverty, and limited government-funded health resources, national health policies that include equal distributions of health services are essential. The policy should guarantee necessary care to prevent illness, diagnose and treat disease, injury, disability, or health conditions associated with avoidable morbidity and mature mortality.[579] This is the aim of the ACA.

ii. Minimum Coverage for Evidence-based-Services.

ACA is a policy that assures quality and affordable healthcare to all Americans. It aims at improving healthcare coverage by prohibiting lifetime or annual limits of benefits for participant.[580] It provides minimum coverage for evidence-based services that are based on the current recommendations of the United States Preventive Services Task Force. For example, the immunization practice and screenings for infants and children are provided under the guidelines supported by Health Resources and Services Administration. As for women, breast cancer screening, mammography, and prevention should be under the current recommendations of the United States Preventive Service Task Force.[581] These guidelines are set up for services to follow the current evidence-based research recommendation to ensure quality care for everyone regardless of income level and employment status.[582] Furthermore, ACA policies include wellness and

prevention programs advocating smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention.[583] All of these measures focus on promoting general health as well as making available of health services to all Americans. The provision of preventive care and treatments potentiates normal functioning leading to fair opportunity that results in the satisfaction of life goal. More importantly, the new policies satisfy the moral rules that defend the rights of others by not restricting health services based on employment status, financial ability, and health status.

1. Quality Healthcare for All Americans

The ACA policy, specifically, prohibits the denial of health coverage based on individual health status, medical condition including physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability including conditions arising out of acts of domestic violence, disability, or any other health status-related factor.[584] The prohibition is supported by the general moral rules that demand to help persons with disabilities and to remove condition that will cause harm to others. W. D. Ross asserts that there is an obligation for everyone to improve the condition of others,[585] which fits in the goal of wellness for everyone that results from the provision of healthcare. This is further evidenced by the ACA health benefits that include medical, surgical, hospital, and prescription drug along with essential health benefits that cover ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, rehabilitation services, laboratory

services, preventive and wellness services and chronic disease management, pediatric services including oral and vision care.[586] These essential health benefits are for everyone and not subject to denial reflecting the support for the principle of human rights.

Another provision of ACA is the allowance for state flexibility to establish basic health programs for low income individuals who are under the age of 65, not eligible for Medicaid, not eligible for minimum essential coverage, and not eligible for an employer-sponsored plan that is not affordable coverage. This plan is for individuals whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line.[587] They are worse off than those who are extremely poor as far as obtaining health care is concerned. Limiting health services due to age and financial ability is injustice and is against the right to health. Health equity seeks equal healthcare access for this group of members in society by allowing state-run basic health programs[588] that assure coverage for those who make just enough money for monthly expenses but not enough for purchasing standard health insurance at work.

2. Testimonies of ACA Beneficiaries

Providing healthcare to all Americans allows individuals to pursue life goals autonomously. The healthcare coverage mandated in the ACA policy intends to service Americans of all ages and in every life circumstance. The quality of ACA is confirmed in the testimonies of individuals who carried a heavy burden of inadequate health service. The story of Alicia and Rusk[589] and their family shows the significance of healthcare coverage for family. This family was without health insurance until the Health Insurance Marketplace opened in 2014. Alicia took immediately actions to see her primary care

physician and gynecologist. She finally was able to check blood work and had a mammogram done. Since she has a family history of breast cancer, mammogram is an important preventative measure. In addition, she also had a BRAC test to check for cancer gene. ACA has included the BRAC test as part of the covered preventive service without out-of-pocket cost. Alicia was relieved to learn that the BRAC test was negative. For Rusk, he saw the need for health insurance as he became older. He realized that it was not only illnesses would require medical care but injury from playing sports. Serious sports injury might require surgeries that put financial burden on the family. Both Alicia and Rush understand how it will affect their children if they are sick with no resources to get well. ACA coverage gives Alicia and Rusk peace of mind.

Elena's story speaks of the hindrance of pursuing life goal when health insurance is unaffordable.[590] Her dream was to work on her parents' farm, which was not possible due to lack of insurance coverage. She explains that working with farm equipment and animals expose her to serious risk of injury. One time a ram knocked her down on her back. Instantly she thought the accident had indeed caused serious injury. It shows how easily and quickly physical injury can occur on the farm. Healthcare coverage, thus, provides a sense of protection indicating medical treatment is assured.

b. Balancing Right and Responsibility

Utilizing a national health system, such as ACA, involves the consideration of balancing the right for health services and the responsibility to maintain the resources.

i. Benefiting from HealthCare

Shortly after World War II, U.S. Government funded many various medical-related programs such as medical research, medical education, and hospital construction to improve people's health condition. The interest in medical science prompted the proliferation of high technology and advanced medical facilities.[591] In particular, the diagnostic technologies such as computerized tomography, magnetic resonance imaging, and positron emission tomography were highly valued for their potential to advance medicine. Advanced medical treatments were used to treat coronary artery disease, premature newborns, and intensive treatments for the critically ill. It was noted that 70% of Medicare funding was spent on critically ill patients who were roughly 9% of its recipients,[592] and up to 1% of the total gross national product was spent on people in their last year of life.[593] The global sentiment was promoting health care benefits, which overshadowed the burden of cost.

1. Escalating Healthcare Cost

The current condition of limited resources did not occur overnight. Despite the growing expenditure after the advancement of medical technology, people were feeling good about getting better health services, and almost everyone was expected to receive medical treatment. While the new medical technologies were greatly appreciated, the unseen adverse effect of long-term health care cost escalation was emerging resulted in the current state of high cost health care. Other factors that contributed to the uprising health care cost was the practice of reimbursing physician fee for whatever they billed the insurance company. In fact, insurance companies encouraged physician and hospital to

provide any and all interventions that promised health benefits. In so doing, physicians were allowed to provide as many services as possible and reimbursement was comfortably high. The insurance companies would also readily reimburse hospital care than outpatient care. As for the patients, many of them were exempted from any direct cost for health care because of the first dollar coverage by their employers. They were then able to demand the best intervention as they pleased. The combination of allowing physicians to prescribe any treatment and the patients' demand on the best health benefits contributed to the escalation in premium health care costs resulted in the current increased overall cost[594] and millions people without health services.

2. Ethical Guidelines for Health Care Rationing

Ethical rationing must put patients' needs first so that the trust between providers and patients is preserved. For this reasons, Catholic Health Association (CHA) developed eight ethical criteria for evaluating healthcare rationing.[595] First, the need for healthcare rationing must be demonstrable. Second, healthcare rationing must be oriented to the common good which demands government health policy to be for social good. Third, a basic level of healthcare must be available to all based on human right. Fourth, rationing should apply to all regardless of social and economic status. Fifth, rationing must result from a participatory process because its burden affects everyone. Sixth, the healthcare of disadvantaged persons has an ethical priority because their conditions are more life threatening. Seventh, rationing must be free of wrongful discrimination such as age, race, sexual orientation, or ability to pay. Eighth, the social and economic effects of healthcare rationing must be monitored, regulatory safeguards, and revised disproportionately

harmful rationing programs. These guidelines were developed aiming at appraising government proposals to healthcare rationing.

ii. Changing Practice.

Morreim looks at the problem in the health care system from the roles of physicians and patients. Although she shares the view of the CHA on eliminating unnecessary expenditures instead of denying health services to individuals in need.[596] Unlike CHA's perspective, she does not think government policy bears the sole responsibility on solving limited health care resources. Rather, she asserts new obligations should apply to both the physician and patient. For physicians, their obligation to patient care is no longer a single-minded commitment; it is now in consideration with health care regulation.[597] They are not obligated to bypass health care program limits to satisfy the patient's demands. For patients, they are now expected to make responsible lifestyle choices that lead to better health. The active participation of the physicians and patients in their new roles is expected in order to shape the new healthcare economy.[598]

1. The Role of Physicians

Traditionally speaking, physicians have the duty to look out for patients' interests. They are expected to make some personal sacrifice for the sake of their patients' welfare. However, the current limited health care resources demand new obligations on physicians. Morreim believes that physicians can help reduce health care cost by performing two duties to their patients: economic disclosure and minimize the conflicts

of interest.[599] Not only will these obligations strengthen the physician-patient relationship, but also allow the patients to exercise their autonomy as well.

Economic disclosure requires physicians to inform patients in advance about the price tag of the prescribing drugs or interventions. Current healthcare demands out-of-pocket cost that can potentially create a financial burden on the patient. Such concern was noted in Hippocrates' statement, "I advise making no excessive demands, but to take into account the means and income of the patient."[600] Since the patient is the one who is bearing the illness and the burden of proposed treatments, he is entitled to know the cost of physician visits, medications, interventions, and hospital stay. It is also his right to decide how he wants to use his money. For example, he may prefer to bear the minor ailment than spending a few hundred dollars on diagnostic tests or treatments. A patient might even forgo cancer treatment upon knowing he cannot financially afford it and prefer to opt out of the surgery to avoid financial hardship. Hence, patients should be provided with medical information so that they can make their own decisions based on their personal goals and values.

Specifically, patients should be given three areas of economic information related to the cost of tests and treatments.[601] First, the actual costs of required payment for proposed treatment should be disclosed to the patients prior to the service. Second, physicians should disclose any economic influences, such as incentive programs, that might affect his commitment to the patient's interests. Third, patients should know about the factors, including economic controls or limits on facilities, that might hinder the physician from prescribing what he thinks is the desirable treatment for the patient. For this to work, physicians need to know the expected cost of what they prescribe, from

ancillary services to medication. As they recommend certain drugs or procedures, they will be able to disclose the actual cost of the treatment, and patients are then given the choice to decide for themselves whether they can bear the cost. Often, physicians' decisions are influenced by those who control the medical and monetary resources of care, such as insurance companies and hospitals. These main parties can either limit physicians' clinical options or influence their decisions with incentives. Physicians are obligated to disclose the economic pressures that influence their clinical decisions and the conflicts of interest involve in their clinical recommendations.[602] The disclosure of these areas will let patients see the options more clearly; hence, they will be able to make decisions that benefit their own interests.

The issue with conflicts of interest arises from physicians' association with the health care organizations. As independent contractors, physicians often experience external pressures from the institutions they work. Institutions have high priority to ensure their services are closely coordinated, integrated, and run effectively to serve broad goals of public services. In contrast, physicians traditionally and professionally focus on their patients' needs. Because the two parties have such disparate goals, the institutions offer incentives to physicians in return for their compliance.[603] This raises the concern that conflicts of interest can affect physicians' professional goals to serve patients' interests.[604] For this reason, physicians must discern to what extent the incentive will influence their decisions on referrals and the expectation of work productivity.[605]

Since incentive programs and bonus payments are unavoidable, physicians should keep several things in mind.[606] First, the association between incentives and patient care decisions should be kept at a distance. Second, they must consider accepting as small a

size of incentives as possible. Third, group incentives have less impact on physicians' individual patient care decisions than individual incentives for specific referrals. Fourth, they must disclose to their patients the conflicts of interest existed between them and the institutions. Revealing conflicts of interest can be done by informing patients of all available options including the disclosure of the one that has personal interest to the physicians. Physicians should not coerce patients into choosing an option that links to their interest, rather, they must encourage patients to choose the option that most benefit them. With these considerations in mind, physicians should be able to balance the institutional relationships and their commitments to serve their patients.

2. The Role of Patients

The emergence of bioethics brought to light the negative effect of physician paternalism and the push for patient autonomy. Prior to that, patients were expected to wait for their physicians to make all the medical decisions for them. It was perceived that physicians knew what was best for their patients since they had medical training. Along that same thought, physicians felt that they should shield the social economic burden from their patients. However, modern bioethics changed the practice from physician paternalism to patient autonomy. It is now believed that patients are moral agents who are capable of choosing what is best for their lives.[607] In as much as the significance of physicians' medical judgment, patients should make decision based on their preference.[608] In order to make sound decisions, patients must know about their clinical conditions along with the social economic factors. This is the moral responsibility within the concept of autonomy. The new medical ethics requires patients to take personal

responsibility for their own health and medical decisions so that they can better utilize the limited resources.

Involving patients in choosing their health plans is the appropriate way to practice healthcare rationing. The current escalated healthcare cost is mainly caused by the serious distortion of value and cost. Contemporary healthcare system can be described as 'one party spends and someone else pays.'[609] This is the result of not involving patients in on how healthcare is financed and delivered. People in society often have to make trade-offs on things they need or value. The same attitude can be expected to making healthcare plans. Since people are moral agents who are capable of making decisions concerning life plans, they should be held competent to the consequences of their choices.[610] This is a well-rounded thought on respecting their autonomy when allowing them to consider and choose what will benefit their interests. Many corporations are now giving employees options to select health plans that have various levels and kinds of services, premiums, and out-of-pocket cost. The serious range of choices requires employees to make trade-offs in exchange for a plan that is best for them.[611] For those who prefer a low premium and low out-of-pocket cost choose a minimum package and adapt healthy behaviors.

Summary

The principle of respect for autonomy considers each person has the right and liberty to choose healthcare without resistance. The right to make healthcare decision is a demonstration of self-governance based on one's personal values. In this way, providing healthcare coverage for all Americans satisfies the individual right to autonomy. Such is understood as human rights which is grounded in human dignity and the belief of sanctity

of life. The reason for supporting ACA is because health ensures normal functioning which protects opportunity resulting in achieving life goals and happiness. The right to choose healthcare also leads to the justification of the right to treatment. The principle of beneficence specifically stresses the moral obligations to act for the benefit of others; these obligations can apply to support tax contribution needed for provision of healthcare to everyone securing the basic protection of treatment. The right to treatment also entitles one to forgo treatment. The providers are to honor patients' medical wishes to treat if treatment is requested and not to treat when treatment is refused. Physicians and patients have to take equal responsibility in bringing down healthcare cost, which involves changing their healthcare behaviors. Both sides must now consider reasonable healthcare spending to ensure the ongoing benefits under ACA.

References

[424] Paul Ndebele. "Research Ethics," In *The SAGE Handbook of Healthcare Ethics: Core and Emerging Issues,* edited by Chadwick, Ruth, ten Have, Henk, and Meslin, Eric. Los Angeles, CA: Sage, 2011.

[425425] Telford Taylor. "Opening Statement of the Prosecution, December 9, 1946," In *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*, edited by G. J. Annas and M. A. Grodin. New York, NY: Oxford University Press, 1992, pp. 67-93.

[426] Michael Grodin. "The Nuremberg Code," In *The Oxford Textbook of Clinical Research Ethics,* edited by Ezekiel J. Emanuel, Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, pp. 136-7.

[427] Michael Grodin. "The Nuremberg Code," in *The Oxford Textbook of Clinical Research Ethics,* edited by Ezekiel J. Emanuel, Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010.

[428] United States District Court for the Southern District of Ohio, Western Division. "In re: Cincinnati Radiation Litigation," 875 F. Supp. 796; [U. S. Dist. 1995]. http://www.fda.gov/ohrms/dockets/dockets/04p0349/04p-0349-ref0001-77-Tab-73-In-Re-Cincinnati-Radiation-Litigation-vol7.pdf. [accessed 4/30/2016].

[429] Anna C. Mastroianni and Jeffrey P. Kahn. "Risk and Responsibility: Ethics, Grimes v. Kennedy Krieger, and Public Health Research Involving Children," *American Journal Public Health* 92, no. 7 [2002]: 1073-1076.

[430] Michael Grodin. "The Nuremberg Code," in *The Oxford Textbook of Clinical Research Ethics,* edited by Ezekiel J. Emanuel, Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010.

[431] Robert Burt A. *Death is That Man Taking Names.* Berkeley, CA: University of California Press, 2002.

[432] Richard Ashcroft. "The Declaration of Helsinki," in *The Oxford Textbook of clinical Research Ethics,* edited by Ezekiel J. Emmanuel, Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, pp. 141.

[433] World Medical Association. "*Code of Ethics of the World Medical Association: Declaration of Helsinki.* Helsinki," *British Medical Journal* 2 [1964]:177.

[434] Richard Ashcroft. "The Declaration of Helsinki," in *The Oxford Textbook of clinical Research Ethics,* edited by Ezekiel J. Emmanuel, Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, pp. 142-44.

[435] Richard Ashcroft. "The Declaration of Helsinki," in *The Oxford Textbook of clinical Research Ethics,* edited by Ezekiel J. Emmanuel, Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, pp. 144-47.

[436] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, Inc., 2009, 149-50.

[437] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, Inc., 2009, p. 150-51.

[438] Christine Grady. *The Search for an AIDS Vaccine: Ethical Issues in the Development and Testing of a Preventive HIV Vaccine.* Bloomington, IN: Indiana University Press, 1995, 42.

[439] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, Inc., 2009, p. 152-54.

[440] Participants in the 2001 Conference on Ethical Aspects of Research in Developing Countries. *Moral Standards for Research in Developing Countries: From* "reasonable availability" to "fair benefits," *Hastings Center Report* 34, no. 3 [2004]: 17-27.

[441] Participants in the 2001 Conference on Ethical Aspects of Research in Developing Countries. *Moral Standards for Research in Developing Countries: From* "reasonable availability" to "fair benefits," *Hastings Center Report* 34, no.3 [2004]: 17-27.

[442] Ezekiel. J. Emanuel and Christine Grady. "What Makes Clinical Research Ethical," *JAMA* 283 [2000]: 2701-11.

[443] Ezekiel. J. Emanuel, J. Killen, D. Wendler, and C. Grady "*What Makes Clinical Research In developing Countries Ethical? The Benchmarks of Ethical Research*," *Journal of Infectious Diseases* 189 [2004]: 930-7.

[444] H. Y. Vanderpool. *The Ethics of Research Involving Human Subjects: Facing The 21st Century.* Frederick, MD: University Publishing Group, 1996.

[445] R. J. Levine. *Ethics and Regulation of Clinical Research.* New Haven, Ct: Yale University Press, 1988.

[446] B. Freedman. "Scientific Value and Validity as Ethical Requirements for Research," *IRB: A Review of Human Subjects Research* 9, no. 6 [1987]: 7-10.

[447] Ezekiel J. Emanuel, David Wendler, and Christine Grady. "An Ethical Framework for Biomedical Research," in *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel,

Ezekiel J., Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, pp.127-128

448 D. Debruin. "Justice and the Inclusion of Women in Clinical Studies," *Kennedy Institute of Ethics Journal* 4 [1994]:117-46.

449 A. C. Mastroianni, R. R. Faden, and D. D. Federmam *Women and Health Research: Ethical and Legal Issues of Including Women in Clinical Studies.* Washington D. C.: National Academies Press, 1994.

450 Ezekiel J. Emanuel, David Wendler, and Christine Grady. "An Ethical Framework for Biomedical Research," in *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel, Ezekiel J., Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, pp.127-128.

451 C. Weijer. "*Evolving Issues in the Selection of Subjects for Clinical Research," Cambridge Quarterly of Healthcare Ethics* 51, [996]: 334-5.

452 Ezekiel J. Emanuel, David Wendler, and Christine Grady. "An Ethical Framework for Biomedical Research," in *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel, Ezekiel J., Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, p.129.

453 Ezekiel J. Emanuel, David Wendler, and Christine Grady. "An Ethical Framework for Biomedical Research," in *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel, Ezekiel J., Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, p.130.

[454] Vilhjalmut Arnason, Hongwen, Li, and Yali, Cong. "Informed Consent," in *The SAGE Handbook of Healthcare Ethics: Core and Emerging Issues,* edited by Ruth Chadwick, Henk ten Have, and Eric Meslin. Los Angeles, CA: Sage, 2011.

[455] Q. A. Karim, S. S. A. Karim, H. M. Coovadia et al. "*Informed Consent for HIV Testing in A South African Hospital: Is It Truly Informed and Truly and Truly Voluntary?" American Journal of Public Health* 88 [1998]:637-40.

[456] Ezekiel J. Emanuel, David Wendler, and Christine Grady. "An Ethical Framework for Biomedical Research," in *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel, Ezekiel J., Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, p.131.

[457] T. M. Scanlon. *What We Owe to Each Other.* Cambridge, Mass: Harvard University Press,1999, Chapter 1 and 8.

[458] Ezekiel J. Emanuel, David Wendler, and Christine Grady. "An Ethical Framework for Biomedical Research," in *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel, Ezekiel J., Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010, pp.131-132.

[459] Roberto Andorno. "Article 3: Human dignity and Human Rights," in *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles, and Application, edited by* Henk A.M.J. ten Have and Michele S. Jean. Paris, France: UNESCO, 2007.

[460] Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010, pp. 133-134.

461 Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, Inc., 2009, p.350.

462 Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010, pp. 133-134.

463 Alain Enthoven. *Health Plan: The Practical Solution to the Soaring Cost of Medical Care.* Reading, MA: Addison-Wesley Publishing Company, 1980.

464 Christopher McCrudden. "Human Dignity and Judicial Interpretation of Human Rights," *Journal of International Law* 19, no. 4 [2008]: 655-724.

465 Catechism of the Catholic Church. Part One The profession of Faith. Section Two The Profession of the Christian Faith. Chapter one Believe in God the Father. Article 1. Paragraph 6, 355-357. http://www.vatican.va/archive/ccc_css/archive/catechism/p1s2c1p6.htm. [accessed on 6/11/2016].

466 Pico della Mirandola. *On the Dignity of Man.* Trans. by Glenn Walls. Indianapolis, IN: Hackett Publishing Company, 1965.

467 Immanuel Kant. "The Metaphysic of Ethics." Trans. By J. W. Semple. http://oll.libertyfund.org/titles/kant-the-metaphysics-of-ethics. [accessed on 6/12/2016].

468 Christopher McCrudden. "Human Dignity and Judicial Interpretation of Human Rights," *Journal of International Law* 19, no. 4 [2008]: 655-724.

469 Giovanni Bognetti. "The Concept of Human Dignity in European and U.S. Constitutionalism," In *European and US constitutionalism,* Foreworded by G. Nolte. *Science and Technique of Democracy* no. 37 [2003]: 75.

470 Yale Law School, Lillian Goldman Law Library. "Declaration of the Rights of Man-1789," Art. 6. http://avalon.law.yale.edu/18th_century/rightsof.asp. [accessed 6/14/2016].

[471] The Rights of Man (1791-1792). "Being an Answer to Mr. Burke's Attack on the French Revolution," http://www.let.rug.nl/usa/documents/1786-1800/thomas-paine-the-rights-of-man/text.php. [accessed on 6/16/2016].

[472] British Library. "Mary Wollstonecraft, A Vindication of the Rights of Woman," http://www.bl.uk/collection-items/mary-wollstonecraft-a-vindication-of-the-rights-of-woman. [accessed on 6/16/2016].

[473] William Wordsworth. "*The Prelude of 1805, in Thirteen Books."* http://triggs.djvu.org/djvu-editions.com/WORDSWORTH/PRELUDE1805/Download.pdf. [accessed on 6/16/2016].

[474] Paolo G. Carozza. "From Conquest to Constitutions: Retrieving a Latin American Tradition of the Idea of Human Rights," *Human Rights Quarterly* 25 [2003]: 281-313.

[475] Nelly Schmidt. "Slavery and its Abolition, French Colonies, Research and Transmission of Knowledge," http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/CLT/pdf/Nelly_Schmidt_Eng_01.pdf . [accessed on 6/18/2016].

[476] Pope Leo XIII. "*Rerum Novarum: Encyclical of Pope Leo XIII on Capital and Labor,"* (Given at St. Peter's in Rome on May 15, 1891). http://w2.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html. [accessed on 6/18/2016].

[477] Pope Pius XI. "Quadraesimo Anno," (Given at Rome, at Saint Peter's on May 15, 1931). http://w2.vatican.va/content/pius-xi/en/encyclicals/documents/hf_p-xi_enc_19310515_quadragesimo-anno.html. [accessed on 6/18/2016].

[478] Pope John XXIII. "Pacem in Terris: Encyclical of Pope John XXIII on Establishing Universal Peace in Truth, Justice, Charity, and Liberty," (Given in Rome at St. Peter's on April 11, 1963).

http://w2.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii_enc_11041963_pacem.html. [accessed on 6/18/2016].

479 Pope Paul VI. "Populorum Progressio: Encyclical of Pope Paul VI on the Development of Peoples," (Given in Rome at St. Peter's on March 26, 1967). http://w2.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_26031967_populorum.html. [accessed on 6/18/2016].

480 Pope John Paul II. "Centesimus Annus: Encyclical Letter to His Venerable Brother Bishops in the Episcopate The Priests and Deacons Families of Men and Women Religious all the Christian Faithful and to All Men and Women of Good Will on the Hundreth Anniversary of Rerum Novarum," (Given in Rome at St. Peter's on May 1, 1991). http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_01051991_centesimus-annus.html. [accessed on 6/18/2016].

481 Jacques Maritain. "Man and the State," (1951). http://www.panarchy.org/maritain/state.html. [accessed on 6/18/2016].

482 Daivd Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.* Washington, D.C.: Georgetown University Press, 2013.

483 Benedict M. Ashley. "Reactions of Various Scholars and Their Comments on the Working Paper, No. 1," In *A Report to the Congregation for the Faith* "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," Braintree, MA: Pope John XXIII Medical-Moral Research and Education Center, 1988, 34-36.

484 Genesis 1:26 [New American Standard].

485 Celia Deane-Drummond. *Genetics and Christian Ethics: New Studies in Christian Ethics.* Cambridge, NY: Cambridge University Press, 2006, p. 29-30.

[486] Stephen Wilkinson. *Choosing Tomorrow's Children: The Ethics of Selective Reproduction.* Oxford, NY: Oxford University Press, 2010. p.2.

[487] Stephen Wilkinson. *Choosing Tomorrow's Children: The Ethics of Selective Reproduction.* Oxford, NY: Oxford University Press, 2010. p. 3.

[488] Chris Ayres. "When IVF Turns into an IQ Test," *The Times,* December, 11, 2007.

[489] Stephen Wilkinson. *Choosing Tomorrow's Children: The Ethics of Selective Reproduction.* Oxford, NY: Oxford University Press, 2010. p. 5.

[490] Stephen Wilkinson. *Choosing Tomorrow's Children: The Ethics of Selective Reproduction.* Oxford, NY: Oxford University Press, 2010. p.5-7.

[491] Stephen Wilkinson. *Choosing Tomorrow's Children: The Ethics of Selective Reproduction.* Oxford, NY: Oxford University Press, 2010. p. 21-29.

[492] Aristotle. *Nicomachean Ethics.* Translated by Martin Ostwald. Englewood Cliffs, NJ: Prentice Hall, 1962.

[493] Immanuel Kant. *The Conflict of the Faculties.* In I. Kant, *Religion and Rational Theology,* edited by A. W. Wood and G. di Giovanni, trans. M.J. Gregor and R. Anchor. Cambridge, MA: Cambridge University Press, [1798] 1996, 239-327.

[494] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[495] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[496] Rebecca Kukla. "Conscientious Autonomy: Displacing Decisions in Health Care," *Hasting Center Report* 35 [March-April, 2005]: 34-44.

[497] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* NewYork, NY: Oxford University Press, Inc., 2009, pp. 103-105.

[498] Immanuel Kant. “Foundation of the Metaphysics of Moral,” trans. Lewis White Beck. Indianapolis, IN: Bobbs-Merrill, 1956.

[499] Paul Guyer. “*Kant on the Theory and Pracitce of Autonomy,” Social Philosophy and Policy.* 20 [2003]: 70-98.

[500] Immanuel Kant. “The Doctrine of Virtue, part II of the Metaphysics of Morals,” trans. Mary Gregor. Philadelphia: University of Pennsylvania Press, 1964, p. 127.

[501] Barbara Herman. "Mutual Aid and Respect for Persons," *Ethics* 94 [July, 1984]: 577-602.

[502] Onora O’Neil. "Universal Laws and Ends-in-Themselves," *Monist* 72 [1989]: 341-361.

[503] Tom L. Beauchamp, and James F. Childress. *Principles of Biomedical Ethics.* New York, NY: Oxford University Press, Inc., 2009, pp. 103-105.

[504] Carl E. Schneider. *The Practice of Autonomy: Patients, Doctors, and Medical Decisions.* New York: Oxford University Press, 1998, p xi.

[505] Tom L. Beauchamp, and James F. Childress. *Principles of Biomedical Ethics.* New York, NY: Oxford University Press, Inc., 2009.

[506] Ezekiel J. Emanuel. *Reinventing American Health Care.* New York, NY: PublicAffairs, 2014, p. 95.

[507] PBS-Healthcare Crisis. "The Uninsured," http://www.pbs.org/healthcarecrisis/uninsured.html. [accessed on 6/22/2016].

[508] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[509] Norman Daniels. *Seeking Fair Treatment: From the AIDS Epidemic to National Health Care Reform.* Oxford, NY: Oxford University Press, 1995, p. 85.

[510] Leon. R. Kass. "Practicing Ethics: Where’s the action?," *Hastings Center Report* 20, no. 1 [1990]: 5-12.

[511] Jay Katz. *The Silent World of Doctor and Patient.* New York: Free Press, 1984.

[512] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[513] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[514] Gerald Dworkin. *The Theory and Practice of Autonomy.* New York, NY:Cambridge University Press, 1988, pp. 34-35.

[515] Andrea S. Christopher and Dominic Caruso. "Promoting Health as a Human Right in the Post-ACA United States," *AMA Journal of Ethics* 17, no. 10 [2015]: 958-965.

[516] Linda J. Blumberg. *"The Affordable Care Act: What Does it Do For Low-income Families?* (Institute for Research on Poverty, December 2012). http://www.irp.wisc.edu/publications/fastfocus/pdfs/FF15-2012.pdf. [accessed 7/14/2106].

[517] World Medical Association. "WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects," http://www.wma.net/en/30publications/10policies/b3/. [accessed on 6/30/2016].

[518] Maria Patrão Neves. "Respect for Human Vulnerability and Personal Integrity," In *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles, and Application,* edited by Henk A.M.J. ten Have and Michele S. Jean. Paris, France: UNESCO, 2007, pp. 159-160.

[519] Donald Evans. "Autonomy and Individual Responsibility," In *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles, and Application,* edited by Henk A.M.J. ten Have and Michele S. Jean. Paris, France: UNESCO, 2007, p. 111.

[520] Ezekiel J. Emanuel. *Reinventing American Health Care.* New York, NY: PublicAffairs, 2014, p.10.

[521] Tom L. Beauchamp and James F. Childress. *Principles of Bioethical Ethics*. Oxford, NY: Oxford University Press, Inc., 2009.

[522] Heather Gert. "Viability," In *The Problem of Abortion* edited by Feinberg, Joel, and Susan Dwyer. Belmont, CA: Wadsworth, 1997.

[523] Bernard Gert. *Common Morality.* Oxford, NY: Oxford University Press, 2004, p. 30.

[524] Bernard Gert, Charles M. Culver, and K. Danner Clouser. *Bioethics: A Systematic Approach.* New York, New York: Oxford University Press, 2006, pp.32-33.

[525] Bernard Gert, Charles M. Culver, and K. Danner Clouser. *Bioethics: A Systematic Approach.* New York, New York: Oxford University Press, 2006, p. 34.

[526] Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics.* NewYork, New York: Oxford University Press, Inc., 2009, p.372-373.

[527] Norman Daniel. *Just Health Care.* New York, NY: Cambridge University Press, 1985.

[528] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, 2009.

[529] Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010

[530] Genesis 3:6 [New American Standard].

[531] Genesis 3:8-16 [New American Standard].

[532] National Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care services," *Origin* 24(1994): 452, citing Genesis 1:26.

[533] Elliot N. Dorff, *Matters of Life and Death: A Jewish Approach to Modern Medical Ethics.* Philadelphia, PA: Jewish Publication Society, 1998, p. 26.

[534] Richard A. McCormick, *Health and Medicine in the Catholic Tradition.* New York: Crossroad, 1987, p. 8.

[535] Benedict M. Ashley and Kevin D. O'Rourke. *Health Care Ethics: A Theological Analysis.* Washington, D.C.: Georgetown University Press, 1997, pp. 36-46.

[536] National Conference of Catholic Bishops, "Pastoral Letter on Health and Health Care," *Origin* 11 [1981]: 396-402.

[537] Aaron L. Mackler. *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.* Washington D.C.: Georgetown University Press, 2003, pp. 3-7.

[538] David F. Kelly. *Contemporary Catholic Health Care Ethics.* Washington, D.C.: Georgetown University Press, 2004, p. 11-15.

[539] Reformed Church of North America. "Nicene Creed," https://www.crcna.org/welcome/beliefs/creeds/nicene-creed. [accessed 7/30/2016].

[540]Aaron L. Mackler *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.* Washington D.C.: Georgetown University Press, 2003, pp. 32-36.

[541] Thomas Aquinas, *Summa Theologiae.* I-II q.91, a.1-2; q.94, a. 2; in Blackfriars ed., vol. 28, trans. Thomas Gilby. New York: McGraw-Hill and London: Eyre and Spottiswoode, 1966, 19-25, 77-83.

[542] Thomas Aquinas, *Summa Theologiae.* I-II q.91, a.1-2; q.94, a. 2; in Blackfriars ed., vol. 28, trans. Thomas Gilby. New York: McGraw-Hill and London: Eyre and Spottiswoode, 1966, 19-25, 77-83.

[543] Kelly, David F. *Contemporary Catholic Health Care Ethics.* Washington, D.C.: Georgetown University Press, 2004, pp. 88-90.

[544] Mackler, Aaron L. *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.* Washington D.C.: Georgetown University Press, 2003, pp. 28-30.

[545] The Library of Congress Thomas. *Patient Self Determination Act of 1990*. H.R..4449. Sec.2.

[546] U.S. General Accounting Office. "Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain, 1995," http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed April 21, 2015]

[547] U.S. General Accounting Office. "Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain," 1995, pp.2-3. http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed April 21, 2015]

[548] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009.

[549] Eric J. Cassell. *The Nature of Suffering and the Goals of Medicine.* Oxford, New York: Osford University Press, Inc., 2004.

[550] *The Genuine Works of Hippocrates: The Book of Prognostics,* trans. Francis Adams. Baltimore: Williams and Wilkens Company, 1939, p.42.

[551] P. D. Wall. *Pain: The Science of Suffering.* New York: Columbia University Press, 2000.

[552] Eric J. Cassell. *The Nature of Suffering and the Goals of Medicine.* Oxford, New York: Osford University Press, Inc. 2004.

[553] Jodi Halpern. "What is Clinical Empathy," *J Gen Intern Med* 18 [2003]: 670-674.

[554] P. Butow, M Maclean, S Dunn, et al. "The Dynamics of Change: Cancer Patients' Preferences for Information, Involvement and Support," *Ann Oncol.* 8 [1997]: 857-63.

[555] W. Levinson and D. Roter. "Physicians' Psychosocial Beliefs Correlate with Their Patient Communication Skills," *Journal of General Internal Medicine* 10 [1995]: 375-9.

[556] U.S. General Accounting Office. Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain, 1995, p.2.

http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed on November 16, 2013].

557 Public Broadcasting System. "The Kevorkian Verdict," http://www.pbs.org/wgbh/pages/frontline/kevorkian. [accessed on November 14, 2013].

558 U.S. General Accounting Office. Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain, 1995, p.2-3. http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95- 135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed on November 16, 2013.

559 K. A. Koch. "Patient Self-Determination Act," *The Journal of the Florida Medical Association* 79, no 4[1992]: 240-3.

560 Janna C. Merrick. *Death and Dying: The American Experience.* Cambridge, Massachusetts: The MIT Press, 2005, pp. 228.

561 Janna C. Merrick. *Death and Dying: The American Experience.* 2005, pp. 228-229.

562 Janna C. Merrick. *Death and Dying: The American Experience.* 2005, pp. 229-230.

563 Cruzan v. Director, Missouri Department of Health. 1105. CT, 1990, pp. 2843, 2851-2852.

564 Janna C. Merrick. *Death and Dying: The American Experience*. 2005, pp. 229-230.

565 U.S. House. *To Provide Affordable, Quality Health Care for All Americans and Reduce the Growth in Health Care Spending, and for Other Purposes.* 2009, H.R. 3200, section 1233.

566 The Library of Congress Thomas. Patient Self Determination Act of 1990. H.R..4449, Sec. 2-3.

567 U.S. House. *To provide affordable, quality health care for all Americans and reduce the Growth in health care spending, and for other purposes.* 2009, H.R. 3200, section 1233.

568 Jennifer Prah Ruger. *Health and Social Justice.* Oxford, NY: Oxford University Press, 2010.

[569] United Nations Treaty Collection. "Treaty Series: Treaties and international agreements registered or filed and recorded with the Secretariat of the United Nations," New York: United Nations vol. 993, 1983.

[570] Norman Daniel. *Just Health Care.* New York, NY: Cambridge University Press, 1985.

[571] Jennifer Prah Ruger. *Health and Social Justice.* Oxford, NY: Oxford University Press, 2010.

[572] Norman Daniels. *Just Health: Meeting Needs Fairly.* New York, NY: Cambridge University Press, 2008.

[573] Norman Daniels. *Just Health: Meeting Health Needs Fairly,* 2008.

[574] John Rawls. The basic liberties and their priorities. In *The Tanner Lectures on Human Values,* vol. III. Salt Lake City: University of Utah Press,1982.

[575] Norman Daniels. "Equal liberty and unequal worth of liberty," In *Reading Rawls* edited by Norman Daniels. New York: Basic Books, 1975, pp. 253-81.

[576] Norman Daniels. *Just Health: Meeting Health Needs Fairly,* 2008.

[577] Norman Daniel. *Just Health Care.* New York, NY: Cambridge University Press, 1985.

[578] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, 2009.

[579] Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010

[580] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2711.

[581] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2713.

[582] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2716.

583 U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2717.

584 U.S. Senate and U.S. House. 2010. The Patient Protection and Affordable Care Act. HR 3590, Sec. 2705.

585 W. D. Ross. *The right and the Good.* Oxford: Clarendon, 1930.

586 U.S. Senate and U.S. House. 2010. The Patient Protection and Affordable Care Act. HR 3590, Sec. 1302.

587 U.S. Senate and U.S. House. 2010. The Patient Protection and Affordable Care Act. HR 3590, Sec. 1331.

588 Michael Walzer. *Spheres of Justice: A Defense of Pluralism and Equality.* New York, NY: Basic Books, 1983.

589 Alicia Elatassi. "#GetCovered Story: Staying Healthy for the Future and Their Family," (Posted on January 12, 2105).
http://wayback.archive-it.org/3909/20150925135950/http://www.hhs.gov/healthcare/facts/blog/2015/01/alicia-rusk-getcovered-story-staying-healthy-future.html. [accessed on 9/29/2016].

590 Elena Miller-Terkuile. "Elena's #GetCovered Story: Pursuing Her Dream to Farm," (Posted on January 6, 2015).
http://wayback.archive-it.org/3909/20150925135952/http://www.hhs.gov/healthcare/facts/blog/2015/01/elenas-getcovered-story-pursuing-her-dream-farm.html. [accessed on 9/28/2016].

591 A.S. Relman and U. Reinhardt. "An exchange on for-profit healthcare," In *For-Profit Enterprise in Health Care,* ed. B.H. Gray. Washington: National Academy Press, 1986,

pp. 209-23.

592 L.C. Thurow. "Learning to say 'No'," *The New England Journal of Medicine* 311, [1985]: 611-14.

593 Daniel. Callahan. "*Adequate Health care and an aging society: Are they morally compatible?*"*Daedalus* 115 [1982]:247-67

594 E. haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics.*1995, pp. 9-11.

595 The Catholic Health association of the United States. *With Justice for All?: The Ethics of Healthcare Rationing.* 1991, p. x-xi.

596 The Catholic Health association of the United States. *With Justice for All?: The Ethics of Healthcare Rationing.* Lt. Louis, MO: The Catholic Health Association of the United States, 1991, p. 18.

597 Mark. A. Hall. "The Malpractice Standard under Health Care Cost Containment," *Law, Medicine and Health Care* 17 [1989]: 347-355.

598 E. haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics.* Washington DC: Georgetown University Press, 1995.

599 E. haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics.* Washington DC: Georgetown University Press, 1995.

600 M.S. Lachs, J.L. Sindelar, and R.I. Horwitz. "The forgiveness of coinsurance: Charity or cheating," *The New England Journal of Medicine,* 322:1599-1602.

601 E. haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics,* 1995.

602 M. A. Rodwin. "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and the Obligations in a Changing Health Care System," *American Journal of Law and Medicine* 21 [1995]: 241-257.

603 A.L. Hillman. "Financial incentives for physicians in HMOs: Is there a conflict of interest," *The New England Journal of Medicine* 317 [1987]:1747.

604 A.L. Hillman. "Health Maintenance Organizations, Financial Incentives, and Physicians' Judgments," *Annals of Internal Medicine,* 112 [1990]:892.

605 S.A. Marcus. "Trade unionism for doctors: An idea whose time has come," *The New England Journal of Medicine,* 311 [1984]:1509.

606 E. haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics.* 1995.

607 H. T. Engelhardt, Jr. *The Foundations of Bioethics.* Oxford: Oxford University Press, 1996.

608 Ronald Dworkin. "Life Past Resaon," In *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* edited by Ronald Dworkin. Mew York: Knopf, 1993, pp. 218-242.

609 E. haavi Morreim. *Balancing Act: The New Medical Ethics of Medicine's New Economics.* 1995.

610 J. Savulescu and R. W. Mommeyer. "Should Informed Consent be based on Rational Beliefs?" In *Medical Ethics* edited by M. Boylan. Upper Saddle, NJ: Prentice Hall, 2000.

611 Anne Beeson Royalty. "Estimating Workers' Marginal Valuation of Employer Health Benefits: Would Insured Workers Prefer More Health Insurance or Higher Wages?," *Journal of Health Economics* 27, Issue 1 [2008]: 89-105.

Chapter Four

Population Health: Vulnerability, Justice, & Entitlement Programs in the ACA

Section One. Introduction

As people of all walks of life congregate to form a society and take on the different societal roles, one of the pressing issues is how to keep them healthy so they can continue to be a part of the human community. Notably, there are several complex questions arise from the issue of population health. Who's responsibility is it to lead a healthy life? Should people in society help those who do not participate in healthy lifestyle such as healthy diet and exercise? Who's job is it to protect people from infectious diseases? These thoughts often lead to the question of how much should the government force its health agendas on citizens.

The health of the population is essential to the society as a whole because it directly affects the success and the ongoing progress of society. Some believe public health is warranted while others hold a very different view on the issue. This, essentially, leads to the health debate that raises four ethical questions.[612] The first ethical question is concerned with the responsibility of the government, the individuals, and the organizations on public health, and how each part can be affected by the health policy. The second ethical question is whether government's intervention is warranted when an individual's actions affect others. John Stuart Mill asserts that it is sufficient to justify a public health policy based on his Harm Principle. The third ethical issue is concerned with the extent to which it is acceptable for the government's policy to influence the

health of the population. The concern is that the government oversteps its role in public health services and violates the autonomy of the individual. The fourth ethical issue is related to what level of intervention from the government that might improve population health. Some believe that the government has a duty to provide measures that allow people to be healthy for the purpose of greater productivity.[613]

The World Health Organization defines the concept of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"[614] It is recognized that the achievement of individual health cannot be separated from the collective population health. The faculty of Public Health of the Royal Colleges of Physicians of the United Kingdom defines public health as "is about improving and protecting the health of groups of people (or 'populations') rather than treating individual patients…must take action to promote healthy lifestyle, prevent disease, protect and improve general health and healthcare services for their local 'population'..."[615] The organized efforts include nonmedical provision such as clean water, social housing, and environmental protection. The efforts should also include medical measures for treatment and prevention of illness. The main idea of public health is for the government to provide adequate resources for those who do not have the means and need assistance to stay healthy.[616]

In addition, in order to obtain population health, there needs to be measures that help people to make good choices for their health. The objective can only be accomplished through government-run system because not everyone can afford programs from privatized insurance companies. It is obvious that the inequality of healthcare that

creates various health problems in society. Thus, instead of leaving healthcare to private companies, the role of the government is to provide health services to everyone, particularly those who cannot afford them so as to promote population health and reduce inequality.[617]

Opponents perceive government-funded health services as a form of control. For example, libertarian's perspective affirms the right of man to life, liberty, and property. These rights are naturally given to all men. This has become the basic moral view on social life in western society, which also is the background for political health ideology.[618] Therefore, the governmental involvement in individual's life is viewed as the infringement of personal freedom. It is essentially based on the notion of personal freedom that libertarian objects the concept of the public health.

To understand the reason for liberal objection to public health, it is helpful to consider the concept of autonomy. Liberals emphasize the importance of the individual's ability to make choices that reflects personal autonomy.[619] Commonly, autonomy has the meaning of 'self-governance' and the freedom to choose one's action. They believe that human beings are rational creatures possessing comprehension and intelligence that enable them to make choices. These features along with the rights of individuals allow people to pursue their own conception of the good. The conception of the good is understood as the view of how one wants to live his life according to his own beliefs and values.[620] Any policy that enforces judgment on how individuals should live their lives is said to restrict people's freedom.

Based on this thought, liberals advocate a type of government that does not

interfere with individual rights and freedom. The basic objection to public health is the assertion that population health is valued as the conception of the good without personal choice and preference, which is a strict limitation on liberty. For example, public ban on smoking is believed to have infringed freedom of choice. Another example is compulsory childhood immunization which is objectionable on the bases of violating parental rights.[621] To the liberals, one should have the freedom to consider whether or not population health is good without the authoritative judgment from the government. Whatever the choice of action one makes for himself should be respected, and the practice of self-determining should be upheld at all cost. Even in cases when people refuse to participate in preventive health and be treated for illness, the exercise of autonomy should be encouraged. In contrast, to make all people consider population health as a value is too controlling and imposing. This is viewed as an intrusion to personal life and stepping into the territory of personal freedom.

Because of the caution of interfering with personal freedom, the question is how far the government should provide health services to reduce the risk to population health that will not infringe personal rights. This is an obvious conflict between the government and the people. Should the fear of infringing personal freedom stop the provision of public health or a probable solution that can both protect personal autonomy and promote the welfare of all people?[622] The following three responses to liberal's objection to public health can clarify opposing perspectives and support the promotion of government-funded health services.

The first response to liberal's objection to public health is the freedom as

autonomy. According to Swift, autonomy is self-rule reflecting one's ability to be in control of governing oneself.[623] Based on this definition; an individual who acts on what he wants may or may not be considered as acting autonomously. The reason is that the individual's action has to be based on what he desires to do and in a manner of in control of himself. For instance, a drug addict who uses cocaine reflects what he wants but fails to be in control of his life. Norman agrees and asserts that doing what one desires does not fully satisfy the definition of autonomy. It must be done with the capacity to be self-determining and in control.[624] It seems easy for one to do what he wants; it is the part that being in control distinguishes between negative freedom and freedom as autonomy.

It is based on this definition that liberals will appeal to certain kinds of public health interventions. They believe, in order for an individual to be in control of doing what he wants, he needs to be given necessary information prior to making an informed decision.[625] Using the previous example, when a teenager wants to try cocaine out of curiosity without realizing the health risks. His action is not autonomous but just simply doing what he happens to desire. In this situation, public health interventions that aim at providing education on the health risk of cocaine allow the teenager to control his desired action with proper knowledge, thus satisfy as freedom as autonomy.

The second response is based on the concept of effective freedom. Understanding effective freedom will require the analysis of negative freedom and positive freedom/effective freedom. Negative freedom means a person is free from constraint on doing an action.[626] For example, a late stage multiple sclerosis patient is free from constraint to hike in the mountain. It is clear that the law does not forbid any disabled MS

patient to walk in the mountain. However, effective freedom explains that the actual physical capability to hike in the mountain reflects a viable positive account of freedom. These definitions shed lights into the liberals' perspectives on public health.

As commonly accepted, the government's provision of healthcare is justified based on the idea of promoting freedom. Some argue that public services are decisions of the government for the citizens. The available health programs reflect what the government wants its citizens to do. As a result, when citizens participate in those health programs, their freedom to do those things is actually restricted to the permissibility of the government.[627] That might be true to a certain degree. However, liberals support effective freedom because of the notion of enabling people to do what they want. They will accept health measures that enable people to do more of what they otherwise cannot do.[628] For instance, a patient who has emphysema and cannot work full time due to tiredness from decreased oxygen level. The government is obligated to provide treatment so as to increase the patient's effective freedom. Going further, the government might consider that getting smokers to quit smoking before they have emphysema is the best way to increase effective freedom; that leads to preventive health campaigns that provide information about the risks of cigarette smoking.[629] This action appears to be justified on the ground of effective freedom because of the aim at enabling people to do more of what they want.[630]

The third response is the Mill's harm principle which aims at resolving the friction between the promotion of public health and the protection of individual rights. In his essay on liberty, John Stuart Mill asserts that the only reason that warrants any means

used for the purpose of controlling or coercing others is self-protection.[631] However compelling the physical and moral ideal of one's value of good is not sufficient to impose action on an individual who does not want it. He explains the exercise of power and authority on members of society against their will is allowed only on the ground of preventing harm to others. To justify the use of authoritative action, according to Mill, the exerted behaviors have to be carefully evaluated and judged as producing evil to others. In other words, it is only for the safety of someone else that the use of power on others is permissible.

The significance of Mill's principle is its allowance for state interference, to a degree, for the purpose of preventing harm to others in society. His specific comments can be used for the framework of public health ethics. First, Mill acknowledges the need for public assistance in the population of children and vulnerable individuals. He recognizes that these groups of people required protection from the government. Because of their immaturity and lack of capability, it is acceptable for the government to protect them from damaging their own health and the harm from others.[632] Second, Mill allows government efforts in the interest of society, such as providing clean water to protect and promote population health. That acceptance of governmental involvement is extended to other areas such as banning smoking in restaurants. In this case, the authoritative power is justified because cigarette smoking can harm others in the restaurants (waiters and other patrons).[633] Third, Mill asserts the importance of educating people so that they can clearly discern the actions of the government and make decision about their own lives. Because he opposes public health programs that coerce people into living a certain way, he

supports services that provide information for the purpose of making informed decision about their own health.[634] Fourth, and the last one, Mill strongly advocates the exercise of freedom in one's personal life as the fundamental human rights. Even with the acceptance of public health services, he only supports programs that are less intrusive to individual rights.[635]

Because Mill is able to balance the importance of individual freedom and the duty of the government, his principle actually can serve as a liberal framework for pubic health. While he allows public health services in the four areas mentioned earlier, he emphasizes the aim of minimizing the interference of personal life for as long as these programs are being used. To Mill, governmental involvement in citizens' lives is sometimes allowed so long as one's individual autonomy is not violated.

Section Two. Vulnerability

This section focuses on the distribution of healthcare to vulnerable population including the elderly, poor, and disabled. The concern for population health raises the awareness of unequal distribution of healthcare that affects individuals with disadvantage. The problem can be corrected by using a statewide health policy that distributes health resources equally.

a. Physical Limitation

Physical limitation is linked to diseases and disability. Individuals who suffer these conditions are disadvantaged and vulnerable, and the level of vulnerability is

depended on the severity of damage to their physical ability to function. No doubt, these individuals are in need of healthcare.

i. Disease

According to Center for Disease Control (CDC), approximately 117 million US adults, representing half of the adult population, have one of the 10 chronic diseases.[636] One of the significant effects from chronic diseases is decreased functional capacity.[637] The commonly accepted definition of disease clearly expresses such effect on the human body. Disease causes organ and system malfunction leading to disorder in body functioning.[638] For example, arthritis decreases joint movements and congestive heart failure decreases physical endurance for activities. Besides physical illness, the psychological conditions such as depression also decreases functioning.[639] These conditions notably decrease the individuals' ability to perform their roles in families and communities. On personal level, diseases affect the use of their talents and skills. The worse outcome is when a disease causes permanent damage to the body resulting in disability. In other word, disease and illness reduce individuals' means to achieve goals[640] and chances of success.

1. Factors Link to Increased Risk for Disease

Inequality in health raises the concern for diseases that leads to the increase of morbidity and mortality rates. It also affects the health state of the entire country. For example, in 1995, the life expectancy for men at age 15 in Russia is ten years less than

that of those countries of European Union.[641] The significant difference clearly reflects the policy of the state. That is not all, other factors also play a part in mortality such as lack of education in women's health. Improving women's health leads to healthy pregnancy and proper infant health that increase survival rate.[642] Although health inequality is noted in all countries, lower mortality is commonly seen in rich countries than in poor countries as supported by the record of life expectancy. It leads to the notion that health inequality in society is associated with social inequalities. For many years in the United States, a significant number of people were either without health coverage or had inadequate health coverage. The overall condition of health in society was less than desirable.

Some of the causes of social inequalities bear significant health consequences as seen in smoking and in hazardous work environments. It is worth finding the factors that link people to higher exposure to tobacco, environmental pollution, worse diet, and psychological stress that increase their risk for respiratory disease, lung cancer, heart disease, and mental illness. One study shows the effects of grade of employment and smoking on 25 years mortality from lung cancer. It was documented of 638 deaths from lung cancer and fewer than five percent of them were non-smokers.[643] It can be said that if smoking did not occur, the 95 percent of lung cancer deaths would not have occurred. It also communicates that smoking contributes to lung cancer and eliminating smoking will have a significant impact on health. The new health policy ACA now includes health education and encourages companies to promote healthy lifestyle and habits. It aims at reducing factors that link to the increased risk for diseases.

2. Income Inequality

Michael Marmont includes a study in his writing that shows the lowest grade of employment has 70 percent increased risk of coronary heart disease mortality as compared to the highest.[644] Data shows life expectancy for positions in administrative/professional/executive was 4.4 more years than those of clerical/other. It also compared the life expectancy at age 45 between death causes by coronary heart disease and others was four years, meaning it would add four years to life if coronary heart disease were eliminated. Based on the study results, it can be argued that jobs and income level affect health. An obvious reason is higher income provides better affordability to purchase health insurance. For individuals who live "paycheck to paycheck", high premium takes away their spending on essentials such as food and shelter. Naturally, people will forgo purchasing health coverage to afford daily essentials. The consequence of lacking health insurance is the failure to get treatment, which leads to the increased risk for illness or diseases.

In earlier period, more cases of coronary heart disease were seen in higher socio-economic groups.[645] However, in recent years, education on health, good health habits, and better food choices have lowered the incidents of coronary heart disease among people in the higher socio-economic groups. It is believed that these groups of people are able to improve their health habits leading to better health are due to their higher financial ability. Amartya Sen argues that breaking the link between income inequality and health inequality can result in greater equality in health among people in society.[646] If certain group of people can improve their health and reduce the rate of disease process, other

societal groups should be given the same opportunity to do so. In the United States, it is noted that Utah has the longest life expectancy of 77.5 years for men at birth while men in District of Columbia, poor residential area, has life expectancy of 62.2 years at birth.[647] The gap in life expectancy is 15 years between the high and low-income levels. Although genetic link must be considered when comparing the difference, the implication of social environmental causes is strong. The idea of leveling off the health by bringing up the health of the worst-off to that of the better-off can result in significant improvement of health in society. That can be achieved by having a health system that provides basic coverage of treatment to all in society.

ii. Physical and Mental Disability

In the United States, approximately 56.7 million people, reflecting 1 in 5 people, had some kind of disability in 2010.[648] Among them, about 38.3 million had a severe disability. Those who need assistance with activities of daily living (ADL) amount to approximately 12.3 million. Severe disability and the need for ADL increase with age. Based on the same Census Bureau's report, severe disability prevented 55.5 percent among the 16 to 64-year-olds disabled from being employed. The challenge to perform ADL and work restricts an individual's overall participation. Impairment of normal physical and mental function as in disability destroys individuals' fundamental way to exercise their talents and skills. Disability, mild or severe, restricts an individual's opportunity and ability to perform his skills and talents forcing him to void his life plan. His fair share of normal range in life is then taken because of disability.[649] It should also be noted that not being able to use one's ability to purposefully pursue goals diminishes

happiness and satisfaction.

1. Quality of Life in Individuals with Physical Disability

Disability is more than a health problem; it has serious effects that disrupt living and decrease ability to be productive. In the United States, the prevalence of disability is on the rise due to aging population and higher risk of disability in older adults. This is mainly the reason of increase in chronic diseases among the elderly population. Common health conditions include diabetes, cardiovascular disease, cancer, and mental health disorders. Aside from disability caused by chronic diseases, other causes include genetic disorders and injuries. The effect of disability is immobilization and decreased functionality. There are challenges on multiple levels for individuals with disability. Both mental and physical disability pose participation restrictions and activity limitation resulting in direct effect on the individual's daily functioning capacity.[650] Participation restriction is referred to problems with involvement in life situations such as employment discrimination and activity limitation is referred to the difficulty in executing activities.[651] It is noted they generally earn less money when employed[652] and income level worsens with severe disability.[653] The challenge of employment is escalated by the limited access to transport.[654] It has been globally recognized that people with disability have increase risk of poverty and are likely to experience social disadvantage.[655] With restriction and limitation, individuals with disability are unable to fully engage in activities of daily living, to be employed, and to connect to society. Managing the basic activities such as eating, dressing, personal hygiene, and ambulating can be impossible with limited use of

limbs or no use of limbs. The use of personal assistance is paramount to achieving these daily necessities. Without sufficient assistance, quality of life is seriously compromised. This reason justifies the provision of assistance. Another challenge is environmental limitation which includes the lack of transportation and accessibility. They may also be denied equal access to healthcare, education, social events because of their disability. Since most disabled people are without employment, they cannot get private health insurance. They rely on the healthcare access provides by the government. For disabled people, they tend to have complex health conditions that require specialized care and longer office visits. Access to healthcare is critical to stabilizing health status. Hence, the need for better services and assistance must be provided for this population to support functioning and living.

2. Needs for Services and Assistance

People with disabilities need assistance for activities of daily living and functioning. They deserve equal respect and enjoyment of human rights. There is a moral obligation to remove barriers for individuals with disability to have better quality of life and be able to participate life and exercise potentials. Denying access of care will hinder individuals with disability from contributing their potential to society. Stephen Hawking, a theoretical physicist, suffers motor neuron disease most of his adult life. He is wheelchair bound and dependent on a computerized voice system.[656] He credits medical care, personal assistants, accessibility in house and workplace for being able to continue to have a family life and productive employment.[657] In addition, a speech synthesizer, an

assisted communication system, allows him to compose lectures and communicate with his audience. Hawking is an example of disability with better quality of life because of the provision of services and assistance. Disability incurs extra costs associating with medical care, assistive devices, and personal care assistance.[658] Government and stakeholders should create measures such as rehabilitation, support services, social protection as well as medical treatment to improve the lives of disability.[659] New and existing policies that benefit people with disabilities must be consistently enforced to ensure continuum. Furthermore, it is critically important to create an environment that is accessible for disability. Examples of positive environment include providing deaf individuals with interpreter for sign language, accessibility for wheelchairs, and computer screen-reading software for blind individuals.

b. Financial Limitation

This section discusses the vulnerability in individuals without employment, in poverty, and who are unemployable.

i. Unemployment and Health

Researchers have documented the correlation between unemployment and health. Depending on the duration of unemployment, the longer period of financial hardship has greater consequences. This is because employment provides means to meet basic human needs.[660] It also satisfies the desire for achievement resulting in higher esteem that inspires greater goals. Conversely, unemployment causes stress and anxiety that are the

commonly seen human response. As the period of unemployment continues, other conditions such as depression, cardiovascular disease, musculoskeletal issues as well as death also emerge.[661] It indicates that unemployment affects physical and psychological health as well as the overall wellness of the individual. In the 6-month study conducted by Linn et al., the unemployed group visited their physicians five times more that the employed group and took twice as many medications than the employed.[662] Reasons for medical attention include both physical and psychological. The unemployed men were also found to stay in bed more days than the employed. Their psychological function is affected by stress, anxiety, and depression as manifested by loss of appetite, sleep, and sexual interests. Pharr et al also reached a similar conclusion on the connection between psychological health and loss of work and added that the unemployed were likely to experience inadequate or delay treatment due to limited healthcare.[663]

1. The Connection Between Health and Job Opportunity

There is evidence to indicate the connection among health, socio-economic level, and less opportunity of employment. The effect can either be that health determines socio-economic position or social status affects health condition.[664] The first explains that health plays a part in determining life chances; meaning one who has ill health will have difficulty in keeping an employment or pursuing advancement. The latter indicates that health selects people into the societal class, which is termed endogeneity.[665] If health plays a role in selecting one's social position leading to better job opportunity, it also leads to the belief that ill health puts one in a lower societal position that increases risk

for unemployment placing one in the possibility of living in deprived neighborhood, lowing chances of participating in social network, and eating unhealthy food. These factors directly decrease the chances of good employment that affords health insurance benefits.

In a longitudinal study of the 1946 birth cohort in the United Kingdom, children who had positive signs of illness were less likely to move upward in society when compared to the healthy children. As a matter of fact, they showed the tendency to move downward in society.[666] However, as the difference of social class was changing, the unskilled group of the bottom class became smaller in size. People with better health in this group were moving upward in social rank leaving the ill health with higher mortality rates. As the higher social classes expanded to include the better health from the lower rank, the assumption was that the mortality rates would increase in these classes due to the recruits from the lower rank. Interestingly, the mortality rates in the higher classes did not increase, and the mortality rate of the lower class did not decrease.[667] As a matter of fact, there was improvement in health in the higher classes.[668] This leads to the belief that there is a relation between social position and health mainly because better health potentiates the opportunity for employments and job advancement leading to higher social status, and those who are in higher social status have greater chance of staying healthy.

2. Material Deprivation Affects Health

Material deprivation is referred to inadequate housing, under nutrition, inadequate

clothing, risky work places, cannot afford to entertain children's friends, cannot go on vacation, and cannot afford to pursue a hobby or leisure activity.[669] These conditions occur in unemployment and under employment. Marmont reveals data showing British executive officers have better health than those who work as clerical officers. Yet, they still have worse health than those whose positions that are above them. The lack of material supply prevents people from fully participate in society and controlling their lives resulting in increase risk for illness.[670] Chronic experience of material deprivation can result in early death.[671] It gives rise to the notion that there is relation between material deprivation and mortality and shorter life expectancy.[672] Clearly, income level reflects social condition and the variant level of material supply. The greater gap of the income inequality is likely to create a wider variant level of material supply in society, which can potentially affect the entire social condition not only for those poor individuals. It is the increase risk for illness and shorter life expectancy that should concern all members in society. A government funded health system that provides standard care across the spectrum of employment levels can successfully insure healthcare in any stage of life and also other social needs.

ii. Poverty and Beyond Working Years

Based on the 2012 report, there were 46.5 million people in poverty in the United States.[673] Poverty is noted to have correlated with health risks.[674] Living in poverty decreases the individuals' ability to remain healthy posing direct effect on personal growth.[675] They face limitation in developing skills that contribute to the work force.

According to Center of Disease Control, low-income individuals experience higher rates of disease as compared to higher-income individuals. Higher mortality rates are consistently found in the lowest income,[676] and individuals with higher incomes have better health and live longer. Conversely, health improves when family income increases.[677] However, children's health is directly affected by low-income condition. Children who live in low-income condition have poorer health outcomes including physical, psychological, and learning readiness.[678] One study shows exposure to poverty in early years leads to hypertension and schizophrenia in adult years.[679] Often, they have difficulty receiving adequate health care.[680] Adult health is a result of health habit begins in early years. Evidence now shows that poverty in childhood links to poor health in adults.[681]

In 2012, 20.4 million people in the United States reported income below 50% of their poverty threshold, and 1.2 million of them were aged 65 and older.[682] The number of these elderly in poverty would have been closer to 15.3 million if social security payment not administered. It should be noted that among the people of the general population, people aged 65 and older represented 13.9 percent. The number of elderly increased to 3.9 million from 3.6 million in 2011. The population over age 65 generally has decreased ability to work posing the risk for poverty. That leads to the decrease in financial ability to afford preventive care, drug, and even necessities.[683] It is noted their poor health condition yields the need for health care.[684] In one particular study, the findings indicate the health of the elderly improved after receiving Medicare as compared to uninsured prior to enrolling in the program.[685]

1. Societal Obligation to Care for the Poor

Catholic Health Association of the United States (CHA) advocates the belief in which societal has the obligation to provide healthcare to all members.[686] Withholding beneficial services to people who need them but cannot afford them raises serious ethical questions as it can jeopardize their dignity. In particular, CHA considers the societal obligation to care for the poor is ethically justified. Based on this view, it disagrees with cutting the poor population out of government services. For instance, the policy to set the income eligibility level below the federal poverty line is intended to reduce participation in Medicaid services. Other policies include discouraging physicians from serving the poor by inadequate payment and burdensome paperwork requirement are also the measures to reduce healthcare costs. According to the U.S. Census Bureau reports, the uninsured and underinsured were often the population of minorities.[687] The inadequate health coverage also can affect some insured individuals, it is seen in cases when health insurers refuse to cover serious preexisting conditions, deny coverage to the category of the "uninsurable," and raise the deductible to discourage people from seeking healthcare services.

The withholding of beneficial care can affect people's life prospects and opportunities to pursue advancement. It also raises the following ethical concerns: [688]1) it is unethical to deny help to those who are in need of healthcare, 2) withholding health services poses harm, 3) people's dignity will be jeopardized when healthcare is denied, 4) those without healthcare experience isolation from society, and 5) it is unfair to withhold beneficial healthcare. The consequence of no health services can result in more suffering,

disabilities, or premature deaths. CHA holds individual and private institutions responsible for the ongoing healthcare crisis. More directly, it places the responsibility on the government for its failure to handle health issues adequately.

2. Senior Citizens

A significant number of Americans aged 60 live below the federal poverty level. Based on data in December 2014, social security benefits were paid to 42.9 million people aged 65 or older.[689] In most cases for a single elderly person, the annual income is $29,425.[690] According to National Council on Aging, The older American adults have limited income creating a challenge of affording monthly expenses. These older adults have passed their working years and not hirable in many cases. They face many challenges such as food insecurity, adequate medications, and housing issues. The Supplemental Nutrition Assistance Program under the function of the United States Department of Agriculture serves more than four million seniors.[691] High out-of-pocket costs for medications cause older Americans either forgoing treatment or skipping dose[692] resulting in poor management of health conditions. More seriously, it can lead to loss of life. Wall Street Journal reported a case of a cancer patient who was prescribed a new promising leukemia drug that had moderate side effects.[693] She learned that she would need to pay nearly $8,000 (after Medicare coverage) for a one-year treatment. She decided to forgo the medication to avoid the financial burden. However, when her income declined, she qualified for aid that paid for her prescription. Blood work showed that her condition improved after taking the medication. The outcome could have been

different if she did not take the medication. Another serious problem is mortgage delinquency. It is found that the delinquent loan increased from 1.1 percent in 2007 to 6 percent in 2011.[694] In December 2011, it was noted 3.5 million home loans among people age 50 and over was seriously delinquent. These three areas have direct effect on living. In consideration of the elderly, one thing to remember; they made contribution to our society during their working years. For this reason, their needs should not be neglected.

The ethical criteria, advocate by CHA, are developed from the context of Catholic social values that are according to the Catholic faith that affirms every human is made in the image of God. The Catholic social justice teaching promotes the act of caring for human needs in accordance with the concept of human rights. The following four themes clearly reflect the value of the Catholic social belief:[695] 1) The common good is achieved when communities of mutual concern and responsibility work on behalf of all, 2) Human dignity involves life, bodily integrity, and the means for the proper development of life, 3) The common good and the protection of human dignity require a "preferential option for the poor," and 4) responsible stewardship requires the prudent and careful use of resources necessary to sustain life. Relating the second theme, Pope John XXIII, in his encyclical, included medical care as one of the necessities for the proper development of life.[696] He clearly equates medical care with food as the element that sustains life. Based on this, the Catholic Church believes the government has the responsibility to provide healthcare to people for the good of society and for solidarity. It further believes the government is obligated to ensure healthcare benefits, in particular, for the poor, elderly, and disabled for the preservation of human dignity.

Section Three. Justice

The principle of justice calls for equal treatment based on fair, equitable, and appropriate distribution of social goods that is owed to the persons. The current medical ethics justifies healthcare as a kind of social good,[697] and moral justification also demands distribution of medical services for the reason of well-being.[698] Both perspectives strongly support the provision of health services to all people based on justice.

a. Theories of Justice

i. Distribution of Healthcare as Social Goods

Many theories of justice are based on the principles of equal share and need. Those who concern with healthcare often use need base for their arguments. For example, unemployment subsidies, welfare assistance, and many public healthcare programs are distributed on a need base. The approach of distributive justice on the basis of need presumes the obligation of providing basic needs to sustain living, and healthcare is part of the basic needs.[699] Without healthcare, the duration of living can be shortened. That leads to the recommendation of providing decent minimum healthcare services.[700] In addition, the argument for equal share is also used in healthcare setting involving equal access of medical research benefits. Most people in the United States agree that there should be available access to health services for all Americans.[701] Both material principles aim at the provision of healthcare to every member in society.[702]

Various theories of justice have attempted to explain justifiable distribution of

social benefits and burdens. Quality egalitarian theory of justice views healthcare as part of social goods that should be distributed equally with the acceptance of inequalities so long as they benefit the disadvantage in society.[703] Although egalitarians do not believe equal sharing of all possible social benefits, they consider healthcare as basic goods that should be equally distributed.[704] The well-known Theory of Justice claims that 1) each person should be permitted with maximum basic liberty and 2) inequalities in income, rights, and opportunities are only allowed if they benefit everyone based on fair equality of opportunity. These are the basic principles of justice.[705] Although the focus of Theory of Justice is not on healthcare, other theorists have extended these principles to apply in health policies.

1. Utilitarianism

John Stuart Mill explains justice from the perspective of a natural sentiment in human beings. He believes that all human beings possess the desire for happiness,[706] self-interest, security, and earthly benefits, and based upon these sentiments come the moral necessity.[707] He defines happiness as pleasure and free from pain[708] and agrees that happiness is the goal of human life. For this reason, the natural feeling of each person is to have happiness; it, then, is natural to resent any action that is harmful and disagreeable.[709] This specific feeling compels people to uphold their moral standard when interacting with others in society, which ultimately will lead to the general good. Hence, the idea of happiness is used to support the explanation of justice.

Based on happiness is the goal of life, the rightness of every action is determined

by whether it contributes to happiness; in other words, the "right" is dependent on the "good".[710] This is the starting point of Mill's utilitarianism. It suggests the conclusion of the "right" will be based on whether the action produces happiness. This is also supported by Jeremy Bentham who asserts that happiness is the one and only good.[711] Every human being is led to pursue choices that lead to happiness. Similarly, Mill believes that humans have natural tendencies of action that derive from the principle of utility. However, the action is only considered right if it is abided by the rules. Mill asserts that rules are set up on the bases of their utility for the purpose of assessing human actions. Thus, an action is judged to be right when it abides by the rules rather than judging it by the consequence of it. Because he does not specifically define the detail of the rules; it leads to the speculation of it might be the general rules. To enhance his assertion on right and wrong or justice and injustice, Mill provides six common circumstances to extricate his idea.

According to Mill, to explain the meaning of justice is to point out the injustice.[712] He lists six common situations most people agree to be unjust.[713] Firstly, to take away anything that belongs to a person is considered unjust.[714] It clearly presents the notion that it is unjust to violate one's right to keep what is lawfully his. It, then, is just not to deprive anyone of his belongings. Secondly, it is unjust to deprive anyone of things to which he has a moral right to possess. Coming from the perspective of infringing somebody's right, not in the legal sense in this case, Mill concludes that it is injustice to withhold things to which someone has a moral right to possess. Thirdly, it is unjust for someone to receive good or evil that he does not deserve. Specifically, a person is to deserve good from the one to whom he does good deed. Based on this, returning good for

evil is never deemed as justice. Fourthly, it is unjust to break engagement or disappoint expectations, particularly, when these promises are initiated by voluntary intention. Fifthly, it is unjust to be partial that is to show favoritism to one over the other. This is particularly concerned with given favor and preference when they do not apply. Acting partially violates the obligation of giving everyone his right. Sixthly, in connection with the idea of impartiality is the idea of equality. Mill asserts that equality is a component to the concept of justice. It seems right to think that justice demands giving equality for the sake of everyone's benefit. The morally acceptable actions, in these circumstances, are to produce happiness to the recipients. From the perspective of giving benefit to others that satisfies justice, these ideas of justice support the use of a healthcare system that provides services to all members of society instead of only individuals who can afford it.

2. A Theory of Justice

John Rawls approaches justice from a different perspective. He offers an alternative theory on justice with the consideration of individual rights, particularly with the focus to avoid risking personal well-being for the sake of others' benefits as suggested in utilitarianism.[715] He constructs "justice as fairness" with solid method to explain how to distribute goods fairly and justly.

The basic approach of Rawls's theory of justice is to construct principles for justice that entails fair choices. The central idea is to allow people in society to choose principles to form the basic structure of society. These principles are to be fair to all and agree by all, and no one choice should dominate the others resulting in the loss of

freedom for one and gain greater good for another. Hence, the principle of fairness promotes a result of fair choices among people in society.

Rawls asserts that people who choose the "original position" have done so with a "veil of ignorance." By veil of ignorance, Rawls means that members who make choices for the original principles do not know their positions in society and their particular life goals.[716] Lacking this kind of knowledge make them easily follow the tendency of choosing principles that favor themselves. However, what they do know is that society is characterized by conflicts and cooperation, which is termed "circumstances of justice".[717] The condition of cooperation is certainly beneficial to society as a whole.[718] Often, circumstances of justice occur in situations where supplies are scarce and conflict of unfair distribution. Also, they must have known of some level of economic theory, social organization, and human psychology to predict compliance to selected principles. In both situations, they show no concern for each other's interests, what they want is the basic goods to support their own life without the envy of greater gain for others.[719] It is under this type of attitude that a "contract" is initiated. By contract, Rawls means that an appropriate division of goods must be agreed by all.

Their approach is to set up principles that can handle the distribution of rights and duties, and can also address the benefits and burden of societal cooperation. The idea is to set up a social structure reflecting the justice that the public agrees and will adhere to. In other words, social fairness based its theory on supporting personal interests and to use the benefits to fulfill life plans.

ii. Two Positions on Justice

Justice basing on utility claims the action is right only when it can maximize the good; that is to produce the greater happiness possible. The thought is that as long as the "greater good" requires it, the claims of all personal rights can be overlooked.[720] Mill proceeds to explain that justice is grounded on utility, not just a feeling, and justice is useful to society. He supports the rules of justice in circumstances in which the need to promote happiness and security in society is present. In other words, the rules of justice exist to preserve order in society, which is correlative to the idea of utility. This is particularly concerned with the dispute over possession that leads to the issues of distributive justice. In this sense, Mill agrees that justice arises from the necessity to settle societal disputes, thus, it calls for a higher moral obligation than any others.[721]

According to Rawls, people in the original position, that is the ignorance of each other's society and social status, would prefer principles that protect their own interests rather than solely looking out for the interests of the greater good. They consider the social and economic inequalities are just only if they result in benefiting everyone, in particular for the least advantaged, which is termed "difference principle".[722] Much consideration for the "least advantaged" is apparent in Rawls' writing. He writes about the strategy of "maximin" in that the members in the original position would choose policies that maximize the minimum.[723] Hence, Rawls would allow inequality so long as the least advantaged can be benefited. This perspective can apply to the approach of ACA.

1. Justice as Utility

The central idea of utilitarianism is concerned with doing what produces the greatest good to the greatest number of people. Mill defines "Utility" as the right actions when they promote happiness and wrong when they promote the opposite effect.[724] The two basic assumptions of this perspective are to encourage actions that produce the greatest good to society and the actions are determined to be right or wrong depending on the end result; that is whether they promote happiness.[725] This concept links the idea of utility to justice.

The previous mentioned six common circumstances listed by Mill indicate the application of morality and duty. For duty, Mill sets the distinction between duties of perfect obligation and duties of imperfect obligation. Duties of perfect obligation refer to doing right to others, and that the recipient has a right to receive the good. On the other hand, imperfect obligation speaks to the condition in which the duty of doing good to others stands, but the recipient does not have the right for one to do good to him.[726] According to Mill, the rights based on the duties of perfect obligation are within the concept of justice. It suggests that justice allows the individuals to claim their rights from others as their moral rights. The notion of rights or claim is the significant distinction of justice.

Another aspect of the sentiment of justice is identified as the natural human desire to repel hurt, both to self and others.[727] The feeling of the animal desire to repel hurt is not in the consideration of moral feelings, but the desire to impose punishment on those who violate the rules of justice is. The desire to punish stems from the interest to protect

security, which is also in the same way as the protection of rights. In this sense, the rules of justice are supported by utility; therefore, justice is grounded in utility.

2. Justice as Fairness

Rawls's concept of justice centers on the idea of letting people to decide prior to setting up policies on how they will settle claims and distribute social benefits.[728] This is a contradiction to the condition that men are born into a social system and, therefore, must comply with the rules and principles that are in place. However, complying with the existing principles threatens the security of equal liberty and, at the same time, the risk for unequal division. Rawls only supports the position in which people in the original principles do not have to give up their rights and liberties for the sake of other people's social benefits.[729]

In justice as fairness, the essential features are that people in the society do not know their place in society and social status. Furthermore, no one in society knows each other's fortune and abilities. The state of ignorance ensures all people have equal rights and equal liberties during the choosing of the principles, and no one will be advantaged or disadvantaged from the selected principles for the social system. Because everyone has the same status, the choice of principles will not favor anyone in particular. Rawls believes this is the only way to set up principles of justice that are fair to everyone.[730]

According to Rawls, people in the original position would prefer principles that protect their own interests rather than looking out for the interests of the greater good. They consider the social and economic inequalities are just only if they result in

benefiting everyone, in particular for the least advantaged, which is termed "difference principle".[731] Much consideration for the "least advantaged" is apparent in Rawls' writing. He writes about the strategy of "maximin" in that the members in the original position would choose policies that maximize the minimum.[732] Hence, Rawls would allow inequality so long as the least advantaged can be benefited.

Lebacqz's explains it in this way, for example, a factory employs five workers, and each earns $10,000/year. One of the fives workers has a heavier responsibility which leads to lower production. But when his pay is increased to $13,000/year, his production also increases resulting in $7000 surplus. The surplus is then divided among the other four workers raising their salaries to 11,750/year. Although salary amount varies among the five workers, all of them are better off. [733] Important note, Rawls stresses that the inequalities of position and power do not belong to certain individuals but open to all persons in society so as to promote fair equality of opportunity. These concepts are fundamental to the security of liberty and fair management of inequalities.

b. Needs and Fairness

i. The Principle of Need

One principle of justice specifies the characteristics for equal treatment from the perspective of need base. Material principle of justice demands that social resources including health care to be distributed according to needs. This is speaking of the obligation to provide health services on the basis of need rather than the ability to pay.[734] Based on the principle of need, a person will be harmed without what he needs. This is

presumably referring to the fundamental needs such as food, shelter, and important information for making critical decisions. Not meeting these needs can have detrimental effect. For this reason, all public and institutions use principles of justice to specify, refine, or balance policies.[735] Some of the proposed principles are accepted and have been used for material of distribution justice. They are 1) to each person an equal share, 2) to each person according to need, 3) to each person according to effort, 4) to each person according to contribution, 5) to each person according to merit, 6) to each person according to free-market exchanges.[736] Examining these principles from the perspective of health care, they indicate the obligation to distribute health services to those who need them.

1. Utilization for Need-Based

The approach of equity as utilization for need is based on the theory of Andersen and Aday.[737] It is a focus on utilization per need, which means that different measures of need will give different utilization per need rates. The normative use of this approach gives rise to the understanding beyond the description of the causal relationships among the phenomena involved in access to health care. The importance of the potential access variable redefines the definition of equity of access. Andersen and Aday argue that the greatest equity of access exists when need or individual factors determine who receives access to health care. It refers to that access is considered equitable if the potential access variables are related to health status in the proper way. It also means that inequity in health service distribution occurs when individuals receive their health services according

to their social status or the policy of the health system instead of need. The proper utilization of health services should be based on physical symptoms and disability.[738] Young people might have lower utilization rate due to good health while a large number of elderly people experience illness and disability resulting in higher utilization rate. In these situations, health inequity might be apparent. However, the idea is to provide health service to those who have health need.[739] It makes sense that, in general, individuals with good health will have decreased need and the older population has greater need. It should be noted that all human beings will have need for health services at different stages of their lives, the idea of utilization for need to guarantee healthcare when illness occurs.

The approach of equity as utilization for need is further supported by the argument from function. As stated earlier, the determinant of equitable distribution of health care services must be based on illness. This stems from the widely accepted belief that the main function of healthcare services is to prevent and treat illness, which satisfies the concept of meeting healthcare needs. However, the distribution of healthcare services that are not based on healthcare needs is deemed inequitable. For example, if two people are sick, one gains access to healthcare services while the other is denied of treatment, the inequitable distribution is clearly indicated because it fails to uphold the function of healthcare, that is to prevent and treat illness.

2. Utilize Healthcare without Barriers

Equity as equality in process oriented approach points out the equity of healthcare when it is more difficult for certain groups of people to get care than others.[740] When the

process of acquiring health services is burdensome to some and not others, it is said to be healthcare inequity. The definition of equity also applies to the condition even if people make adjustment to the process to get the level of care they need. The process approach advocates the decisions to utilize healthcare that are not difficult for some and are made easy for others. The equal respect for persons requires treating everyone fairly. In the case of the provision of healthcare services, this principle is applied in the form of equal distribution of reasonable set of healthcare amenities.[741] In particular, equal healthcare access without difficult process is important to the vulnerable people in need of healthcare for the consideration of their self-esteem. They may feel affronted by the inequity of health services, to which it demands the society to pay special attention.[742]

The market approach claims that healthcare services are commodities like any other goods in society. When viewing as commodities, health services can be accommodated by marketing them to respond to people's preferences.[743] The goal is to provide equity of access to all members in society. On this view, three conditions must be met to satisfy the definition of equity of access: 1) the marketing items must have true social cost, 2) those who use the system must be capable of making rational decisions, and 3) income distribution among people must be equitable. A look at the opposite of these conditions helps to better understand the proposed definition of equity of access. By the definition of the market approach, equitable access to healthcare is without information barriers, financial barriers, or barriers to prevent decent basic healthcare services. This approach advocates for basic access to healthcare services that satisfies the demand of justice. It guarantees the purchase of minimum plan that provides minimum

healthcare services, fair health procedures, and the inclusion of the simple listing of services. This idea is implicitly accepted based on the important moral claims that apply to the concept of welfare.

ii. Justice as Fairness in Healthcare

Daniels writes the moral importance of health drawing on the insight of Rawls' theory of justice as fairness. The theory of justice as fairness emphasizes the importance of protecting opportunity so that each person will have a fair share of the normal opportunity range.[744] Daniels advocates for a just healthcare system using the principle of "fair equality of opportunity."[745] In his argument, just healthcare with considered arrangement of healthcare distribution allows each member in society to have a fair share of opportunities to pursue life goals. It also means to eliminate barriers that prevent fair equality of opportunity and correct disadvantages. One significant barrier to pursue life goals is illness and societal disadvantages; both put restriction on one's opportunity to life goals. In this sense, equal access to healthcare is critical to sustain health leading to the result of the awareness of opportunities. It then becomes clear that healthcare is needed to achieve, maintain, and restore functioning by preventing disease, illness, or injury as well as providing treatments. For example, a patient who has emphysema and cannot work full time due to tiredness from decreased oxygen level. The government is obligated to provide treatment so as to resume the patient's level of opportunity. Going further, the government might consider that getting smokers to quit smoking before they have emphysema is the best way to maintain functioning; that leads to preventive health campaigns that provide information about the risks of cigarette smoking.[746] In this sense,

justice is ensured through distributing healthcare resources, which in turn secure fair equality of opportunity.[747]

1. A Special Moral Obligation to Provide Healthcare

As seen in today's societies, social goods such as education, housing, opportunity, and income are unequally distributed; the effect of social inequality links to health inequality. Norman Daniels suggests that the policies on distributing these social goods should change to aim at limiting inequality so as to mitigate the effect on population health.[748] It has been in question whether meeting health needs can be justified by using theory of justice and whether members of society have the obligation to provide healthcare and its distribution within a population. Although most people have tolerated the inequality of wealth in a society, they tend to advocate healthcare provision for the sick who cannot afford it. In the United States, the idea of universal healthcare is not popular among people but the policies for Medicare and Medicaid are welcomed by most. It indicates a level of moral conviction of distributing health measures to those who cannot afford them. In doing so, not only does it narrow the gap of healthcare inequality in society but also expand social justice as well. Some European countries in favor of universal healthcare, so much so that they prohibit private supplemental health insurance plans for the purpose of closing the gap between best-off and the worst-off. These actions reflect healthcare is important to human existence, and the moral response is to provide healthcare needs to sustain human life. The importance of health is further strengthened by governmental efforts to protect employees from health hazard at work. It was a significant stand on the message of the importance of health when the U. S. Supreme

Court sided with Congress against employers to protect the health of workers stating it was "technologically feasible."[749] On the same level, the judgment reflected health has moral importance that worth monetary investment to develop new technologies to obtain it. It further sustains the implication of the secondary value that comes with health.

The significant value of health is the normal functioning that all humans desire. The ability to function without impairment enables one to pursue life goals leading to happiness. Conversely, illness or disability threatens the hope of life plans and satisfaction and limits the exercise of one's capability resulting in an unfair share. Because the pursuit of reaching life goals is fundamentally important, the meeting of health needs also become fundamentally important.[750] Daniels uses Rawls' theory of justice as fairness to address fair equality of opportunity so that each person will have a fair share of the normal opportunity range. Understanding that opportunity can be affected by underdeveloped talents and skills, he points to the improved use of the socially controllable factors of educational or job-training programs. The idea is not necessarily to level individual differences, rather, the suggestion is to remove the interference of social disadvantages so that individuals can have the fair opportunity range. In other words, the exercise of social justice can protect people's fair share of the normal opportunity range.

2. Meeting Health Needs Fairly

Daniels acknowledges that health is not the only good that affect opportunity. The opportunity-promoting factors such as law and order, education, job creation, and job training also can affect opportunity and should be included in resource allocation

decision.[751] He proposes the "accountability for reasonableness" as a form of public accountability for important limit-setting decisions. It includes the following four conditions: publicity condition, relevance condition, revision and appeals condition, and regulative condition.[752] The idea suggests that "fair-minded" people seek to cooperate with others on terms and rules they can justify to each other. Relating the terms and rules to healthcare allocation, they are opened to seeking acceptable rules that minimize the disagreement. Accountability for reasonableness requires the insurer to develop health plan with limited resources but still provide high quality care. This is a health plan that centers on patient care and requires insurers to revise and improve decisions over time based on outcome.[753]

The public condition requires health plan companies to commit to transparency by offering clear rationale on coverage decisions, particularly in cases of denial. And that the limitation needs to be reasonable and based on the welfare of the patients. The relevance condition focuses on decisions that meet the health needs under resource constraints. It imposes two constraints on decision for reasonableness of limited resources- when a coverage decision disadvantages one group more than the other with both groups experience similar symptoms and when a decision disadvantages someone more than anyone need to be disadvantaged. The revision and appeals condition enable people to understand under what reason is the decision made and allow people to raise argument or make appeal leading to reconsideration of original decision resulting in fair outcome of allocating limited resources. Lastly, the regulative condition requires a form of public regulation to assess the function of the first three conditions and to ensure their utility.[754]

Section Four. Entitlement Programs in the ACA

This section focuses on health care justice for the elderly and the poor. The discussion involves the justification for Medicare and Medicaid benefits.

a. Medicare

The following discussion is concerned with health services for the old population in the United States. This is the group tends to have more health issues and lower financial means which poses a greater demand for access to healthcare.

i. Opportunity for Every Stage of Life

Distributive justice requires equal opportunity for each person. It then is agreeable to distribute healthcare fairly in society to meet the needs of the young and the old. Daniels asserts that fair share of healthcare distribution should be done from behind the veil of ignorance that keeps the age unknown to ensure the older population receive adequate health services.[755] The importance of healthcare is the enabling of normal functioning, which in turn allows one to have fair share of opportunity. Daniels recognizes opportunity at each stage of life, thus protecting health will ensure ongoing enjoyment of opportunity.[756] On the contrary, decreased health level, a result of lacking healthcare, impairs normal functioning that can affect every stage of life including the later stage. In that sense, the elderly should be guaranteed adequate healthcare to protecting their functioning and opportunity. Furthermore, the traditional values of recognizing their past contributions and efforts made in society must be considered.[757] Jonsen also points out the peremptory approach to respect people equally.[758] Moreover,

understanding that each person passes through the same stages of life, thus, all persons should be treated the same.[759] This perspective is to apply to healthcare distribution.

1. Fair Equality of Opportunity for Aged Population

Fair equality of opportunity to health access is based on the reason of keeping people as close as possible to normal functioning; that should include the older population. Further reasoning can be derived from Rawls's theory of justice in which the concept of fairness manifested in a social contract that is meant for free and equal people in society. Not only does it justify basic liberties but also the principles that limit inequalities as well. When applying this theory to actual healthcare, the reason for maintaining normal functioning is a significant ground for argument because it protects the range of opportunities to individuals throughout their lifespan.[760] The principle of guaranteeing fair equality of opportunity should be the base of governing the distribution of healthcare that must include primary and secondary preventive health.[761] Because it aims at the promotion of normal functioning for all, it then provides the rationale for accommodation to disabilities resulting in improving population health and reduction of health inequalities. Seemingly, the relationship between healthcare provision and fair opportunity in society is tightly connected as such that lack of healthcare impairs normal functioning reducing range of opportunity open to individuals to pursue life goal. This is particularly unfair and unjust given that all people possess talents and skills at every stage of life. The deprivation of pursuing life goal is detrimental to health leading to possible early death.[762] If healthcare access leads to fair equality of opportunity, then it can be said

that healthcare inequality stifles individual potential and obstructs the maintenance of normal functioning.

2. Life for the Older Adults

Since the study on aging began in the late 1990s, the results have provided significant understanding on life for the older adults. In terms of function, although there is a variability that ranges from functional and independent to feeble and dependent, one common condition seen among the elderly is physical limitation.[763] A considerable number of older adults have difficulty with mobility such as walking. According to data,[764] people age 65 and over face decreased physical functioning such as lifting heavy objects, overhead reaching, and walking two to three blocks. It also states in the same report; in 2007, 42 percent of individuals age 65 and over had functional limitation, 14 percent had difficulty performing instrumental activities of daily living, and 25 percent had difficulty with activities of daily living. Another characteristic of aging is chronic health diseases that decrease functional abilities.[765] The prevalence of older adults with multiple chronic diseases is higher as compared to the statistic that shows one in four Americans in the general public.[766] It is estimated 80% of people age 65 and older have at least one chronic condition such as pain, heart disease, diabetes, or arthritis.[767] It is also noted two-third of Medicare expenditures are responsible for beneficiaries with five or more chronic conditions[768] Other types of physical difficulties include decreased hearing, vision, and cognition that require assistance with daily personal needs.[769] In all, the physical condition of the older adults gets weaker as they age. It should be that the provision for care must increase in response to the need.

ii. Medicare for the Elderly

For the elderly groups who are eligible for Medicare, part of the improvement in the Medicare program is the establishment of the Center for Medicare and Medicaid Innovation (CMI) to conduct research by clinical and analytical experts with expertise in medicine and healthcare management for better services for Medicare as well as Medicaid. The purpose of the CMI is to test innovative payment and service delivery models in attempt to control cost while preserving the delivery of quality of care.[770] The idea of improving Medicare also leads to using bonus payments in assessing Medicare Advantage insurer's level of care coordination and care management.[771] Furthermore, improvement in Medicare prescription drug including 50% coverage gap discount for brand-name medications to Part D enrollees. The initial coverage limit in the standard Part D benefit will be expanded by $500 for 2010.[772] These new arrangements intend to deliver quality care to the elderly population through public health programs with reduced out-of-pocket cost. The efforts satisfy justice demand for distributing healthcare resources to those who cannot financially afford it.

1. Successful Aging

The baby-boomer generation is growing and aging. Data available in 2014 shows population of persons 65 years or older represented in one in every seven Americans.[773] It was also noted 3.4 million people reached 65th birthday in 2014 representing an increase of 1.5 million people of the age 65 and over between the years 2013 and 2014.[774] Riley and Riley made an observation stating the combination of economic gains, medical discoveries and improvements in public health in the 20th century led to the increase of

longevity.[775] However, governmental policies have lagged behind on keeping up with the needs of the older people. With the growing population of elderly people at hand, a greater healthcare provision is needed to ensure quality care so as to maintain their functioning. In studying aging population, Rowe and Kahn emphasize the definition for successful aging should include function (maintain mental and physical function), health status (minimizing the risk of disease and disability), and social inclusion (maintain an active engagement of life).[776] The emphasis is to allow older adults to continue to engage in life by involving in activities that are meaningful to them. For this reason, necessary health provision is needed for the purpose of enabling them to maintain vitality in old age. Rowe and Kahn also assert that society has the responsibility to help the elderly people to continue to be productive. Then, healthcare provision is understood to play an essential role in their ability to sustain functionality. The consideration should include necessities of daily care, medications, nutritious meals, transportation to healthcare appointments, and home safety. Appropriately, ACA includes the policies for prevention of chronic disease and promotion of wellness. This is intended to be accomplished by cross-agency collaborations and the promotion of health for older population.[777]

2. Medical Necessities Required

Following the understanding of older adults who suffer higher risk for chronic conditions, it should also be acknowledged that older adults face the decline in biological reserve resulting in slower rebound from physical illness. Furthermore, physical frailty poses the risk for falls, hospitalization, and mortality. These older individuals are also likely to suffer pneumonia and dehydration.[778] They are expected to have higher

frequency of primary care visits, hospital care, home health services, and nursing home services.[779] The physical condition of older adults requires short term and long term care services. Short term care is used for acute illnesses and injuries, and long term care services are mainly for supporting functional needs including community-based services, skilled nursing facilities, adult day care, home health services, wellness programs, referrals, durable medical equipment, transportation, and meal programs.[780] Quality of life improves with the use of these services. However, long term care can be costly for some individuals if they do not qualify for public funds.[781] According to Congressional Budget Office (CBO), approximately $120 billion was spent on long-term care in 2000 with 59% covered by public funds.[782] Hence, supplying financial resources is critical to providing care for older adults. The goal should involve in allocating funds for improving care delivery and expanding health services in multiple care disciplines. Maintenance care must include consideration of necessities of daily care, medications, nutritious meals, transportation to healthcare appointments, and home safety. It should also include an emphasis on health promotion, exercise, and chronic disease management can potentially decrease health complication. ACA policies aim at supporting these promotions.

b. Medicaid

This section discusses the health needs for the poor and disabled population.

i. Equal Resources for the Disadvantaged Population

Justice demands intervention to remedy disadvantage condition and prevent nocuous consequences.[783] The groups of the poor and disabled are entitled to equal respect considering they are full moral agents. The stigma attached to the poor and disabled is said to have negative effect on their well-being,[784] and it is unlikely these individuals are able to improve their health through their own efforts. Unfortunately, the long-term disadvantage without health resources places these individuals at risk for shorter life expectancy.[785] Such detrimental consequence also affects the young as seen in infants and children in low-income families.[786] Their chances of opportunity to pursue life goal is severely reduced. Ronald Dworkin asserts that justice demands redistribution of resources to compensate their disadvantage so as to restore opportunity.[787] The benefit of healthcare is its potential to maintain or restore human functioning enabling individuals to compete for social positions.[788] These conditions are significant to living. Hence, equal healthcare resources are justified.

1. Factors Contribute to Differences in Healthcare Coverage

It is documented individuals with lower socioeconomic status receive fewer health screenings, suffer greater risks for disease morbidity, face higher mortality rates, and have lower life expectancy.[789] People with lower socioeconomic status often have low occupational prestige,[790] lower education level,[791] or unemployed[792] leading to living in poverty.[793] Another noted factor is lacking transportation or not owning a vehicle posing a challenge to get to health services.[794] In short, social position including prestige, power, money, education, social support, and social network has major influence in

differences in healthcare coverage.[795] The opposite is true in that greater finances allow access to material and non-material resources that promote health status. For example, one study was conducted to examine the prevalence of cervical cancer screening and mammogram.[796] It concluded 80 percent of women with college education were screened for cervical cancer as compared to 50 percent of women with high school education underwent the same screening. The same study also found 75 percent of women with family income of $50,000 or greater had mammogram as compared to less than 50 percent of women with family income equal to $20,000 or less. For those individuals who do not have the financial means to gain access to health services, their ability to maintain in a healthy state is compromised. For society, the concern for health should be equal among all people regardless of socioeconomic.

2. Minority Populations Receive Poorer Quality of Healthcare

Healthcare quality among minority groups have been studied, and data shows minority populations suffer disproportionately from diabetes, asthma, cancer, and cardiac diseases.[797] Diabetic complications (end-stage renal disease and amputation of lower limbs) are more common among African Americans, and Hispanics have 60 percent higher mortality rate from diabetes than that of non-Hispanic whites, African American children have a 60 percent higher rate of asthma than white children, African Americans are 33 percent greater to die from cancer than whites; and in 2005, African American men were 30 percent more likely to die from heart disease than non-Hispanic white males.[798] Also, Mexican Americans have higher rate of obesity which is a risk factor for heart disease. According to research results, African Americans and Latino, on average,

are less healthy, receive poorer quality of healthcare, and more likely to have no health insurance.[799] People received Medicaid are likely to experience poorer quality of healthcare as seen in fewer health screenings, poorer disease management, less frequent routine follow-up.[800] The outcome of poor care can be detrimental. A study conducted by Joint Center for Political and Economic Studies shows that the cost related to health inequalities and premature death in the United States was $1.24 trillion between 2003 and 2006.[801] Hence, the advocacy for equitable access to medical care is essential to promoting health among these groups.[802]

ii. Medicaid for the Low Income

Justice for health is seen through the ACA expansion of eligibility for persons with lower income. It expands the eligibility for Medicaid to all children, parents, and childless adults who are not entitled to Medicare. The qualifying criterion requires individuals with family incomes at or below 133 percent federal poverty line. To strengthen the program, the cost of covering newly eligible enrollees will be funded with federal medical assistance percentage for two years during the period between years 2014 and 2016.[803] ACA also provides enhanced federal support in simplifying Medicaid and CHIP enrollment, improving Medicaid quality for patients and providers, and providing new options for long-term services and supports. The role of public programs also includes enhancing federal support for the Children's Health Insurance Program by receiving a 23-percentage point, not to exceed 100 percent, increase in the CHIP federal match rate between years 2014 and 2019.[804] These are the provisions for those who do

not qualify for Medicare. Intentionally, ACA makes plans to improve the quality and delivery of care for Medicaid and Medicare participants.

1. Impacted by Uninsurance

Uninsured individuals have less access to recommended health services (such as preventive care) and often suffer worse health outcomes.[805] They are reported to have poor general health status and poor physical functioning.[806] For example, in cases of hypertension and diabetes, their blood pressure and blood sugar are poorly controlled. Their conditions are not regularly monitored and evaluated by physicians. Without health insurance, they are likely to delay seeking medical help due to unaffordability turning a minor health problem into a serious medical condition resulting in increased health cost.[807] They are likely to seek medical treatment in emergency department.[808] Under the Emergency Medical Treatment and Active Labor Act (EMTALA), emergency department cannot turn away people who seek medical help.[809] In 2006, emergency room visits made by uninsured individuals amount to 48 per 100 persons.[810] Looking at the example of homeless people, they utilize the emergency department for acute conditions or medical problems.[811] It is documented that emergency department frequently has high volume of homeless people seeking medical help.[812] CDC data reports 635,000 emergency room visits made by homeless individuals in 2006.[813] They often require longer visit time and likely need transportation resulting in higher total cost for treatment.[814] One of the reasons for homeless adults to have no insurance is the failure to meet eligibility for Medicaid. The federal government requires states to provide Medicaid benefits to the following groups of adults: 1) pregnant women whose incomes are at or

below 133% of the federal poverty level (FPL); 2) low-income Medicare beneficiary; 3) individuals who are disabled and are eligible for Supplemental Security Income (SSI).[815] According to these guidelines, non-disabled single men with no children are unlikely to qualify for benefit. Homeless adults are likely to have mental health conditions, substance abuse, and sexual transmitted diseases. These conditions are not qualified for disability coverage. However, their health conditions are serious and should not be overlooked. This is the same with all other uninsured adults. Their health status should matter as the impact affects the society.

2. Expanding Medicaid

The Supreme Court ruling in 2012 stating that states are no longer mandated to expand their Medicaid benefits, and a number of states plan on opting out of the expansion that is part of the ACA. The main concern for the states is affordability. Zur et al. conducted a study evaluating the net cost of healthcare when combining state and federal expenses.[816] The study analyzed whether states can afford Medicaid expansion to cover homeless adults with substance use disorder, and the conclusion of the study shows that Medicaid expansion would be cost saving to states. Over the course of 7 years, states could see savings potentially be $7,824 to $10,295 per person depending on enrollment. The results were based on the decrease in uncompensated care costs and the federal fund to cover additional Medicaid expenditures related to higher federal medical assistance percentages (FMAP). According to Hadley and colleagues, each uninsured person incurs approximately $1,103 in uncompensated care cost (responsible by states) per year.[817] The expansion will decrease uncompensated cost resulting in saving to states. Although it is

expected expanding Medicaid will incur higher expenditures, the decrease in uncompensated care costs will offset the additional costs. According to Zur et al., there is an estimated additional healthcare spending of $1,388 to $1,827 on Medicaid expansion. Although there is additional cost, it is important to consider the health benefits as a result of implementing Medicaid expansion. One study evaluated the impact of similar Medicaid expansion programs that offered in some states since 2000.[818] The study noted the difference in residents when comparing states that implemented expansion and those that did not. It found residents in states with expansion experienced decrease in mortality, reduction in delay in seeking care, and improvement in health status. These outcomes show the ultimate desirable result of healthcare provision. Hence, it is justified for additional spending.

Summary

The health of the population is essential to the success and ongoing progress of society. Respecting personal autonomy for choosing healthcare is vital to quality of living. The reason is that healthcare coverage ensures the possibility of better health leading to desired functioning, and desired functioning allows one to pursue life goals, flourish, and exercise capability to reach potentials. To successfully reach population health will need to use a government-funded health system. Some believe the government has a duty to provide measures that allow people to be healthy for the purpose of greater productivity. This is an approach that raises four ethical questions. The first ethical question is concerned with the responsibility of the government, the individuals, and the organizations on public health, and how each part can be affected by the health policy.

The second ethical question is whether government's intervention is warranted when an individual's actions affect others. John Stuart Mill asserts that it is sufficient to justify a public health policy based on his Harm Principle. The third ethical issue is concerned with the extent to which it is acceptable for the government's policy to influence the health of the population. The concern is that the government oversteps its role in public health services and violates the autonomy of the individual. The fourth ethical issue is related to what level of intervention from the government that might improve population health. Using public health services actually allows individuals to be in control of desired action that satisfies freedom of autonomy, increases effective freedom, and prevents harm to others. The World Health Organization states that the achievement of individual health cannot be separated from the collective population health. Reaching population health can only be accomplished through government-run system because not everyone can afford programs from privatized insurance companies. It is particularly challenging for the vulnerable populations such as the poor, disabled, minority groups, and older adults to obtain health insurance independently. Often, their need for health services is greater than that of other population groups. The principle of justice calls for equal treatment based on fair, equitable, and appropriate distribution of social goods that is owed to the persons. Current medical ethics justifies healthcare as a kind of social good, and moral justification demands distribution of medical services for the reason of well-being and the pursuit of goals leading to life happiness. Hence, there is a moral obligation to provide health services on the basis of needs regardless of the ability to pay.

References

612 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, Foreward p. v. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

613 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, Executive Summary, p. xv-xvii. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

614 The Constitution of the World Health Organization. "Basic Documents," (45th edition, Supplement, October 2006). http://www.who.int/governance/eb/who_constitution_en.pdf. [accessed 10/31/2016].

615 The Faculty of Public Health. "What is Public Health," http://www.fph.org.uk/uploads/about_us_leaflet_2007.pdf. [accessed on 10/31/2016].

616 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, pp. 7-8. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

617 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, p. 8. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

618Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 38.

619 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, p. 15. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

620 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 38.

621 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 39.

622 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, p. 15. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

623 A. Swift. *Political Philosophy: A Beginners' Guide for Students and Politicians.* Cambridge, MA: Polity, 2001, pp.59-64.

624 R. J. Norman. "Autonomy in Applied Ethics," In *The Oxford Companion to Philosophy* edited by T. Honderich. Oxford: Oxford University Press, 2005. p. 72.

625 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p.51.

626 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 46.

627 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 46-48.

628 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 52.

629 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 47-48.

630 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 52.

631 John Stuart Mill. "On Liberty," In *On Liberty and Other Essays* edited by Collini, S. Cambridge: Cambridge University Press, 1989, p. 13

632 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, p. 15. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

633 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, p. 55.

634 Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, p. 15. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

[635] Nuffield Council on Bioethics. "Public Health: Ethical Issues," London, 2007, p. 15. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

[636] Brian W. Ward, Jeannine S. Schiller, Richard A. Goodman. "Multiple Chronic Conditions among US Adults: A 2012 Update," *Prev Chronic Dis* 11 [2014]: 130389. http://dx.doi.org/10.5888/pcd11.130389. [accessed May 23, 2015].

[637] Mark D. Eisner, Paul D. Blanc, Edward H. Yelin, et al. "COPD as a Systemic Disease: Impact on Physical Functional Limitations," *American Journal of Medicine* 121, no. 9 [September 2008]: 789-796. http://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=18724969. [accessed May 23, 2015].

[638] Thomas Stedman. *Stedman's Medical Dictionary.* New York, NY: Lippincott, Williams, and Wilkins, 2000, p. 509.

[639] W. Brooks, J. Jordan, G. Divine, et al. "The Impact of Psychologic Factors on Measurement of Functional Status: Assessment of the Sickness Impact Profile," *Medical Care* 28, no. 9 [1990]: 793-804.

[640] David Seedhouse. *Health Promotion: Philosophy, Prejudice, and Practice.* Chichester West Sussex, England: John Wiley and Sons, 2004.

[641] M. Bobak and M. Marmot. "East-West Mortality Divide and its Potential Explanation: Proposed Research Agenda," *British Medical Journal* 312 [1996]: 421-5.

[642] Michael Marmot. "Social causes of social inequalities in health," In *Public Health Ethics, and Equity* edited by Anand, Sudhir, Peter, Fabienne, and Sen, Amartya. Oxford, NY: Oxford University Press, 2006, p.46.

643 Michael Marmot. "Social causes of social inequalities in health," In *Public Health Ethics, and Equity* edited by Anand, Sudhir, Peter, Fabienne, and Sen, Amartya. Oxford, NY: Oxford University Press, 2006, p.42.

644 Michael Marmot. "Social causes of social inequalities in health," In *Public Health Ethics, and Equity* edited by Anand, Sudhir, Peter, Fabienne, and Sen, Amartya. Oxford, NY: Oxford University Press, 2006, p.42.

645 M. Marmot, A.M. Adelstein, N. Robinson, et al. "The Changing Social Class Distribution of Heart Disease," *British Medical Journal* 2 [1996]: 1109-12.

646 Amartya Sen. *Inequalities Re-examined.* Oxford, NY: Oxford University Press, 1992.

647 C.J.L. Murray, C.M. Michaud, M.T. McKenna, et al. *US Pattern of Mortality by County and Race:* 1965-94. Cambridge, MA: Harvard Center for Population and Develoment Studies, 1998, pp. 1-97.

648 Matthew W. Brault. "Americans with disability: 2010," United States Census Bureau. https://www.census.gov/prod/2012pubs/p70-131.pdf. [accessed May 23, 2015].

649 Norman Daniels. *Just Health Care.* 1985, pp.33-34.

650 World Health Organization. "World Report on Disability," (WHO Library Cataloguing-in-Publication Data, 2011). http://www.who.int/disabilities/world_report/2011/report.pdf. [accessed 1/14/2017].

651 World Health Organization. "Towards a Common Language for Functioning, Disability, and Health ICF," (Geneva, 2002). http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf. [accessed 1/14/2017].

652 T. Burchardt. *The Education and Employment of Disabled Young People: Frustrated Ambition.* Bristol: Policy Press, 2005.

[653] Tony Emmett. "Disablity, Poverty, Gender, and Race," In *Disablity and Social Change: A South African Agenda* edited by Brian. Watermeyer, Leslie Swartz, Theresa Lorenzo, Marguerite Schneider, and Mark Priestley. Cape Town: HSRC Press, 2006.

[654] P. Coleridge. "Disabled People and "Employment' in the Majority World: Policies and Realities," In *working futures? Disabled People, Policy and Social Inclusion edited by A. Roulstone and C. Barnes.* Bristol: Policy Press, 2005.

[655] Amartya Sen. *The Idea of Justice.* Cambridge, MA: The Balknap Press of Harvard University Press, 2009.

[656] Stephen Hawking. "Brief Biography," http://www.hawking.org.uk/about-stephen.html. [accessed on 1/15/2017].

[657] World Health Organization. "World Report on Disability," (WHO Library Cataloguing-in-Publication Data, 2011). http://www.who.int/disabilities/world_report/2011/report.pdf. [accessed 1/14/2017].

[658] T. Burchardt. "The Dynamics of Being Disabled," *Journal of Social Policy* 29 no. 4 [2000]: 645-668.

[659] World Health Organization. "World Report on Disability," (WHO Library Cataloguing-in-Publication Data, 2011). http://www.who.int/disabilities/world_report/2011/report.pdf. [accessed 1/14/2017].

[660] Margaret W. Linn, Richard Sandifer, and Shayna Stein. "Effects of Unemployment on Mental and Physical Health," *Am J Public Health* 75, no. 5 [1985]: 502-506.

[661] M. H. Brenner. "Mortality and the National Economy," *Lancet* 2 [1979]: 568-573.

[662] Margaret W. Linn, Richard Sandifer, and Shayna Stein. "Effects of Unemployment on Mental and Physical Health," 1985.

663 Jennifer R. Pharr, Sheniz Moonie, and Timothy J. Bungum. "The Impact of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors," *International Scholarly Research Network ISRN Public Health* 2012 [2012]:1-7. doi:10.5402/2012/483432. https://www.hindawi.com/journals/isrn/2012/483432/. [accessed 1/18/2017].

664 J. P. Smith. "Healthy Bodies and Thick Wallets: The Dual Relationship between Healthand Socioeconomic Status," *Journal of Economic Perspectives* 13, no. 2 [1999]: 145- 66.

665 Michael Marmont. "Social causes of social inequalities in health," In *Public Health Ethics, and Equity* edited by Anand, Sudhir, Peter, Fabienne, and Sen, Amartya. Oxford, NY: Oxford University Press, 2006, p.44.

666 M.E.J. Wadsworth. "Serious Illness in Childhood and its Association with Later-Life Achievement," in *Class and Health* edited by R. G. Wilkinson. London: Tavistock Publications Ltd., 1986, pp.50-74.

667 M. Marmot and M. McDowall. "Mortality Decline and Widening Social Inequalities," *Lancet* ii [1986]: 274-6.

668 F. Drever, M. Whitehead, and M. Roden. "Current Patterns and Trends in Male Mortality by Social Class (Based on Occupation)," *Population Trends* 86 [1996]:15-20.

669 Michael Marmont. "Social causes of social inequalities in health," In *Public Health Ethics, and Equity* edited by Anand, Sudhir, Peter, Fabienne, and Sen, Amartya. Oxford, NY: Oxford University Press, 2006, pp. 51-2.

670 S. Stansfeld and M. Marmot. "Deriving a Survey Measure of Social Support: The Reliability and Validity of the Close Persons Questionnaire," *Social Science and Medicine* 35 [1992]: 1027-35.

671 G.A. Kaplan, E.R. Pamuk, J.W. Lynch, et al. "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways," *British Medical Journal* 312 [1996]:999-1003.

672 B.P. Kennedy, I. Kawachi, and D. Prothrow-Stith. "Income Distribution and Mortality: Cross Sectional Ecological Study of the Robin Hood Index in the United States," *British Medical Journal* 312 [1996]:1004-7.

673 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith. "Income, Poverty, and Health Insurance coverage in the United States: 2012," U. S. Census Bureau. https://www.census.gov/prod/2013pubs/p60-245.pdf. [accessed May 24, 2015].

674 Alex Russell. "Ensuring Access to a Healthy Life," (Center for Poverty Research. Spring 2014 Issue). http://poverty.ucdavis.edu/sites/main/files/file-attachments/poverty_research_now-poverty_and_health_2014.pdf. [accessed May 24, 2015].

675 Sigurd R. Nilsen. "Poverty in America: Consequences for individuals and the economy," Government Accountability Office. January 24, 2007. http://www.gao.gov/new.items/d07343t.pdf. [accessed 5/26/2015].

676 Barbara Wolf, William Evans, and Nancy Adler. "The SES and Health Gradient- A Brief Review of the Literature," in *Biological Consequences of Socioeconomic Inequalities,* eds. Barbara Wolfe, William Evans, and Teresa Seeman. New York: Russell Sage Foundation, 2012.

677 A. Case, D. Lubotsky, and C. Paxson, "Economic Status and Health in Childhood: The Origins of the Gradient," *The American Eco- nomic Review* 25, no. 4 [2002]: 1308–1334.

[678] Rita Paul-Sen Gupta, Margaret L. de Wit, and David McKeown. "The Impact of Poverty on the Current and Future Health Status of Children," *Paediatr Child Health* 12, no. 8, [2007]: 667-672.

[679] M. E. J. Wadsworth and D. J. L. Kuh. "Childhood Influences on Adult Health: A review of Recent Work from the British 1946 National Birth Cohort Study, the MRC National Survey of Health and Development," *Paediatric and Perinatal Epidemiology* 11 no. 1 [1997]: 2-20.

[680] Avik Roy. *How Medicaid Fails The Poor.* New York, NY: Encounter Books, 2013, ebook version.

[681] D. Kuh, R. Hardy, C. Langenberg, et al. "Mortality in adults aged 26-54 years related to socioeconomic conditions in childhood and adulthood: post war birth cohort study," *BMJ* 325 no. 7372, [2002 Nov 9]: 1076-80.

[682] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith. "Income, Poverty, and Health Insurance coverage in the United States: 2012," U. S. Census Bureau. https://www.census.gov/prod/2013pubs/p60-245.pdf. [accessed May 24, 2015].

[683] Diane Rowland and Barbara Lyons. "Medicare, Medicaid, and the Elderly Poor," *Health Care Finances Review* 18, no. 2 [1996 Winter]: 61-85.

[684] W.G. Manning, J. R. Newhouse, and J. E. Ware. "The Status of Health in Demand Estimates: Beyond Good, Excellent, Fair, and Poor," in *Economic Aspects of Health* edited by C. R. Fuchs. Chicago: Chicago University, 1981.

[685] M. McWilliams, E. Meara, M. Zaslavsky, et al. "Health of previously uninsured adults after acquiring Medicare coverage," *Journal of the American Medical Association* 298, no. 24 [2007]: 2886-2894.

686 The Catholic Health Association of the United States. *With Justice for All?: The Ethics of Health Rationing.* St. Louis, MO: The Catholic Health Association of the United States, 1991, p. vii.

687 Charles Nelson and Kathleen Short. "Health Insurance Coverage – 1986-1988," Bureau of The Census, U.S. Department of Commerce, current Population Reports, *Household Economic Studies,* series P-70, no. 17, March 1990.

688 The Catholic Health association of the United States. *With Justice for All?: The Ethics of Healthcare Rationing.* 1991, pp. 12-13.

689 Social Security Administration. "Fast Facts & Figures About Social Security, 2015," (SSA Publication no. 13-11785, released in September 2015). https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2015/fast_facts15.pdf. [accessed in 11/26/2106].

690 National Council on Aging (NCOA). "Economic security for seniors facts," https://www.ncoa.org/news/resources-for-reporters/get-the-facts/economic-security-facts/. [accessed 11/26/2016].

691 United States Department of Agriculture. "Fact Sheet: USDA Support for Older Americans," (Last Date Modified: 7/10/2015) http://www.usda.gov/wps/portal/usda/usdahome?contentid=2015/07/0202.xml. [assessed 12/3/2016].

692 Michael A. Steinman, Laura P. Sands, and Kenneth E. Covinsky. "Self-restriction of Medications Due to Cost in Seniors without Prescription Coverage," *J Gen Intern Med* 16, no. 12 [2001]: 793-799.

693 Joseph Walker. "Patients Struggle with High Drug Prices," (Wall Street Journal, December 31, 2015). http://www.wsj.com/articles/patients-struggle-with-high-drug-prices-1451557981. [assessed 12/3/2016].

694 Lori A. Trawinski. "Nightmare on Main Street: Older Americans and the Mortgage Market Crisis," (AARP, July 2012). http://www.aarp.org/content/dam/aarp/research/public_policy_institute/cons_prot/2012/nightmare-on-main-street-AARP-ppi-cons-prot.pdf. [assessed 12/3/2016].

695 The Catholic Health association of the United States. *With Justice for All?: The Ethics of Healthcare Rationing.* 1991, p. 13.

696 John XXIII. *Pacem in Terris*(Encyclical of Pope John XXIII on Establishing Universal Peace in Truth, Justice, Charity, and Liberty, April 11, 1963), http://w2.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii_enc_11041963_pacem.html. [accessed on 12/10/2016].

697 Jennifer Prah Ruger. *Health and Social Justice.* New York: Oxford University Press, 2010, p.120.

698 Madison Powers and Ruth Faden. *Social Justice: The Moral Foundations of Public Health and Health Policy.* Oxford, NY: Oxford University Press, 2006, p.17.

699 Charles J Dougherty. *American Health Care: Realities, Rights, and Reforms*. New York, NY: Oxford University Press, 1988, p. 119.

700 Daniel Wikler. "Philosophical Perspectives on Access to Health Care: An Introduction," In *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services; Volume Two: Appendices, Sociocultural and Philosophical Studies*, edited by

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 108-51. Washington, DC: U.S. Government Printing Office, 1983.

[701] Albert R. Jonsen and Stephen Toulmin. *The Abuse of Casuistry: A History of Moral Reasoning.* Berkeley, CA: University of California Press, 1988, pp.14, 16-19.

[702] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 242-245.

[703] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*. New York, NY: Oxford University Press, 2001, p. 234.

[704] Larry R. Churchhill. *Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone*. Cambridge, MA: Harvard University Press, 1994, p. 35.

[705] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 247.

[706] Karen Lebacqz. *Six Theories of Justice: Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986, p.16.

[707] John Stuart Mill. *Utilitarianism.* London, 1863.

[708] John Stuart Mill. *Utilitarianism.* New York: Bobbs-Merrill, 1957.

[709] John Stuart Mill. "Utilitarianism," https://www.utilitarianism.com/mill2.htm. [accessed 11/5/2016].

[710] Stanford Encyclopedia of Philosophy. "Mill's Moral and Political Philosophy," (revised on August 22, 2014). http://plato.stanford.edu/entries/mill-moral-political/. [accessed on 11/5/2016].

[711] Jeremy Bentham. "*The Works of Jeremy Bentham,* published under the Superintendence of his Executor, John Bowring*"* (Edinburgh: William Tait, 1838-1843, 11 vols). http://oll.libertyfund.org/titles/bentham-works-of-jeremy-bentham-11-vols. [accessed on 11/5/2016].

[712] John Stuart Mill. *Utilitarianism.* ebook edition, 2004, [ebook #11224]. http://www.gutenberg.org/ebooks/11224. [accessed on 11/6/2016].

[713] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[714] John Stuart Mill. *Utilitarianism.* London, 1863.

[715] John Rawls. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

[716] Anthony D'Amato. "International Law and Rawls' Theory of Justice," *Faculty Working papers* Paper 119. http://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=1118&context=facultyworkingpapers. [accessed on 11/9/2016].

[717] John Rawls. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

[718] John Rawls. "Justice as Fairness: Political not Metaphysical," *Philosophy and Public Affairs* 14, no. 3 [Summer, 1985]: 223-251.

[719] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[720] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[721] John Stuart, Mill. *Utilitarianism.* New York: Bobbs-Merrill, 1957.

[722] John Rawls. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

[723] Benjamin R. Barber. "Justifying Justice: Problem of Psychology, Politics, and Measurement in Rawls," in *Reading Rawls.* ed. Norman Daniels. New York: Basic Books, n.d.,1989.

[724] John Stuart Mill. *Utilitarianism.* New York: Bobbs-Merrill, 1957.

[725] Charles J. Dougherty. *American Health Care: Realities, Rights, and Reforms.* New York, NY: Oxford University Press, 1988, p.35.

[726] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[727] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[728] John Rawl. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

[729] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[730] John Rawl. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

[731] John Rawl. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

[732] Benjamin R. Barber. "Justifying Justice: Problem of Psychology, Politics, and Measurement in Rawls," In *Reading Rawls* edited by Norman Daniels. New York: Basic Books, n.d., 1989.

[733] Karen Lebacqz. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

[734] Norman Daniels and James E. Sabin. *Setting Limits Fairly: Can We Learn to Share Medical Resources?* Oxford, NY: Oxford University Press, 2002, p. 17.

[735] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 241-243.

[736] Nicholas Rescher. *Distributive Justice.* Indianapolis, IN: Bobbs-Merill, 1966, ch. 4.

[737] R. Andersen and L. A. Aday. "Access to Medical Care in the US: Realized and Potential," *Medical Care* 16, no. 7 [1978]: 533-546.

738 Rosalind Willis, Karen Glaser, and Debora Price. "Applying the Andersen Behavioural Model to Informal Support among Britain's Ethnic Minorities," (Institute of Gerontology, King's College London). http://www.britishgerontology.org/DB/gr-editions-2/generations-review/applying-the-andersen-behavioural-model-to-informa.html. [accessed 12/22/2016].

739 Norman Daniel. *Just Health Care.* New York, NY: Cambridge University Press, 1985. pp. 63-66.

740 F. Sloan and J. D. Bentkover. *Access to Ambulatory Care and the US Economy.* Lexington, MA: Lexington Books.

741 A. Donabedian. "The Quality of Medical Care: A Concept in Search of a Definition," *Journal of Family Practice* 9 no. 2 [1979]: 277-284.

742 R. Dickman. "Operationalizing Respect for Persons: A Qualitative Aspect of the Right to Health Care," in *In Search of Equity: Heath Needs and the Health Care System* edited by Bayer R, Caplan, A, and Daniel, N. New York, NY: Plenum, 1983.

743 Norman Daniel. *Just Health Care.* New York, NY: Cambridge University Press, 1985.

744 Frank Lovett. *Rawls's a Theory of Justice: A Reader's Guide.* New York, NY: Bloomsbury, 2011. ebook.

745 Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* 2009, pp. 247-248.

746 Stephen Holland. *Public Health Ethics.* Malden, MA: Polity Press, 2007, pp. 47-48.

747 Norman Daniels. *Just Health Care.* New York, NY: Cambridge University Press, 1985, pp.34-58.

[748] Norman Daniels. *Just Health: Meeting Health Needs Fairly.* New York, NY: Cambridge University Press, 2008, p.11.

[749] Norman Daniels. *Just Health: Meeting Health Needs Fairly.* New York, NY: Cambridge University Press, 2008, p.20.

[750] Norman Daniels. *Just Health: Meeting Health Needs Fairly.* New York, NY: Cambridge University Press, 2008, pp.31-36.

[751] Norman Daniels. *Just Health: Meeting Health Needs Fairly.* New York, NY: Cambridge University Press, 2008, pp. 104-105.

[752] N. Daniels and J. E. Sabin. "Limits to Health Care: Fair Procedures, Democratic Deliberation and the Legitimacy Problem for Insurer," *Philosophy and Public Affairs* 26[1998]:303-50.

[753] N. Daniels and J. E. Sabin. "The Ethics of Accountability and the Reform of Managed Care Organizations," *Health Affairs* 17, no. 5[1997]: 50-69.

[754] Norman Daniels. *Just Health: Meeting Health Needs Fairly.* New York, NY: Cambridge University Press, 2008, pp.119-133.

[755] Norman Daniels. *Am I My Parents' Keepers?: An Essay on Justice Between the Young and the Old.* Oxford, NY: Oxford University Press, 1988, p. 64.

[756] Norman Daniels. *Just Health: Meeting Health Needs Fairly.* New York, NY: Cambridge University Press, 2008, pp. 161-162.

[757] J. N. Morgan. "The Ethical Basis of the Economic Claims of the Elderly," in *Social Policy, Social Ethics, and the Aging Society* edited B. L. Neugarten and R. L. Havighurst. Washington D.C.: National Science Foundation, 1976, pp. 67-9.

[758] Albert Jonsen. "Principles for an ethics of health services," in *Social Policy, Social Ethics, and the Aging Society,* ed. B. L. Neugarten and R. J. Havighurst. Washington D.C.: National Science Foundation, 1976, pp.97-105.

[759] Sudhir Anand, Fabienne Peter, and Amartya Sen. *Public Health, Ethics, and Equity.* Oxford, NY: Oxford University Press, 2004, p. 208.

[760] Norman Daniels. *Just Health Care.* New York: Cambridge University Press, 1985.

[761] John Rawls. *Political Liberalism.* New York: Columbia University Press, 1993.

[762] N. Daniel, B. Kennedy, and I. Kawachi. "Health and inequality, or why justice is good for our health," In Public Health, Ethics, and Equity edited by S. Anand, F. Peter, and A. Sen. Oxford, New York: Oxford University Press, 2004, pp. 63-91.

[763] Lynda A. Anderson, Richard A. Goodman, and Deborah Holtzman, et al. "Aging in the United States: Opportunities and Challenges for Public Health," *Am J Public Health* 102 no. 3 [2012]: 393-395.

[764] National Service Center for Environmental Publications(NSCEP). "Older Americans 2010: Key Indicators of Well-Being," https://nepis.epa.gov/Exe/ZyNET.exe/P10081CP.txt?ZyActionD=ZyDocument&Client=EPA&Index=2006%20Thru%202010&Docs=&Query=&Time=&EndTime=&SearchMethod=1&TocRestrict=n&Toc=&TocEntry=&QField=&QFieldYear=&QFieldMonth=&QFieldDay=&UseQField=&IntQFieldOp=0&ExtQFieldOp=0&XmlQuery=&File=D%3A%5CZYFILES%5CINDEX%20DATA%5C06THRU10%5CTXT%5C00000019%5CP10081CP.txt&User=ANONYMOUS&Password=anonymous&SortMethod=h%7C-&MaximumDocuments=1&FuzzyDegree=0&ImageQuality=r75g8/r75g8/x150y150g16/i425&D

isplay=hpfr&DefSeekPage=x&SearchBack=ZyActionL&Back=ZyActionS&BackDesc=Results%20page&MaximumPages=1&ZyEntry=50. [accessed 12/26/2016].

765 U. S. Department of Health and Human Services. "Multiple Chronic Conditions - A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions," (Washington, DC, December 2010), https://www.hhs.gov/sites/default/files/ash/initiatives/mcc/mcc_framework.pdf. [accessed 12/26/2016].

766 Lynda A. Anderson, Richard A. Goodman, and Deborah Holtzman, et al. "Aging in the United States: Opportunities and Challenges for Public Health," *Am J Public Health* 102 no. 3 [2012]: 393-395.

767 Wan He, Manisha Sengupta, Victoria A. Velkoff, et al. "U. S. Census Bureau, Current Population Reports, P23-209, 65+ in the United States: 2005," (Washington, DC, U. S. Government Printing Office, 2005). http://www.census.gov/prod/2006pubs/p23-209.pdf. [accessed 12/26/2016].

768 G. Anderson. "Chronic Care: Making the Case for Ongoing Care," (Publisher: Robert Wood Johnson Foundation, 2010). http://www.rwjf.org/en/library/research/2010/01/chronic-care.html. [accessed on 12/26/2016].

769 Administration for Community Living. "Profile of Older Americans: 2015, Disability and Activity Limitations," (Last modified on 5/23/2016). https://aoa.acl.gov/Aging_Statistics/Profile/2015/16.aspx. [accessed on 12/27/2016].

770 U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3021.

[771] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3201.

[772] U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 3301.

[773] Administration for Community Living. "Administration on Aging(AOA): Aging Statistics," (Last modified on 5/24/2016). https://aoa.acl.gov/Aging_Statistics/index.aspx. [accessed on 12/27/2016].

[774] Administration for Community Living. "Profile of Older Americans: 2015, The Older Population," (Last modified on 5/23/2016). https://aoa.acl.gov/Aging_Statistics/Profile/2015/3.aspx. [accessed on 12/27/2016].

[775] M. W. Riley and J. W. Riley. "Structural Lag: Past and Future," In *Age and Structural Lag* by M. W. Riley, R. I. Kahn, and A. Foner. New York, NY: Wiley, 1994.

[776] J. W. Rowe and R. L. Kahn. *Successful Aging.* New York, NY: Random House, 1998.

[777] T. Hickey, M. A. Speers, and T. R. Prohaska. *Public Health and Aging.* Baltimore, MA: Johns Hopkins University Press, 1997.

[778] J. R. Lunney, J. Lynn, and C. Hogan. "Profile of Older Medicare Decedents," *Journal of the American Geriatric Society* 50 no. 6 [2002]: 1108-1112.

[779] M. Mezey and R. Fulmer. "Quality Care for the Frail Elderly," *Nursing Outlook* 46, no. 6 [1998]: 291-292.

[780] C. J. Evashwick. *The continuum of Long-Term Care.* Albany, NY: Delmar, 2001.

[781] M. Merlis. "Caring for the Frail Elderly: An International Review," *Health Affairs* 19 no. 3 [200]: 141-149.

[782] Congressional Budget Office. "CBO Memorandum: Projections of Expenditures for Long-Term Care Services for the Elderly," (March 1999). https://www.cbo.gov/sites/default/files/106th-congress-1999-2000/reports/ltcare.pdf. [accessed on 1/6,2017].

[783] Madison Powers and Ruth Faden. *Social Justice: The Moral Foundations of Public Health and Health Policy.* Oxford, NY: Oxford University Press, 2006, p. 87.

[784] American Public Health Association. "People With Disability in National Health Care Reform," Policy Statement no. 9307. Washington D.C.: APHA, 1994.

[785] T. Pogge. "A global resources dividend," in *Ethics of Consumption: The Good Life, Justice and Global Stewardship,* ed. D. A. Crocker and T. Linden. Lanham, MD: Rowman and Littlefield, 1998.

[786] D. Gillespie, M. Gleason, H. Mshinda, et al. "Knowledge into Action for Child Survival," *The Lancet,* 362 [2003]:323-27.

[787] Ronald Dworkin. "What is equality? Part 1: Equality of Welfare," *Philosophy and Public Affairs* 10, no. 3 [1981]:185-246

[788] A. Buchanan, D. Brock, N. Daniels, et al. *From Chance to Choice: Genetics and Justice.* Cambridge, MA: Cambridge University Press, 2000, p. 74.

[789] Amy J. Schultz, D. R. Williams, B. A. Isreal, et al. "Racial and spatial Relations as Fundamental Determinants of Health in Detroit," *The Milbank Quarterly* 80, no. 4 [2002]: 677-707.

[790] Michael Marmont, D. Smith, and S. Stansfeld, et al. "Health Inequalities Among British Civil Servants: The Whitehall II Study," *The Lancet* 337 no. 8754 [1991]:1387-1393.

[791] Catherine E. Ross and C. Wu. "The Links between Education and Health," *American Sociological Review* 60 [1995]:719-745.

[792] David R. Williams. "Patterns and Causes of Disparities in Health," In *Challenges in Modern Health Care* by Robert Wood Johnson Foundation. (Published by Rutgers University Press, 2004).

http://www.rwjf.org/content/dam/farm/books/books/2004/rwjf11336. [accessed 12/27/2016].

[793] Alison A. Galbraith, S. T. Wong, and S. E. Kim, and et al. "Out-of-pocket Financial Burden for Low-income Families with Children: Socioeconomic Disparities and Effects of Insurance," *Health Services Research* 40 no. 6 [2005]:1722-1737.

[794] Thomas A. Arcury, J. S. Precisser, W. and M. Gesler, et al. "Access to Transportation and Health Care Utilization in a Rural Region," *The Journal of Rural Health* 21 [2005]: 31-40.

[795] Bruce G. Link and J. C. Phelan. "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behavior* Extra Issue [1995]: 80-94.

[796] Bruce G. Link, M. E. Northridge, and M. E. Phelan, et al. "Social Epidemiology and the Fundamental Cause Concept: On the Structuring of Effective Cancer Screens by Socioeconomic Status," *Milbank Quarterly* 76 [1998]:375-402.

[797] Joseph R. Betancourt, Alexander R. Green, and J. Emilio Carrilio, et al. "Defining Cultural Competnce: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care," *Public Health Reports* 118 [2003]: 293-302.

[798] Center for Prevention and Health Services. "Eliminating Racial and Ethnic Health Disparities; A Business Case Update for Employers," (Issue Brief, February 2009). https://minorityhealth.hhs.gov/Assets/pdf/checked/1/Eliminating_Racial_Ethnic_Health_Disparities_A_Business_Case_Update_for_Employers.pdf. [accessed 12/27/2016].

799 Paulette M. Niewczyk and Jamson S. Lwebuga-Mukasa. "Is Poverty the Main Factor Contributing to Health Care Disparities? An Investigation of Individual Level Factors Contributing to Health Care Disparities," *The Journal of Equity in Health* 1 no. 1[2008]: 22-40.

800 Agency for Healthcare Research and Quality. "2004 National Healthcare Disparities Report," (AHRQ Publication, December 2004). https://archive.ahrq.gov/qual/nhdr04/nhdr2004.pdf. [accessed 12/27/2016].

801 Joint Center for Political and Economic Studies. "Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Population," (July 2010). http://jointcenter.org/sites/default/files/Patient%20Protection%20and%20Affordable%20Care%20Act.pdf. [accessed on 1/6/2017].

802 David R. Williams, and C. Collins. "U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations," *Annual Review of Sociology* 21 [1995]: 349-386.

803 U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 2001.

804 U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec., 2101.

805 J. Michael McWilliams. "Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications,"*Milbank Q.* 87, no.2 [2009]: 443-494.

806 Institute of Medicine (IOM). "Care Without Coverage: Too Little, Too Late," (May 2002). https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2003/Care-Without-Coverage-Too-Little-Too-Late/Uninsured2FINAL.pdf. [accessed 1/13/2017].

807 Anne K. Driscoll and Amy B. Bernstein. "Health and Access to Care Among Employed and Unemployed Adults: United States, 2009-2010," (National Center for Health Statistics, no. 83, January 2012). https://www.cdc.gov/nchs/data/databriefs/db83.pdf. [accessed 1/8/2017]

808 G. M. Curran, G. Sullivan, K. Williams, et al. "Emergency Department Use of Persons with Comorbid Psychiatric and Substance Abuse Disorders," *Annals of Emergency Medicine* 41 no. 5 [2003]: 659-667.

809 Centers for Medicare & Medicaid Services. "Emergency Medical Treatment & Labor Act (EMTALA)," (Last modified on 3/26/2012). https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/. [accessed on 1/8/2017].

810 Stephen R. Pitts, Richard W. Niska, Jianmin Xu, et al. "National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary," (National Health Statistics Reports, no 7, August 6, 2008). https://www.cdc.gov/nchs/data/nhsr/nhsr007.pdf. [accessed on 1/13/2017].

811 B. S. Ku, K. C. Scott, S. G. Kertesz, et al. "Factors Associated with use of urban Emergency Departments by the U. S Homeless Population," *Public Health Reports* 125, no. 3 [2010]: 398-405.

812 G. Oates, A. Tadros, and S. M. Davis. "A Comparison of National Emergency Department Use by Homeless versus Non-homeless People in the United States," *Journal of Health Care for the Poor and Underserved* 20, no. 3 [2009]:840-845.

[813] Stephen R. Pitts, Richard W. Niska, Jianmin Xu, et al. "National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary," (National Health Statistics Reports, no 7, August 6, 2008). https://www.cdc.gov/nchs/data/nhsr/nhsr007.pdf. [accessed on 1/13/2017].

[814] D. A. Pearson, A. R. Bruggman, and J. S. Haukoos. "Out-of-hospital and Emergency Department Utilization by Adult Homeless Patients," *Annals of Emergency Medicine* 50, no. 6 [2007]: 646-652.

[815] Medicaid.gov. "Eligibility," (Centers for Medicare & Medicaid Services). https://www.medicaid.gov/medicaid/eligibility/index.html. [accessed 1/9/2017].

[816] Julia Zur, Ramin Mojtabai, and Suhui Li. "The Cost Savings of Expanding Medicaid Eligibility to Include Currently Uninsured Homeless Adults with Substance Use Disorders," *J Behav Health Serv Res* 41, no. 2 [2014]: 110-124.

[817] J. Hadley, J. Holahan, and T. Coughlin, et al. *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs* 27 no. 5 [2008]: 399-415.

[818] B. D. Sommers, K. Baicher, and A. M. Epstein. "Mortality and Access to Care Among Adults After State Medicaid Expansion," *New England Journal of Medicine* 367, no. 11 [2012]: 1025-1034.

Chapter Five

Organizations: The Health & Human Services Contraceptive Mandate in the ACA

Section One. Introduction

In the wake of skyrocketed healthcare cost in the United States, the government and health insurance companies strategized to control costs and emphasize healthcare priorities. However, needed healthcare services were denied for the purpose of containing cost. People saw the attempt to contain healthcare cost ended up with eliminating services that were needed to maintain health or treatments. Thus defeating the purpose of healthcare.[819] Adding to the issue was a great number of Americans without healthcare services due to unaffordability. The government officials saw the urgency to reduce the effect of these problems. Primarily, the serious issue was the high cost of healthcare, which alerted the government to consider legislative actions. When focusing on reducing cost, strategy might be mostly involved with financial planning. Little energy was left in the discussion of how reducing cost could impact quality patient care. Despite the ongoing attempt to reduce cost, the issue of high healthcare expense remains. It created the need for the strategy to reorganize health services in response to the debatable quality health services. It leads to serious discussions on how to manage healthcare with ethical practice. ACA provides preventive care including women's health services. The inclusion of contraceptives is meant to provide women with better quality healthcare and unwanted pregnancy. However, the announcement of the provision instantly stirred up the conflict between the opposition groups and healthcare policies. The attention was focused on

evaluating the opinions of the opposition groups and the intention of contraceptive provision. Because the need to resolve the conflict was essential to successfully advancing ACA, it is critical to analyze the issue ethically.

The irreconcilable conflicts between the opposition groups and the healthcare policies signal the need to examine the conflict of values and the ethical approach to healthcare. In this case, the evaluation must include addressing the conflict of interest, consent, and choice. The examination of this issue need to include ethical perspective and religious tradition because of their ability to determine the truth in the case, judge the rightness of the actions in the case, and identify the values in the case. The combination of ethics and religious teaching enable the focus on understanding the problems by asking questions leading to the opening of further learning and experience. Because healthcare services concern the people in society, it is important to combine the action of case-based experience and ethical theory to reach a solution. Even in the case of disagreement, a level of consensus can be reached based on the moral and ethical values. It should not analyze the issue solely from the view of regulation, economy, or organizational policies. It should examine and analyze organizational health care issues with ethics and religious values leading to possible policy change. This is a result from the process of ethical analysis that includes clarifying terms, seeking inputs, identifying and prioritizing values, understanding religious teaching, and opening to new solutions. By initiating conversation among all parties promotes a relationship that leads to consensus and opens to necessary changes. Practical approach to the issue involves identifying the ethical tensions in the new healthcare policies. Acknowledging the ethical tension forces

everyone to face the reality of the current healthcare dilemma which is how to provide the best healthcare to every member in society with limited resources. By acknowledging the ethical tension, stakeholders are forced to respect and accept the values of others leading to the process of discussion and change. The open discussion also results in some level of transparency to important healthcare decision potentially mending the broken trust in the public. Members of society will be able to learn about formal rules of procedure and methods for making decisions. Hence, the public gets to voice their concerns and understands how governmental decisions are made. The conflict of contraceptive policy and the process of resolution produced an opportunity to understand the need for more healthcare for women and the appreciation of the opposition group's specific values.

In United States, the population of women age 15 to 44 years are roughly 61 million.[820] This age range is considered childbearing years. For women, the reproductive system is unique and plays a significant role in women's health. Medical problems can affect women and men differently in that symptoms might not be the same in manifestation.[821] For instance, typical recognized symptoms of heart attack might not be the same in women as they are seen in men. For a time, the risk for heart disease among women was overlooked. The reason for the lack of knowledge is due to past research studies mainly involved men. Health prevention was then focused on men's stages of life. Fewer warnings or attention were given to women regarding health prevention or early detection of medical problems. Consequently, healthcare decisions were made without thorough consideration of women's benefits. Now that women's health has gained

attention in the health arena, it takes a major effort to recognize healthcare for women that involves a full spectrum of care ranging from regular medical conditions to reproductive care. ACA policy aims at providing women care with full basic healthcare services. The new policy includes contraceptives as preventive care. The basic healthcare services intend to cover the range of services from well visit to free contraceptive devices. Because women benefit from the full spectrum of healthcare, it worth the effort to resolve the conflict between opposition groups and the healthcare policies.

Section Two. Right to Preventive Care

The right to care includes preventive care as well as treatment for illness for all Americans. This section discusses preventive services for women.

a. The Conflict between Government Mandate and Religious Conviction

The inclusion of contraception in preventive health services does not align with Catholic beliefs resulted in a serious conflict between the Catholic Church and the Obama administration.

i. Health and Human Services (HHS) Announcement

On January 20, 2012, the U.S. Department of Health and Human Services (HHS) announced its final decision, as part of ACA, requiring most health insurance plans to provide women with free contraceptive devices as part of the overall preventive services. It also requires most employers to provide free sterilization and some abortion-inducing

drugs.[822] This policy is intended to resolve the issue of women not getting contraceptive services through their employment. HHS affirms that all forms of FDA approved contraception are within the recommendation for preventive care and should be covered under insurance policy. It further claims that the ruling is consistent with the laws in most states regarding provision of contraceptive services, and the coverage should be without cost sharing.[823]

1. Inclusion of the Contentious Health Service for Women

ACA includes coverage of preventive services which was added to the Public Health Service Act (PHS Act) under section 2713. Section 2713 of the PHS requires non-grandfathered health plans to provide coverage of certain preventive health services without out-of-pocket cost.[824] These preventive services include recommendations of the United States Preventive Services Task Force (Task Force), Immunization Schedules for infants, children, and adolescents of the Center for Disease Control, comprehensive guidelines for preventive care and screenings by Health Resources and Services Administration (HRSA), and preventive care and screenings supported by HRSA and Task Force including all Food and Drug Administration (FDA) approved contraceptives, sterilization procedures, and patient education and counseling for women with reproductive capacity as prescribed by a healthcare provider. The announcement was issued in July 2010, and the new recommended preventive services was set to begin one year later. This is to provide adequate time for health plans and issuers to incorporate recommended services as required by the new regulations and eliminate coverage that is

no longer recommended. To protect against disruption of service, the new regulations requires health plans to provide coverage on the first day of the policy year and continue the coverage through the last day of that policy year even if the recommendation or guideline changes or is eliminated during the policy year. However, in cases of safety concerns, coverage of recommended services is not advised to continue even if coverage has begun on the first day of policy year. Such as in the instance in that Task Force determines a recommendation has strong evidence of no benefit or harm outweighing the benefits. Under such circumstance, health plans are not required to provide coverage through the last day of policy year.

Women's health in relation to contraception has been an ongoing discussion. According to Healthy People 2010,[825] half of pregnancies in the United States are unintended at the time of conception. The high rate of occurrence is among teenagers, women aged 40 or older, and low-income African American women. It estimated 1 million teenage females have unintended pregnancies each year and approximately half of these pregnancies result in abortion. The cost to U. S. taxpayers for teenage pregnancies is roughly between 7 billion and 15 billion dollars a year. (It was reported public funded family planning services decreased 1.94 million unintended pregnancies in 2006.[826]) Another concern is that unintended pregnancies are less likely to seek early prenatal care increasing the likelihood of maternal and infant illness.[827] The fetus is likely to be exposed to harmful substance such as tobacco or alcohol. The infant in such condition is at high risk of low birth weight, premature death, suffering abuse, and not receiving proper developmental nourishment. Moreover, breast milk is recognized to

have nutritious values; the mother is also likely not to breastfeed the infant.

Based on the ACA new regulations, health plans must provide full coverage of contraceptive methods and counselling for all women as prescribed by a healthcare provider. The HHS guidelines specify that the covered contraceptive methods must be FDA-approved.[828] They include barrier methods (diaphragms and sponges), hormonal methods (birth control pills and vaginal rings), implanted devices (intrauterine devices), emergency contraception (Plan B and ella), sterilization procedures, and patient education and counseling. Mandated coverage does not include drugs that induce abortions and services for male reproductive capacity. Adding family planning to preventive services completes women's healthcare needs. Sen. Diane Feinstein described the new policy in this way, "In other words, the amendment increases access to the basic services that are a part of every woman's health care needs at some point in her life."[829]

2. Offended by the Historic Healthcare Mandate

The contentious health service in ACA is the mandated contraception coverage. Although the use of contraception is accepted in the United States, the new regulation specifically mandates provision of contraception is offensive to certain groups. The written submission of the United States Conference of Catholic Bishops (USCCB) clearly expressed their opposition to the new mandate.[830] The written comments were arranged in two categories describing the unlawful mandate. In the first category, the letter contended that prescription of contraceptives, sterilization, and contraceptive education and counseling did not prevent disease and should not be included in health services.

These services prevent pregnancy, and pregnancy was not a disease. On the contrary, contraception disrupts the function of female's reproductive system. By forcing the mandate on religious groups, the government violated the protection from Religion Clauses and Free Speech Clause of the First Amendment, Religious Freedom Restoration Act, and the Administrative Procedure Act. The second category, the letter commented on the religious exemption issued by HHS. The exemption allows employers to refuse contraception provision but it did not provide protection for individual or insurers with religious objection to contraception. These people would still experience the burden on their conscience. On USCCB website, it described the exemption as "narrower than any conscience clause ever enacted in federal law, and narrower than the vast majority of religious exemptions from state contraceptive mandates."[831] The failure to protect individual, insurers, and most employers violated the U. S. constitution. Furthermore, the narrow religious exemption would involve the government to judge whether the organization was religious to be exempted.[832] The entire new healthcare law was brought to the U. S. Supreme Court and the ruling was in support of ACA.[833] In that case, the mandate of contraception was also upheld. Fox News reports Becket Fund for Religious Liberty announced its intention to file lawsuits challenging the requirement the mandate to provide contraception.[834] The decision to move forward with lawsuits came after the Supreme Court ruling in support of ACA. The lawsuits were based on the ground of religious liberty violated by the unconstitutional mandate. The lawsuits charged against the mandate arguing the violation of Religious Freedom Restoration Act. Plaintiffs in the lawsuits were consisted of multiple universities, businesses, and Catholic organizations.

The perspective was that a person who held a religious conviction would be forced to violate his belief or pay a severe fine. Separate from the previous hearing regarding the ACA law, the U. S. Supreme Court agreed to rule on contraceptive mandate on religious charities, schools, and hospitals.[835] However, in their decision, the eight Judges (one vacant seat after Justice Antonin Scalia's death) sent the case back to federal appeals courts in hope of a compromise could be reached.[836]

ii. A Compromise

HHS supports its decision stating scientific evidence shows prescribed contraceptives have significant health benefits for women and their families. They are known as common measures being used by young and middle-age women in the United States. It is noted nearly 99 percent of these women rely on prescribed contraceptives, however, more than half of these women cannot afford them.[837] Besides health benefits, contraceptives have also been documented to reduce healthcare costs. These reasons support the mandate of contraceptive coverage. For employers who do not offer contraceptive services in their health insurance plan, the new mandate allows religious employers an additional year to comply with the new law. However, organizations are required to include service locations where contraceptive devices can be obtained based on income level.[838] It is simply understood that, based on the mandate, religious organizations do not have to provide contraception but their health insurance company will.[839]

1. Accommodating Religious Liberty

The White House made the announcement on behalf of President Obama regarding a policy that accommodates religious liberty while keeping the mandate of contraception provision.[840] Based on the reasons of approximately 99 percent of U. S. women use contraception at some point in their lives and more than half of the women between the ages of 18 and 34 have financial difficulty paying for it, the ACA policy upholds the free contraception provision to protect the health of women. The basis of ACA policy is that women can receive contraception without out-of-pocket cost through their employers. For women who work for religious employers who object to contraception provision, their insurance will directly offer contraceptive services without cost sharing. In this case, the religious employers are not required to provide, pay for, or offer referrals. The new guidelines are meant to sustain the free contraception provision and to exempt religious employers from including contraception in their healthcare coverage. Because this was a serious conflict that required a clear description of the exemption process. The new guidelines include the following specific rules:

- Churches, houses of worship, and organizations with religious objection to contraception qualify for exemption.
- Religious organizations are not required to provide contraception coverage or referral to seek coverage elsewhere.
- Religious organizations are not required to finance the expense of contraception.
- Religious employers' insurance companies will directly provide free contraception without any involvement of the employers.

- Insurance companies are required to provide contraception with no cost to insured women.
- Set up one-year transition period for new policy to be implemented.

The fine details regarding notification for exemption created yet another disagreement. Religious groups with objection to contraception argued the process of filing a request for exemption did not guarantee their nonparticipation in the mandate. Further accommodation was made regarding notification option. The new option required an eligible organization to:

- provide self-certification to the insurance company, and the insurance company is required to provide contraception to the insured women without cost to the organization, or
- provide a note to the Department of Health and Human Services (HHS) in writing stating its sincere religious objection to cover contraception. The HHS would then notify responsible insurance companies mandating contraceptive coverage for insured women.[841]

The Supreme Court also extended accommodation to include for-profit organizations that have objection to providing contraception.[842] The basic qualifying criteria include the following:

- The organization is not nonprofit.
- The organization has no publicly traded ownership interests.
- More than 50 percent of the value of the ownership interest is directly or indirectly owned by five or fewer individuals.
- An organization that has substantially similar ownership structure as described above

can also qualify for the accommodation. To make clear of the eligibility, when the ownership interests are held by members of a family are considered as a single individual.

2. Voicing the Restriction on Eligibility

Guidelines and procedures for requesting eligibility for contraceptive exemption were written clearly that organizations may adopt as part of healthcare process. However, religious groups had their reasons to oppose the accommodation. They claimed that the accommodation still restricts them from fully expressing their religion in this matter of not providing contraception to their employees. They argued that notifying insurance companies for requesting the accommodation will result in the government using their insurance plan as a vehicle to provide the morally wrong contraceptive coverage to their employees.[843] Although religious employers were not required to pay for contraception, however, the contraceptive coverage would still be part of the employers' plan. The U. S. Court of Appeals for the District of Columbia Circuit rejected the challenge by the religious groups stating the small amount of paperwork to submit for accommodation is minimal as compared to the requirements that other nonprofit organizations had to comply. The court further expressed that writing a letter or submitting a two-page form allows religious groups to express their beliefs in action. It appears that the court considered this matter from the angle of administrative work while the religious groups were advocating their absolute refusal to take any part in the policy of contraception provision based on their moral values and conscience. To the religious groups, providing

the required notice was still causing them to commit an action that they deemed as sin,[844] which is to "trigger" the insurance coverage for contraception. What they sought in an exemption was that their employees would not be provided with any contraceptive coverage. It should not be misunderstood that they were seeking financial relief; rather, they devoted to upholding their religious faith. Their religious conviction mattered to them that they objected the accommodation which would exempt them from the mandate but still entitled full contraceptive coverage to their female workers.[845] In their perspective, they would be forced to take part in the contraception provision. Religious groups intended to continue their effort in seeking court decisions to remove contraceptive provision in their organizations.

b. Needing More Provision of Women's Health Services

ACA policies aim at providing health care to all men and women. This involves providing health care that meets their health needs.

i. IOM Recommendations

Institute of Medicine (IOM) released their report in July 2011 advising preventive services for women.[846] IOM promotes optimal health by recommending women's preventive services ranging from well woman visit to screening to contraception. These services are in line with the goal of ACA to provide health care to men and women of all ages. IOM noted medical research for women's health needs received less attention as compared to men. Health care premium is reported higher for women than for men. The

difference can reach as high as 48 percent.[847] However, female population was slightly more than half of the total U.S. population in 2010.[848] The lack of research on women's health needs has decreased the availability of health information that could improve their quality of health.[849]

1. Validating the Gap in Women's Healthcare

In recent years, health topics have extended to include discussing women's health. Health articles have become more open to discussing issues such as menstrual cycles, pregnancy, birth control, menopause, heart disease, breast cancer, ovarian cancer, and osteoporosis.[850] That led to the alert of preventive care that includes screening and preventive measures. However, it is noted many women forgo preventive care because they cannot afford copay or do not have health insurance. Women with low socioeconomic status often have difficulty getting health coverage. They are more likely to suffer chronic illnesses and have overall poor health. They also have lower education level leading to lower paying jobs resulted in less likely to have health insurance. In comparison with women who have higher education, women with lower level of education are less likely to use preventive services.[851] Another study indicates there are health issues across the lifespan among women.[852] It noted the younger female group needs usual care, women begin to suffer chronic health problem in ages between 45 and 64, and multiple health issues are seen in their elderly years. It is apparent that attention on women's health is needed.

One of the reasons why women's health has been neglected is the lack of research

study to increase knowledge and understanding. This is being acknowledged by the Institute of Medicine, and effort has been made to make changes. Enrollment of women in clinical research studies increased from 9% in 1970 to 41% in 2006.[853] In clinical trials that enrolled both males and females, female enrollment has increased from 18% in 1970 to 34% in 2006. Women have been particularly included in studies on hypertension, diabetes, stroke, heart failure, coronary artery disease, and hyperlipidemia. Studies found that women accounted for 53% of all individuals with hypertension, 50% with diabetes, 51% with heart failure, 49% with hyperlipidemia, and 46% with coronary artery disease. It is now recognized that cardiovascular disease (CVD) is a major cause of death among women.[854] However, there is still a gap in knowledge and understanding of CVD as well as prevention and treatment. In 1993, the National Institutes of Health Revitalization Act required clinical trials to include both women and men in diseases that affect both genders.[855] The purpose was to generate data to evaluate the efficacy of treatment for both men and women.[856] Despite the legal requirement, recruitment for women in National Heart, Lung, and Blood Institute trial studies did not meet the expectation.[857] Even the Food and Drug Administration became interested in promoting inclusion of women in clinical trials to learn whether the safety and effectiveness of new drugs vary in male and female.[858] It was noted CVD prevention guidelines for women were based on 13% of research studies that involved all-male participants. One important aspect to consider in the case of medicating women and men is that dosing should be based on body weight, renal function, underlying risk profile that may influence the risk-benefit ratio.[859] This is the area of concern when medicating male and female because of their

pathophysiological differences.[860] It justifies seeking more knowledge in understanding women's health.

2. Women's Preventive Care Supported by Studies

Women's health has gradually received attention in the United States. Various studies have devoted to studying the complexity of women's health and concluded women bear burden of certain diseases[861] such as STD including Chlamydia trachomatis infection which can lead to pelvic inflammatory disease, ectopic pregnancy, infertility, miscarriage, premature birth, infant mortality, and neonatal infection.[862] For the case of Chlamydia, all 50 states and the District of Columbia require reporting the infection. Because of high prevalence of Chlamydia and the nature of the infection is asymptomatic, United states Preventive Services Task Force recommended routine screening in 2001. The guidelines specifically recommended screening all sexually active women under age 25. The Centers for Disease Control and Prevention has recommended annual screening for women through age 25.[863] In the United States, the second leading cause of cancer-related death among women is breast cancer.[864] Researchers indicates mammographic screening can possibly reduce mortality by 20-35% in woman between ages 50 and 69.[865] The recommendation by the U. S. Preventive Services Task Force for screening mammography for women ages 50 to 74 is biennially.[866] For women aged 40 and older, The Task Force recommends breast mammography every 1-2 years with or without conical breast examination. The goal is to reach 70% of mammography screening for women age 40 and older. Cervical cancer is the second most common cancer among

women. The incidence has decreased by almost 50% in the United States since 1970s because of the widely use of Pap smear.[867] However, higher risk for occurrence is associated with the failure for regular screening.[868] The American Cancer Society recommends routine screening at regular intervals among women aged 21 to 65.[869]

Healthcare for young adults is important as they transition from adolescence to adulthood.[870] The focal years for this population are between ages 18 and 25. Although individuals in this age group have reached developmental ability as well as maturation of brain system,[871] they are often seen to be at risk for health-damaging behaviors, mental health problems, substance abuse, and sexual transmitted infections.[872] These health problems are noted to be preventable. Primary care providers can perform preventive screening and early intervention to improve the health of young adults.[873] However, record shows that young adults are the age group that is less likely to have health insurance and receive preventive care[874] resulted in low screening rates for critical health areas such as injury, mental health, obesity, and sexual transmitted infections.[875] Although there is no specific preventive screening for young adults, the Task Force includes recommended preventive services for individuals aged 18 or older. These guidelines for preventive services are evidence-based recommendations. Most of the recommended health services are beneficial; it is noted contraception and gestational diabetes screening can reduce healthcare cost.[876] Under expansion of ACA, young adults up to age 26 can stay in their parents' insurance so that they can receive preventive care.

ii. Women's Health Concerns

Research in recent years found that harmful behaviors such as smoking, poor diet,

and sedentary life style contribute to a great number of deaths among U. S. women. For women, tobacco use has been documented to increase the risk of cancers of the cervix and vulva as well as complications including menstrual problems, reduced fertility, and premature menopause[877] in addition to the commonly known risks of cancers of the lungs, esophagus, stomach, bladder, kidneys, and pancreas that affect both men and women. The report also points out women are at higher risk and also experiences more complications than men for most sexual transmitted diseases resulting in infertility, ectopic pregnancy, and chronic pelvic pain. On pregnancy, it poses physical and psychological health concerns as well as financial burden on women. These findings indicate women's health cannot be overlooked.

1. Pregnancy Complications that Involve the Mother's Health

Pregnancy adds on significant stress to the mother's body. Women who are usually healthy may still encounter health problems during pregnancy. These health problems can jeopardize the health of the mother and also make the pregnancy a high-risk pregnancy.[878] High blood pressure is often seen during pregnancy. The condition occurs when arteries become narrow causing pressure to increase in the arteries. It affects both the mother and the fetus. For the fetus, high blood pressure affects blood flow to reach the placenta which supplies nutrients and oxygen to the fetus.[879] For the mother, it increases the risk of preterm labor and preeclampsia.[880] Even women who do not have high blood pressure before pregnancy will need to be put on medications during the pregnancy. Preterm labor can be caused by multiple conditions including, but not limited

to, infections, shorter cervix, or high blood pressure. Women who are at risk for preterm labor may have to take progesterone to prevent, slow, or stop preterm birth.[881] Gestational Diabetes is referred to a health condition in that the pregnant woman normally do not have diabetes but develop the condition during the pregnancy. The normal process is for the body to digest food into glucose and move the glucose into the blood. Glucose is used as the body's main source of energy. From the blood, glucose moves into the cells. The Pancreas releases insulin which carries glucose into the cells. In the condition of gestational diabetes, the hormonal changes in the pregnant woman affects the production of insulin resulting in less glucose is being moved into the cells. Glucose then builds up in the blood causing high blood sugar. High blood sugar can cause heart disease, vision problems, and kidney disease.[882] Other complications such as severe and persistent nausea and vomiting. Although it is a normal experience in pregnancy, severe condition can cause weight loss, dehydration, and feeling faint.[883] In serious cases, the pregnant woman may need to be hospitalized to receive fluids and nutrients. Iron deficiency is also common in pregnancy. During pregnancy, the woman needs more iron to boost the increase production of blood volume. Depletion of iron causes symptoms of shortness of breath, fatigue, and paleness.[884] Mental health problems are often experienced by pregnant women. Depression and anxiety are the most common conditions seen in pregnancy.[885] This is due to the changes physically and psychosocially. Pregnant women experience the responsibility of bearing the child, the physical discomfort, the hormonal changes, the fear of childbirth, the change in her role, the change in relationships, and the lack of support. These issues can cause the pregnant woman to feel depressed and

anxious. It is also worth noting the complication in teen pregnancy. Pregnant teens are likely to develop high blood pressure, iron deficiency, and early labor.[886] The pregnancy and labor and delivery can be further complicated by exposure to sexual transmitted disease or infection that can affect her health. Teens are less likely to get prenatal care and understand medication safety.[887] This put them in a serious health risk during the pregnancy. Pregnant women endure a significant ordeal both physically and psychologically during their pregnancy. Providing them with preventive care that includes contraception is crucial to their health management.

2. Health Conditions Affect Women Differently Than Men

Women's health problems are unique mostly due to the conditions of the reproductive system. Thus, health issues affect women differently than they do men. Although men and women may encounter a lot of the same health problems, the course of the disease process is different in women than in men.[888] The following few areas are examples that worth noting:

- As compared to men, women are more likely to die after a heart attack.

-Women are more likely to suffer urinary tract infection than men.

- Osteoarthritis strike more women than men.

- Women are likely to show signs of anxiety and depression as compared to men.

- Women suffer more serious effects of sexual transmitted disease than men.

There is explanation regarding the different health effect in women than in men. It was mentioned previously that heart disease is the leading cause of death among women in

the United States. In regards to heart condition, one study concludes that 52% of women delayed emergency care.[889] Also, postmenopausal women are at high risk of heart attack due to uncontrolled cholesterol levels.[890] As for mental health, women are prone to experience stress and depression as compared to men. Noted determinants such as their susceptibility and exposure to certain mental health risks.[891] They are likely to delay getting treatment. According to the National Cancer Institute, 12.4% of women in the United States face the risk of breast cancer in their life time[892] as compared to 1% of men who are usually diagnosed between the ages of 60 and 70.[893] The alcohol effect is more serious in women than in men. While the common disposition of alcohol abuse in men and women is addiction or dependence, women have increased risk for breast cancer, heart disease, stroke, and fetal alcohol syndrome.[894] Another experience that demonstrates the different affect in men and women. New evidence shows that aspirin works differently in men than women. It decreased first heart attack in men and first stroke in women.[895] Although incidence of stroke occurs to both men and women, 55,000 more women suffer a stroke than men each year.[896] The risk factors for women include taking birth control pills, being pregnant, using hormone replacement therapy to relieve menopausal symptoms, having frequent migraine headaches, bigger waist line during post-menopausal, and high triglyceride levels.[897] Women suffer urinary tract problems more frequently than men. In fact, women face a lifetime risk of greater than 50 percent of having urinary tract infection and urinary incontinence due to the structure of female urinary tract.[898] On the contrary, urinary tract infection is not as common in men. As presented here, women's body system is unique and required ongoing healthcare

throughout her lifetime.

Section Three. Protecting the Religious Identity of Organizations.

Catholic tradition promotes the provision of healthcare services to all people. However, one provision in ACA contradicts the Catholic teaching. This section discusses the issue of contraceptive mandate.

a. The Reaction Regarding the Contraceptives Mandate

The response to contraceptives mandate includes a strong reaction from the leadership of the Catholic Church.

i. Contraceptives Mandate Violates Religious Liberty

The contraceptive mandate received forceful opposition from US bishops and the Catholic Health Association. Their arguments were based on that the mandate violated their religious freedom and conscience rights. On the same day of the announcement of the contraceptive mandate, Bishop Timothy M. Dolan, a soon-to-be Cardinal, responded by saying the new mandate is unconscionable; for it would force Americans to either violate their consciences or forsake healthcare.[899] He continued stating that the mandate was an attack on religious freedom and on access to healthcare. The mandate would pose a challenge to religious liberty and require American citizens to compromise with their religious conviction. His response came after the knowledge of contraceptive mandate also involved the demand of providing sterilization and abortifacients. These measures

are directly against the Catholic faith and the Catholic teaching. When including contraception, sterilization, and abortifacients in preventive services, pregnancy is viewed as a disease to be prevented. The government responded swiftly by allowing religious organizations to decline contraceptive coverage but demands the insurance companies to provide contraceptives without cost.[900]

1. Religious Liberty

United States is known in the world for religious liberty. The signers of the U. S. constitution believed strongly the right to religion and made it an official law in Amendment I of the Bill of Rights to allow freedom of religion.[901] The importance of religious freedom is because it allows one to express his values, moral, and conviction in his speech and conduct. These are the critical elements for forming one's perspective and principle leading to a particular standard of living. In history, the importance of religious liberty was played out in the conflict between the Roman Catholics and Protestants during the Protestant Reformation in Europe. Martin Luther was the leader in the reformation. Luther stood firm on his belief against the doctrine of Catholicism in the 16th century. He was summoned to Imperial Diet and told to recant his teaching. He would not recant his theses when he was pressed with pressure and faced punishment. Instead, he voiced his conviction by saying, "…my conscience is captive to the Word of God. I cannot and I will not recant anything for to go against conscience is neither right nor safe. God help me. Amen."[902] Martin Luther's refusal to deny his belief even in the face of punishment is an example of what it means to express one's religious conscience and

deep conviction. After nearly 30 years of conflicts, then came a realization of a conviction that Protestant should have liberty to express and practice their faith.[903]

The right to religious freedom is important in a free society. It allows people to practice their religious faith. After all, the American settlers came to the New World seeking freedom of religious worship, and the religious conscience was initially based on the Protestant Christian faith.[904] Holding firm on their religious faith was a strong practice among them. Even the first president of the United States, George Washington, prayed for the nation asking God's protection over the people and the land.[905] Religion was respected in society from peasants to government officials. Benjamin Franklin openly acknowledged God in his speech in the Constitutional Convention "…the longer I live, the more convincing proofs I see of this Truth- that God governs in the Affairs of Men. I also believe without his concurring Aid, we shall succeed in this political Building no better than the Builder of Babel. Have we now forgotten this powerful Friend? Or do we imagine we no longer need His assistance?"[906] The belief in putting God in the center of everyday matter was strongly promoted. The signers of the Constitution defined religious liberty in Amendment I as the free exercise of religion without prohibition by the government.[907] Further details on religious liberty was established in modern time. In 1993, the Religious Freedom Restoration Act was enacted.[908] The new federal law guarantees individuals to practice their religion without substantial burden from any agency, department, or official of the United States or any state government. The exception is in the situation of a compelling governmental interest. In such incident, the least restrictive means to satisfy that compelling governmental interest must be used. The

law has clearly stated each person in the United States is allowed to freely exercise his religion.

2. Religious Conscience

Catholic belief supports universal healthcare based on the concept of human dignity. Human dignity is satisfied when certain conditions are met. In 1942, Pius XII declared human dignity must consist of basic personal rights.[909] Among them, a few areas of personal rights can be used to support patients' right to healthcare access and physicians' choice to refuse services. For patients, healthcare should be provided based on the right to maintain and develop one's body and the right to the use of material goods. For physicians, they have the right to refuse objectionable services based on the right to intellectual and moral life and the right to worship God. It acknowledges the human rights to healthcare, at the same time; it supports the right to uphold personal moral values such as in the action of refusing services that contradict one's faith.[910] Pius XII's writing indicates equal value of every human being; in this case, the patient and the physician have their right to express what is meaningful to their own life.

The teaching of the Catholic church explains that conscience is present at the heart of the person. It is a law of the mind that give judgment at the appropriate moment to do good and not evil.[911] Formation of conscience should be derived from the Word of God. One of the principal documents of Vatican II, Gaudium et Spes (GS), describes conscience rests deeply in a man and draws him to obey its prompting.[912] It is an inward voice that calls the person at the right moment to make decisions that follow God's

commands. With consistent and persistent abiding by one's conscience, there arise the right solution to many moral problems because it enables us to take responsibility for our actions. The Church always teaches believers to hold firm to their religious conscience for it is the sanctuary of the man.

The contraceptive provision in ACA violates the catholic conscience as it mandates healthcare providers to take part in abortive action. Cardinal Dolan wrote to both Houses of the United States Congress on February 8, 2017 urging support for the Conscience Protection Act of 2017.[913] He stated the Conscience Protection Act would protect the rights of healthcare providers in their service to patients. It would ensure them to provide healthcare coverage without being mandated by the government to perform service that would kill unborn children. Although existing federal laws are meant to protect conscientious objection to take part in abortion, the law has not proven to be effective in practice. The Conscience Protection Act provides the detail protection that is lacking in the existing laws. This proposing law guarantees the healthcare providers the right to legally defend themselves. For instance, many obstetric physicians refuse to perform abortion. They should be able to defend their conscience while serving as physicians. It is even included in the Hippocratic oath to reject abortion when serving in the profession of medicine.[914] A clear protection in the law for healthcare providers can facilitate life-affirming healthcare treatment. On the contrary, mandating healthcare that includes abortion service will undermine access to lift-affirming healthcare in America.

ii. Upholding the Catholic Faith

The historical Catholic teaching on contraception has been consistent for the past

centuries. The church position on the issue had a distinctive contribution to moral theology in the second half of the twentieth century.[915] The official teaching disallows deliberate actions taken to prevent conception. That includes contraceptive devices and oral drugs. It further concludes the deliberate avoidance of sexual intercourse during a woman's ovulation time is also wrong.[916] Beginning with Augustine, the conception of a child was the sole reason for sexual intercourse. Any other reason (sexual pleasure) to engage in sexual act was deemed as sin. His theological reason, thus, forbade any preventive measure for conceiving a child. Until 1951, Pope Pius XII declared permission for married couple to intentionally postpone conception due to serious reasons such as medical or financial.[917] However, he upheld the forbidden use of artificial contraception because they prevent sexual act from conceiving a child. Here, the strong value of procreation is explicitly expressed in the Catholic faith.

1. Forbidden Use of Artificial Contraception

The Catholic Church has always been in opposition to contraceptives. Other Christian traditions also in favor of prohibiting contraception. Birth control was associated with condemning sins such as adultery and promiscuity. In the 1930s, the position on birth control began to change.[918] Protestant churches began loosening their stand in opposition to contraception. However, the Catholic Church continued to hold its ground. To understand the reason behind the opposition of the Catholic Church, it is important to examine the Church teaching on human sexuality. Pope Paul VI wrote on this topic 25 years ago intended to explain human sexuality from God's perspective in the

modern world.[919] The current trend perceives sexual activity as a natural response to human instinct and human need. The sexual desire can be carried out by the help of medicine to avoid unwanted pregnancy. It is then people seek to be free from the Church teachings regarding contraception. Such view is incomplete. Human sexuality is not merely a natural response to human instinct and human need; it must include the consideration of human life and the human spirit. Human sexual activity is the process by which life is conceived. God created sexuality for men and women to fulfill the purpose of procreation. It is meant to unite a man and a woman into a union to experience God's design of love.[920] Through this union of marriage, men and women might better understand and appreciate God's love for them. In this context, human sexuality with human dignity is understood as a way married couples express their love for each other. With the understanding of sexuality as a gift from God, the married couples strengthen their relationship through sexual union and reach a deeper level of life of intimacy. As a result, the positive openness to life occurs at this peak of their loving union and children are born. These children are the testimonies of both their parents' love and God's love. They are God's creation who endow insurmountable dignity to fulfill their human destiny. For this reason, couples should make decision regarding spacing births free of pressure from cultural attitude and current trend of birth control use. Instead, they should consider with correct value their responsibility to God, themselves, their family, and the society. Currently in the United States, there occurs the incidents of non-marital cohabitation, out-of-wedlock pregnancy, abortion, and divorce. These situations reflect the non-biblical understanding of human sexuality. Many people have viewed sex as a

mechanism of personal pleasure which diminishes personal commitment and the value of human life. The use of artificial contraception enables them to satisfy personal pleasure without fulfilling responsibility and commitment to sexual partners. This is a destructive mentality that diminishes human love and marriage. Catholic teaching speaks against unrestrained satisfying sexual instinct for merely pleasure and enjoyment[921] and maintains that the two aspects of sexual activity are the strengthening unity between the couple and the procreation of children.

2. Prohibiting the Termination of Life

Catholic social thought regards healthcare as a right to support life and living. Every man has the right to life, which entitles him to the means of food, shelter, medical care, and social services. However, it does not mean that all treatments are rendered without question. As mentioned earlier, moral theology is present in the teaching of medicine. The obligation of physicians to do good and not harm is influenced by the moral principles. The Roman Catholic Church also has long tradition regarding moral in medicine. For example, based on the fifth commandment that forbids killing, Catholic teaching prohibits any form of medical procedure that voluntarily terminates life including abortion, euthanasia, and sterilization.[922] Because these issues are significant to one's faith and personal values, several Catholic theologians address them using philosophical and theological principles. In addition, other studies also deal with the topic of birth control. All of them are in support of physicians' actions to refuse services in those areas.[923]

Catholic teaching based the prohibition of terminating life on the fifth commandment that forbids killing.[924] The Church holds the view that human life is sacred. It is sacred because the initial creation of life revealed God's design and plan. The profound connection between God and man was formed, and the relationship was tied forever. God, the Creator, initiated life and shall be known as the Lord of life. He holds life from the beginning until its end. No human shall claim the right to intentionally or directly destroy life. An incident in the Bible clearly describes God who holds the authority over man's life. In the biblical story of Cain murdering his brother Abel out of jealousy and anger, God judged Cain's action as evil. God made known to Cain that the murder did not go unnoticed. Because Cain ended his brother's life, he was punished as he was now cursed from the ground. It is written, "Surely I will require your lifeblood; from every beast I will require it. And from every man, from every man's brother I will require the life of man. Whoever sheds man's blood, by man his blood shall be shed, for in the image of God He made man."[925] It should be noted that blood has the meaning of a sacred sign of life in the Old Testament. God's response to Abel's murder and Cain's punishment showed His respect for human life. Clearly, human life mattered to Him, and no man shall kill an innocent life. It then becomes the fundamental principle of prohibition against the killing of the innocent. Killing an innocent life is now deemed as contrary to the rule of the Creator. One may argue stating killing does occur in the case of self-defense. In that case, one life is preserved and the other is killed. It is important to understand that the former is intended and the latter is not. The fundamental principle of morality defends the love towards oneself. Hence, he is not guilty of murder if he has to

kill the aggressor in order to preserve his own life. In all, God's love teaches us to respect human life and to protect life from the moment of conception to its entire existence.

b. Permitting Abortion

There are exceptions to some forbidden practices in Catholic teaching. This section presents the reasons and conditions that allow such exceptions.

i. Catholic Faith in the Secular World

Direct abortion is deemed intrinsically evil and prohibited according to the Catholic teaching. However, it is seen that Catholic teaching allows voting for laws that also support abortion. This is a situation when the principle of cooperation can be used to explain how Catholic values are upheld in secular practices.[926] The Church mission, according to the US bishops, is to shape society, transform the world, and promote the common good.[927] The Church is to spread the message of God in the society, which requires taking an active role in society and interact with secular organizations without forsaking the Catholic conviction.

1. Symbol of the Church

The Catholic Church beholds Jesus Christ as the head of the people in the church assembly.[928] The Church explains Jesus Christ as the Shepherd and the people are His sheep. Hence, Christ leads His people, the flock, by unfailing nourishing. Christ is the good Shepherd, who gave his life to His sheep. More precisely, his death on the cross, the

raising from the dead, and being glorified by the Father give meaning to the community of believers. He willingly became the sacrificial lamb to atone the iniquity of His people. Only Christ has the power to forgive the sin of men and save them from eternal damnation.[929] Christ himself said He came to the earth not to be served but to serve, and to give His life to save many. It was to fulfill the will of the Father's plan of salvation. Such love can only be found in God alone. Christ is the symbol of love, and the Church should represent that love. It is God's desire for His people to be cared for in the church by human shepherds. Christ is also described as the vine and the church is the vineyard where those who abide in the vine will bear fruit in their life. On the contrary, one can do nothing away from Christ. Then church is a place where people learn about the life of Christ and follow His example to love others. Those who are called together in the "family of God" share the divine life of Christ, which is purposeful according to God's plan. It should be that the family of God consists of a diverse group of people is held together by their faith in Jesus Christ and the teaching of the Pope who is the successor of Saint Peter whom Christ appointed to be the first head of His church.[930] The Church teaching centers on Christ's love and advocate that love by supporting the right to life, rights of workers, defending the rights of oppressed people, and opposing uncontrolled capitalism.[931]

2. The Church Mission

The Son of God came to earth to accomplish the task of salvation and instructed His people to make disciples by preaching the gospel.[932] This is the mission of the

church. Through the help of the Holy Spirit, His people are able to follow Christ's teaching of charity, humility, and self-denial in obedience to proclaim the kingdom of God. The church and the people are the seed of that kingdom and have the calling to serve God by reaching out to others. Archbishop John C. Niendstedt commented on the mission of the Church stating Catholics hoped to grow their faith and to maintain a sense of hopefulness as they continue the works of Jesus Christ.[933] Doing mission means to be sent out into the world to represent Christ in works such as preaching, teaching, and acts of charity, and justice. Non-Catholics might perceive the mission of the Church is to gather people to form social clubs or political arenas. In these cases, the Catholic church is either gained favor by the public for providing a venue to meet the modern culture or criticized for its political stand.[934] Neither of these are the focus of the Church. The Church has long been teaching on reaching out to the poor and needy. Pope Francis once reminded the Bishops to preach the message to the church regarding the united effort to reach out to the poor saying it should be "the essential element of the Christian life."[935] This ideal should be in the hearts and on the minds of believers so that it would reflect in every aspect of life. He continued saying more young people would be touched by the love of Jesus if the church is represented as a place of love. In his 1990 encyclical, Saint John Paul II wrote that the Church should set its mission to be a church of the poor.[936] He quoted the teaching of the Beatitudes of Christ particularly in 'Blessed are the poor in spirit' to emphasize the importance of reaching out to the poor. Because the 'Blessed are the poor in spirit' is first mentioned in the Beatitude, it follows that the mission to reach out to the poor takes priority. The sense of mission urges a call to the wealthy to

remember the poor. Just as Jesus came to the earth to serve and teach, so should the church to follow His example in practice. Pope Francis asserted that Christians are to continue such mission in anticipation of Christ's return.[937] The mission to serve the poor is considered a type of evangelism that proclaims the Gospel for the purpose of drawing men and women to Christ. The Gospel reveals the love of God that was revealed in salvation through Jesus Christ. When considering the number of people who do not know Christ and are not a part of the Church, the urgency of the mission is ever greater. Seeing this large portion of humanity who is loved by the Father and do not yet know Christ should inspire and motivate the work of mission. Hence, participating in mission is essential and not optional for all believers. This is the reason why the Catholic Church habitually care for the poor on multiple levels. It is also the reason for supporting healthcare for all.

ii. Voting for Laws that Support Forbidden Practices

In the matter of justifying legislators who vote for laws that also support abortion, Pope John Paul II explains that the attempt to completely overturn the abortion law will not succeed. Rather, the effort should be put on reducing harm by improving protection for unborn human life resulting in decreasing the negative impact of the abortion law.[938] When a legislator has a personal ambition to oppose abortion; voting for him will help support his proposal that aims at reducing the harm from the abortion law. The principle of cooperation can apply in this scenario so long as the pro-life legislator who votes for a law that permits abortion has the intention to limit the harm done by legislation regarding

abortion.[939] It allows Catholics to vote for legislators who advocate many good services and, at the same time, support abortion.

1. Political Responsibility of Catholics

The faithful Catholics have the responsibility to exercise their rights and duties as participants in the democratic society of the United States. The Church teaching provides guidance to civil duties in participating political election in light of religious conscience. For Catholics, the first and foremost commitment is Jesus Christ whose precepts should be upheld when participating in political activities. Quite often, social and political issues threaten the welfare of the people. It calls for the reminder to place the needs of others ahead of selfish desire as a demonstration of God's love.[940] Pope Francis explains the connection between the behaviors of the Catholics and social involvement. He asserts that redemption of Christ is for both the individual and social relations.[941] There is an inseparable connection between salvation and the Father's love which stirs the concern for the welfare of others. Christ considers the service to the public as a service to Him. This is to fulfill Christ's commandment to love one another. God's spirit is at work in everyone extending to every human situation and social connection. Being loved by God at the initial time, Catholics are called to live everyday life according to that love and demonstrate it through seeking the good of others. The obedience to God helps us to appreciate the earth and to love the human family. All dwellers on this planet are brothers and sisters to each other, and the Church must participate in seeking justice for them. The gift of hope from God is the motivation for fighting for social justice.[942] Then the

confidence is in God when serving the public to seek the common good with joy and hope. Political issues present opportunities to serve the public, at the same time, poses challenges to religious reliefs. As the Church reaches out to serve life, the right to life is not fully protected in the United States. There is injustice in killing unborn children and neglecting the needs of the elderly and the terminally ill. In these situations, the Church teaches how to form consciences in accordance with God's truth. The life of Jesus Christ and His teaching shows the true meaning to be human. His sacrificial love reveals human dignity in full clarity that compels the conviction to protect life.[943] It also teaches us a balanced understanding of dignity, rights, and duties. In Catholic Tradition, participation in political life is a moral obligation based on the commitment to follow Jesus Christ and to bear Christian witness in a secular world. It is important not to be attached to a political view that will transform perspective in a way to deny the fundamental moral truths into approving evil acts. This becomes the center of the Catholic moral and social teaching. The Church teaching helps form consciences in political life that advocates justice. It is particularly helpful when the issue creates conflict between policy and personal beliefs. Even in such situation, the Church discourages nonparticipation in politics as it will forsake the fight for justice.[944]

2. Difficult Political Choices

Making political decision requires the exercise of conscience. It means to follow the resounding voice of God in the human heart to do good and not evil. At times, the exercise of conscience might come in opposition to the public policies that contradict the

protection of human life. The direct support of such legislation is a violation of moral principles and religious conscience.[945] For existing laws that contradict religious conscience may restore partial justice if the possibility occurs for amendment or change in practice. Pope John Paul II spoke of his insight in such situation. When a pro-life government official cannot successfully overturn a pro-abortion law, the prudent judgment is to seek ways to improve protection for unborn human life. This will actively decrease the harm done by the law resulting in less negative impact.[946] The gradual or partial improvement of justice is acceptable as it is making progress in restoring justice. The intention should always be seeking full protection for human life as it is the moral requirement. Catholic teaching is against voting for candidate who favors and support a policy that produces evil act such as abortion, euthanasia, mistreating the poor, gay marriage, or racial prejudice. Voting for such candidate would be considered guilty of formal cooperation. However, there is a condition in that the candidate's political position favors and supports policies that promote evil act but he also works to promote good moral causes in other policies. In such case, it is permissible to vote for this candidate for the reason of good moral causes. When all candidates support policies that promote evil act, the next step is to carefully review their position on those policies and choose not to vote for any of them if there is no good moral cause. Another possibility is to vote for the candidate who has no intention to advance the policies that produce evil act but very likely to pursue other policies that promote greater good for humanity. Making a prudent decision in these situations is a difficult task. It is important to form conscience based on moral teaching that recognizes all political issues carry different moral weight. There is

room in consciences to consider each situation separately as it could have different effect in actions. It is wise to carefully examine the candidate's character, integrity, commitments, and ability to influence the political issues will help identify the candidate's true intention for moral causes. The participation in political voting is important, and the challenges should not be the reasons to avoid it. As Pope Benedict XVI encourages us to take part in political position as it will publicly demonstrate the faith in Christ.[947] He asserts that the political choice should be based upon the fundamental values that defend unborn children from conception to natural death, the institution of marriage between a man and woman, and the promotion of common good. The diminished effects in these areas demands social justice, and involvement in voting for public policies is a way to fight for justice.

Section Four. The Principle of Cooperation

This section discusses the right to preventive care without violating religious conviction.

a. Categories of the Principle of Cooperation

Allowing forbidden services involves the use of cooperation. The following discussion includes categories of the Principle of Cooperation.

i. Settling the Conflict

Catholic teaching advocates health care services for all people; yet abortion,

assisted suicide, sterilization, and artificial contraception are forbidden. However, United States is a pluralistic society that allows these religiously forbidden services. The issue is whether the Catholic organizations can work with the government that provides forbidden services. Seeking to live with convictions among secular practices, the Catholic tradition approves specific compromise justifying certain proscribed practices. For example, the Catholic tradition allows killing in some circumstances based on the ethical theory of just war. The action of killing is justified in a specific circumstance while the ethical principle of violence is upheld. Cooperation is a possible way to settle the conflict between Catholic values and secular practice.[948]

1. Justifying Killing While Forbidding Violence

There are times when killing is allowed while forbidding violence is upheld. Catholic teaching forbids direct killing based on the Fifth Commandment that clearly states "Thou shall not murder."[949] This serves as the underpinning of the moral standard of taking an innocent life. It is also written in the Word of God that the human body is the temple of God. Hence, direct killing of an innocent life destroys the foundation of God's dwelling. It follows that direct Abortion is never morally tolerable as it is a violent act against a woman and her unborn child. As it is understood, direct act of killing violates the fundamental right to life.[950] However, there are circumstances in which killing is unavoidable. For instance, a soldier faces his enemies in the war. The soldier is put in a situation where he will be killed if he doesn't strike down his enemies to protect his own life. This is the reality in a war. The Church teaching explains how killing is justified in

this scenario as long as violence is not intended. In this scenario, the primary duty of a soldier is to bring peace and not to kill. If during the call of duty that the soldier faces his enemy who will not hesitate to kill him. The soldier is now facing the danger of "to kill or be killed." The Church teaching permits killing unjust aggressor in self-defense and deems the action morally acceptable.[951] It follows that killing an aggressor to defend and protect others is also permitted. Killing under these circumstances is based on love and no evil intention. Rather, faith is seen in soldiers who love their country and its people to risk their lives to protect peace and freedom. If there is no other solution besides killing the aggressive enemies, the killing in self-defense is justified. Another example is the role of police officers whose duties are to enforce security and safety. They are not called to dutifully draw weapons to kill. When circumstances arise that threaten their own safety or the safety of others, firing their weapons is considered a just reason. It should be reminded that the duties of both the soldier and the police officer contribute much to the common good. In the above scenarios, the action of killing satisfied the three minimum conditions stated by St. Thomas Aquinas: 1) the killing is in defense of the common good; 2) the killing has a just cause; and 3) the killing is not stemmed from vengeance to cause harm.[952] These types of killing are acceptable because there is a distinction between justified killing and murder. Murder is a sin based on the Fifth Commandment and the command not to kill the innocent and just[953]. Murder is the opposite of Christ's desire to draw for peace of heart. It stems from anger and hatred which are deemed immoral.[954] On the other hand, killing in self-defense or killing for the purpose of protecting others stems from love. When the conflict cannot be resolved by peaceful means, killing in self-

defense the last and only option in a life-and-death situation.

2. A Case Study of Compromise

This is a case of compromise between Seton (Catholic facility operated by the Daughters of Charity of St. Vincent De-Paul) and Brackenridge Hospital (public hospital).[955] The case took place in a region in Austin, Texas where services are primarily provided for indigent patients. The tax-supported public hospital carried majority of women's reproductive services including sterilization and contraception. The conflict between the Catholic organization and the hospital was regarding the use of reproductive services. Although Brackenridge Hospital served the main role in providing health services for the poor patients, the hospital was $61 million in debt. The consolidation agreement between Seton and Brackenridge Hospital included an initial payout of $10 million by Seton and an annual $2.2 for leasing Brackenridge building and consolidate services. The city agreed to pay Seton an annual $5.6 million for providing charity services at Brackenridge. The issue was that Seton complied to the moral objectives of Ethical and Religious Directives for Catholic Health Care Services that developed by United States Conference of Catholic Bishops. These religious directives forbid the use of contraception, sterilization, abortion, in vitro fertilization, and artificial insemination.[956] However, the Ethical and Religious Directives allowed indirect involvement in these services in the case when Catholic hospitals became partners with non-Catholic institutions. Brackenridge was adamant to keep providing all reproductive services except abortion. Seton needed to present the hospital requests to the local bishop

who took the responsibility to communicate the issue with the Vatican's Congregation for the Doctrine of the Faith. The local bishop and Seton's leaders also consulted four healthcare ethicists to study the lease agreement/arrangement making sure it was in compliance with the Ethical and Religious Directives. It was explained that the lease did not mean ownership; it gave certain rights and privileges to Seton without a full Catholic identity. Brackenridge would retain ownership. Gerard Magill, an ethicist, studied and analyzed the Seton/Brackenridge partnership using Catholic Tradition of social justice and the Ethical and Religious Directives. It stated in Directive 69 that Catholic institutions may be involved in services that were prohibited by Catholic teaching based on the principle of material cooperation. Using material cooperation allows participation in forbidden services that might bring greater good to the community so long as Seton did not intend evil act. Then the good outcomes (Brackenridge would continue to serve the indigent population) outweighed the bad effects (violation of moral objectives). Magill explained that Seton neither promoted the forbidden services nor preferred them in the hospital, it showed Seton had no intention for evil act. Vatican was not convinced that Brackenridge did not carry a Catholic identity after the contract was signed and insisted that all sterilizations and contraceptive programs be discontinued. Brackenridge claimed the right to continue all reproductive services as stated in the contract.

The Vatican gave instruction to revised the Ethical and Religious Directives adding the participation in immediate material cooperation in abortion, euthanasia, assisted suicide, and direct sterilization was immoral. The revised Directives prompted a new negotiation with the city of Austin stating Seton could no long allow sterilization or other

contraceptive services. The city then proposed to use the fifth floor as separate entity designated for reproductive services. The compromise was agreed by both sides. Seton was responsible for the remodeling of the fifth floor that furnished with pharmacy, nursing unit, medical records, housekeeping, and separate elevator. Vatican did not object to the "hospital within a hospital" solution. The compromise agreement in this case is now served as a model for resolving conflict between religious organization and public institution.

ii. Distinctions of Cooperation

The principle of cooperation is used as a guide for allowing secular actions without forsaking the Catholic conviction. Two distinctions in this principle are formal and material cooperation. Formal cooperation is to permit and participate in the wrongdoing of another. Mediate material cooperation involves participating in what is morally good which is also connected to perceived wrongdoing of another. It requires the cooperator not to take actual action of the perceived evil and to keep a distance from the perceived wrongdoing. This form of cooperation allows compromise when dealing with conflict between Catholic values and secular practices.[957]

1. Material Cooperation

Applying ethics in healthcare policies secures moral standard. David Kelly, an ethicist, considers Roman Catholicism has the most influence in the development of the Western contemporary medical ethics.[958] Notable reason is the involvement of the

Catholic church in healthcare. Not only does Catholic ministries get involved in practice but also provide moral and ethical teaching in conducting health services as well. Theology has significant contribution in doctrinal foundation to ethical dilemma.[959] This is because the hermeneutic meaning in theology has the power to discern right and wrong actions.[960] Christian theology has distinctive moral characteristics[961] suitable for explaining and resolving human and societal condition and conflict.[962] The core of this moral-based theology is Jesus Christ who is the moral exemplar.[963] His life and teaching are suitable for explaining human experience. Hence, forming ethics using theology provides acute insights into issues associated with humanity.

Ethical conflict is commonly seen in situations when public policies violate moral values. The principle of cooperation can be used as a way to resolve this type of issues. The fundamental concept of the principle of cooperation is knowingly assisting in evil act either by an individual or an organization.[964] One alternative to resolve the conflict is the application of material cooperation. The principle of material cooperation is based on theological values. It validates the existing evil and judges the possibility of utilizing compromise. While evil act is never acceptable, toleration in some situations is permitted.[965] Theological values judge the involvement and intention of the cooperator whether the moral standard have been violated.[966] In material cooperation, the cooperator is one who becomes involved in an evil act that is committed by an immoral agent. The cooperator neither approves of the evil act nor intends the bad outcome as a result of the evil act. It is important to note that the cooperator does not initiate or intend the evil act. This arrangement is permissible. Material cooperation subdivides into immediate material

cooperation and mediate cooperation. Immediate cooperation is referred to the situation in which the cooperator makes actual contribution to the evil act or provides actual aid to the immoral agent without the intention of the evil. This arrangement is not permissible. For mediate material cooperation, the cooperator is involved in the evil act by providing secondary aid or indirect aid without intending the evil. This arrangement is permissible as long as all parties are to affirm their commitment.[967] Mediate material cooperation is further divided into proximate mediate material and remote mediate material cooperation. The terms are not to be interpreted as a difference of physical or geographic location, rather, they are intended to describe a causal difference. In proximate material cooperation, the cooperator's contributing help is considerably closer in connection with the evil. On the other hand, remote mediate material cooperation describes the cooperator's help is not closely in connection with the evil.[968]

2. Formal Cooperation

Formal cooperation is referred to one (cooperator) helps the immoral agent who actively and directly participating in sinful or evil act. It indicates the cooperator intends the evil act. If the cooperator intends the same outcome as the agent who commits the evil act, the cooperator is said to have participated in formal cooperation because he knowingly intends the evil. It is morally impermissible. In formal cooperation, the cooperator's help does not have to be essential to be considered illicit. Formal cooperation subdivides into explicit and implicit cooperation.[969] Explicit formal cooperation involves the cooperator directly approves the immoral agent's evil act. For

example, a member of the healthcare committee established a policy for abortion intending to kill unborn children. The member of the committee is not the actual immoral agent who carries out the evil act of abortion. However, the committee member did provide aid through establishing the policy with the intention of evil. In implicit formal cooperation, the cooperator intends the evil of the immoral agent but also intends to seek a morally good outcome from the evil act. Because implicit formal cooperation intends to seek a morally good end, it is not looked upon as negative. Implicit formal cooperation is used to achieve a good end in a condition where the evil act is being carried out by the immoral agent.[970] In this situation, the cooperator implicitly approves and intends the evil act of the immoral agent. This is a common alternative to resolve conflict between Catholic moral teaching and secular policies.[971] For instance, a public hospital needs to include the provision of full service of women's reproductive care including sterilization for the reason of viability. Utilizing implicit formal cooperation, the Catholic organization can negotiate with the public hospital regarding using non-Catholic providers to directly conduct reproductive services including sterilization. Including in the implicit formal cooperation is the condition in that the Catholic organization will need to ensure the establishment of the agreed-upon provision for conducting sterilization. This is to ensure that The Catholic organization will not take part in assisting the actual immoral procedure. In this scenario, the Catholic organization engages in implicit formal cooperation in any sterilization even without participating in the actual service. The end outcome in this scenario is the greater good for the community where the hospital can continue to provide healthcare services to treat the poor, the sick, and the needy.[972]

b. Cooperation Justifies Health Policies that Provide Forbidden Services

The following discussion involves the conditions in which the support for forbidden services is allowed.

i. Support without Violation

When HHS first made the announcement, the mandate of providing contraception to all employees applied to Catholic organizations. The Catholic Health Association and the US bishops strongly opposed the policy. Following the revision of the policy in which Catholic organizations are exempted from providing contraception, the Catholic Health Association supported the policy.[973] The principle of cooperation played a part in the compromise. The support of the Catholic Health Association after the exemption of contraceptives provision indicates the principle of cooperation justifies the legislation. Their initial opposition demonstrated the mandate was a perceived wrongdoing and no participation was intended satisfying the crucial component in the use of the principle of cooperation.

1. Final Regulations

On June 28, 2013, the Department of Treasury, Labor, and Health and Human Services (HHS) announced the final ruling along with detail description on exempting religious groups from providing contraception under ACA.[974] The final regulations are to accomplish two goals. First, the regulations intend to guarantee access for women's care including contraception. This is to promote public health and ensure women have equal

access to healthcare. The second goal is to provide regulations that allow nonprofit organizations not having to provide contraceptive coverage, either through contract, arrange, pay, or refer for such coverage. The final regulations are in response to over 400,000 comments seeking to simplify the policy.[975] Congress sees that it is necessary to provide preventive health services without out-of-pocket cost. It is believed that nation-wide health insurance coverage can achieve access to basic healthcare for most Americans. The intention to amend the ACA policy is to communicate the importance of women's health and the coverage of recommended women's health services including contraception.[976] Congress considered the scientific review and medical evidence presented by Institute of Medicine (IOM) in the report titled "Clinical Preventive Services for Women: Closing the Gaps" that unintended pregnancy can affect women's health. It is very likely that women with unintended pregnancy delay prenatal care and continue smoking and alcohol use which carry the risk of preterm birth and low birth weight.[977] Contraceptives are also beneficial to women who are contraindicated for pregnancy, women with menstrual disorders, and acne. Furthermore, access to contraception improves the social and economic status due to cost saving policy.[978]Another benefit of providing contraception is allowing women to pursue their career in the workforce.[979] For these reasons, the government amended the regulation of the policy to keep the provision of all women health services including contraception. It should be considered that there is a greater tendency to use preventive health services if there is no out-of-pocket cost. It is the projection that a healthier nation will result from more people utilizing preventive health services. It will also reduce healthcare cost by

avoiding preventable conditions or providing early treatment. The regulation specifically provides the following details intended to accommodate religious objections:[980]

- The definition of religious employer has been simplified for the purpose of eliminating the earlier regulation regarding provision of contraception. Religious employers are now exempted from providing contraceptive coverage to their employees, and those employees will not be provided access to alternative contraceptive coverage. Furthermore, based solely on section 6033(a)(3)(A)(i) or (iii) of the internal Revenue code, a house of worship, even if it conducts charity work or employs workers of different religious faith, is exempt from providing contraception.
- An accommodation is established to allow nonprofit religious organization that do not qualify as religious employers. These organizations are not required to provide contraceptive coverage meaning they are exempt from having to contract, pay, or refer for contraception.[981] They are allowed to continue the same health plans without including contraception and sterilization as did prior to ACA.
- Provide a temporary extension for compliance with the final regulation for health plans between August 1, 2013 and December 31, 2013 until next plan year.[982]
- Requiring insurance company to separate premiums for eligible organizations. Insurance companies are to pay for contraceptive services using other funds.

The accommodations included in the final regulation are intended to resolve conflicts with religious group to keep contraception as part of women's health services.

2. Support for the Final Rule

After the issue of the final regulation, on July 9, 2013, the Catholic Health

Association (CHA) expressed its support for the HHS mandate.[983] Catholic Health Association is the largest group of non-profit healthcare providers in the United States representing over 600 hospitals and 1,400 health facilities. Approximately 1 in 6 patients in the United States are treated by Catholic Hospital; in such vital role, CHA holds a significant position in healthcare issues.[984] CHA accepted the exemptions and accommodations that allows religious organizations to continue their usual health plans prior to ACA. The two concerns regarding the contraception mandate were eliminated: The first concern was the four-part definition of 'religious employer' and the second concern was mandating religious employers to include contraception in their health plans. More specifically, CHA accepted the details of not requiring religious organizations to contract, provide, pay or refer for contraceptive coverage. The final regulation resolved the issues. In its summary of final regulation to its member organizations, CHA explained that an authorized personnel will be responsible for executing the self-certification in a form specified by HHS to satisfy the criteria as an eligible organization at the time prior to the first day of health plan year.[985] The form does not need to be filed to government agency, rather, it should be kept in record as required of the Employee Retirement Income Security Act of 1974 (ERISA) and be made available for inspection on request. The next step is to present the self-certification to insurance companies, and the eligible organization does not have further responsibility regarding contraceptive coverage. The insurance companies will assume full responsibility for contraceptive services. From the beginning, CHA put its narrow focus on working towards solving the problems that deal with the protection of religious organizations.[986] Hence, the final regulation was

perceived as a workable solution from the perspective of both legality and theology.

ii. Considering the Greater Good

There are conditions in the mandate of forbidden practices actually justify the use of the principle of material cooperation. As the government, an external force, poses mandate of contraceptive coverage, Catholic organizations are forced to cooperate with services that against their conviction. Even with having to comply with the mandate, the provision of health plans to employees results in greater good. In consideration of the greater good, cooperating with the contraceptive mandate would have been justified. For the Catholic organizations that provide health insurance through outside sources, remote material cooperation is justified based on the coverage of contraceptives is provided through other companies. For Catholic organizations that self-insure their employees, proximate material cooperation is applied due to provision of contraceptives through insurance component of the Catholic organization. To a lesser controversial end, Catholic organizations, whether insured by other insurance companies or self-insured, are now exempted from the mandate.[987]

1. Social Teaching

Catholic social teaching is rooted in Jesus Christ who came to serve the poor, release the captives, heal the blind,[988] feed the hungry, and invite the stranger.[989] Based on the life of Christ, the Catholic Church focuses on reaching out to the poor as a way to remember Christ through serving the needy.[990] The belief of Christ is that He is the triune

God who dwells among people. The Gospel reveals God the Father who sends His Son Jesus Christ to save His people and gives the Holy Spirit as helper to His people in an act of love. God demonstrates His nature as relational in Trinity and not aloneness. For God's people who are made in His image also share His nature as relational and communal. There is the specific part of social nature in God's people that inspires the reaching out to others to build love and justice. Because humans are made in God's image and redeemed by Jesus Christ, they are members of the human family. Hence, human life and human dignity are invaluable and worthy of respect. More importantly, human dignity is solely given by God and cannot be obtained through means of human work. When God places humans in such sacred status, they are worthy of love and care. It is the commitment to follow Christ's example leads to reaching out to others particularly the poor and needy.

The seven themes of Catholic social teaching highlight the perspectives that strengthen the reasons for social work.[991] The key themes are as follow:

1) Life and Dignity of the Human Person emphasizes people are more important than material things and nations are to protect the right to life;[992]

2) Call to Family, Community, and Participation stresses the right and duty for all people to participate in society and community for the purpose of seeking common good and well-being of all including the aid for the poor and sick;

3) Right and Responsibilities claims that every human has a right to necessities required for living;

4) Option for the Poor and Vulnerable instructs the first priority is the needs of the poor

and vulnerable;

5) The Dignity of Work and the Rights of Workers advocate the respect for workers, the right to productive work, and fair wages;[993]

6) Solidarity expresses all humans are each other's keepers, and the love for each other demands the pursuit of justice and peace;[994] and

7) Care for God's Creation speaks of a command to protect people and the planet as a demonstration of faith to the Creator.[995]

These seven themes clearly advocate service to people, particular those who are in need, as a way to show God's love. Furthermore, Pope John Paul II asserts the burden of poverty is intolerable because it destroys hope and causes suffering.[996] The inadequate provision of food and healthcare has direct effect on the condition of human living. The fact remains true that a great number of those who struggle to afford basic necessity of food and healthcare. The poor distribution of the goods and services is injustice. In countries where the abundance of goods and services are readily available, the help to the indigent population should not delay. Then supporting ACA policies will reach a greater number of uninsured people in the United States. These individuals will benefit from healthcare coverage resulting in better functioning and
living.

2. Catholic Charity Work

Statistics show most American citizens believe in God and affirm that religious involvement in society improves the quality of life.[997] It is noted there is an increase in

spirituality and religious involvement in Americans' lives.[998] The influence of religious beliefs in the United States initiated by organized social work in churches and religious groups.[999] Religious belief is often the expressed reasons for charity work and the interest of entering a profession that intends to serve the people in society.[1000] Survey, in 1985, showed 14,000 social service agencies were affiliated with religious organizations[1001] as compared with 2783 religious associated agencies in 1955.[1002] Religious groups became more involved in social work when the government scaled back on their responsibility for social services provision.[1003] The Catholic Church has been recognized by the public for its involvement in social work. The long history of charity service provides by Catholic organizations indicates its commitment to seek greater good in society. Its service reaches the young and the old and provides aids from food service to healthcare. In 2013, Forbes named Catholic Charities USA (CCUSA) the ninth largest charity organization in the United States.[1004] The services provide by this charity group is being recognized for its effort to fight against poverty. CCUSA carries the mission to serve the poorest and most vulnerable people regardless of faith. It reaches out to provide disaster relief, shelter those in need, feed the hungry, support healthy lives, provide education and training, build financial security, welcome newcomers, assist with adoption, and caring for the vulnerable.[1005] Serving in the area of healthcare, Catholic Health Association operates more than 600 hospitals and 1,400 long-term care facilities in 50 states.[1006] These health facilities provide acute care, skilled nursing, hospice, assisted living, senior housing, and home health. The Catholic health system is the largest nonprofit healthcare provider in the United States. More specifically, Catholic hospitals provide more healthcare than

public health systems with five million admitted patients each year, nearly 20 million ER visits, and over 101 million outpatient visits. Today, every one in six patients in the United States is treated in a Catholic hospital. These services demonstrate the dedication of the Catholic social belief in serving the common good. ACA policies have the potential to provide millions of uninsured people with basic healthcare services. This is a potential to do greater good for the public particularly for the poor and the needy.

Summary

It was noted lacking health insurance coverage can be a contributor to the high cost of healthcare. The basic understanding includes the following: 1) Uninsured individuals will delay seeking health treatment due to unaffordability resulting in more serious health problems that require greater healthcare spending; 2) uninsured individuals will use Emergency Department for healthcare services resulting in higher cost per visit; and 3) those who are insured may delay or avoid seeking preventive care due to the cost of copayment. These situations significantly increase healthcare spending. The secondary concern is the health of the people in society. When people are not well, they are stressed and less productive at work and at home. Without health insurance creates the concern for health and increases the risk for illness. ACA policies cover basic preventive health services in attempt to encourage healthy living and avoid serious health problems. One specific group of individuals requires all the preventive care services due to the unique nature of pathophysiological makeup. In United States, the population of women age 15 to 44 years are roughly 61 million. This age range is considered childbearing years. For

women, the reproductive system is unique and plays a significant role in women's health. According to Healthy People 2010, half of pregnancies in the United States are unintended at the time of conception. It estimated 1 million teenage females have unintended pregnancies each year and approximately half of these pregnancies result in abortion. The cost to U. S. taxpayers for teenage pregnancies is roughly between 7 billion and 15 billion dollars a year. It is seen that unintended pregnancies are less likely to seek early prenatal care increasing the likelihood of maternal and infant illness. The fetus is likely to be exposed to harmful substance such as tobacco or alcohol. The infant in such condition is at high risk of low birth weight, premature death, suffering abuse, and not receiving proper developmental nourishment. Based on scientific evidence that shows prescribed contraceptives have significant health benefits for women and their families, HHS supports IOM's recommendation on women's preventive health services including contraception. Religious groups, particularly USCCB, opposes to the contraceptive mandate stating it forces them to violate their religious conscience. The Church perceives providing contraception is wrong based on the value of procreation. They filed lawsuits against the mandate on the ground of violation of Religious Freedom Restoration Act. When an exemption for specific organizations with religious objection to contraception did not satisfy the description of religious freedom, an accommodation was made in attempt to resolve the conflict while keeping the provision of contraceptive services in ACA. Catholic teaching allows voting for laws that support forbidden practices as long as the legislator who votes for a law that permits forbidden practices has the intention to limit the harm done by legislation regarding those practices. The principle of cooperation

can be used as a compromise when dealing with conflict between Catholic values and secular practices. This will allow Catholic health ministries to continue serving the poor, needy, and the sick in a significant capacity in the United States.

References

819 Steven D. Pearson, James E. Sabin, and Ezekiel J. Emanuel. *No Margin, No Mission: Health-Care Organizations and the Quest for Ethical Excellence.* New York, NY: Oxford University Press, Inc., 2003, pp. 4.

820820 Jeff Lyon. "Concerns About Women's Health," JAMA Network, January 10, 2017. http://jamanetwork.com/journals/jama/article-abstract/2596274. [accessed 1/25/2017].

821 Janet M. Torpy. "Women's Health," *JAMA* 295, no. 12 [March 2006]: 1474.

822 Carol Zimmermann. "U. S. Bishops Want to Give "careful analysis' to HHS Final Rules," Catholic News Service. http://www.catholicnews.com/data/stories/cns/1302837.htm. [accessed J une 8, 2015].

823 U.S. Department of Health & Human Services. "Administration Takes Steps to Ensure Women's Continued Access to Contraception Coverage, While Respecting Religious-based Objections," News release August 22, 2014. http://www.hhs.gov/news/press/2014pres/08/20140822a.html. [accessed June 8, 2015].

824 Federal Register. "Coverage of Certain Preventive Services Under Affordable Care Act," (A rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department on 7/14/2015.) https://www.federalregister.gov/documents/2015/07/14/2015-17076/coverage-of-certain-preventive-services-under-the-affordable-care-act. [accessed on 1/27/2017].

825 U. S. Department of Health and Human Services. "Healthy People 2010: Understanding and Improving Health," (November 2000).

http://www.healthypeople.gov/2010/document/pdf/uih/2010uih.pdf. [accessed on 1/27/2017].

826 Jessica Arons and Alex Walden. "HHS: Contraception is Prevention," (Posted on August 3, 2011). https://www.americanprogress.org/issues/women/news/2011/08/03/10133/hhs-contraception-is-prevention/. [accessed on 1/31/2017].

827 Adam Sonfield. "Contraception: An Integral Component of Preventive Care for Women," (Guttmacher Policy Review Volume 13, Issue 2, June 1, 2010.) https://www.guttmacher.org/gpr/2010/06/contraception-integral-component-preventive-care-women. [accessed 1/27/2017].

828 HealthCare.Gov. "Health Benefits and Coverage: Birth Control Benefits," https://www.healthcare.gov/coverage/birth-control-benefits/. [accessed 1/27/2017].

829 Adam Sonfield. "Contraception: An Integral Component of Preventive Care for Women," (Guttmacher Policy Review Volume 13, Issue 2, June 1, 2010.) https://www.guttmacher.org/gpr/2010/06/contraception-integral-component-preventive-care-women. [accessed 1/27/2017].

830 United Sates Conference of Catholic Bishops, Office of the General Counsel. "Interim Final Rules on Preventive Services File code CMS-9992-IFC2," (Submission Electronically on August 31, 2011). http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08.pdf. [accessed on 1/30/2017].

831 United States Conference of Catholic Bishops. "USCCB Urges Rescission of HHS Contraceptive Mandate, Criticizes ‘Inexplicably Narrow’ Definition of Religious Freedom," (August 31, 2011).

http://www.usccb.org/news/2011/11-168.cfm. [accessed on 1/30/2017].

832 Nancy Frazier O'Brien. "HHS Delays, but does not Change, Rule on Contractive Coverage," (Catholic News Service, January 23, 2012). http://www.catholicnews.com/services/englishnews/2012/hhs-delays-but-does-not-change-rule-on-contraceptive-coverage-cns-1200287.cfm. [accessed on 1/30/2017].

833 Adam Liptak. "Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama," (The New York Times, June 28, 2012). http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html. [accessed on 1/30/2017].

834 Fox News Politics. "Groups Opposed to Contraception Mandate will Push Forward with Lawsuits," (Published June 28, 2012). http://www.foxnews.com/politics/2012/06/28/groups-opposed-to-health-care-mandate-to-push-forward-with-lawsuits.html. [accessed 1/30/2017].

835 Richard Wolf. "Supreme Court Agrees to Rule on Birth Control Insurance Mandate," (USA Today, November 6, 2015). http://www.usatoday.com/story/news/2015/11/06/supreme-court-contraception-abortion-obamacare-religious-freedom/75287750/. [accessed on 1/30/2017].

836 Richard Wolf. "Supreme Court Sends 'contraceptive Mandate' Cases Back to Lower Courts," (USA Today, May 16, 2016). http://www.usatoday.com/story/news/2016/05/16/supreme-court-contraception-mandate-obama-religious-objectors/82358568/. [accessed on 1/30/2017].

837 Center for Medicare & Medicaid Services. "Women's Preventive Services Coverage and Non-Profit Religious Organizations,"

http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html. [accessed September 9, 2015].

838 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.* Washington D.C.: Georgetown University Press, 2013, p 282.

839 United States Conference of Catholics Bishops. "U.S. Bishops Vow to fight HHS Edict," United States Conference of Catholic Bishops. http://www.usccb.org/news/2012/12-012.cfm. [accessed August 18, 2013].

840 The White House, Office of the Press Secretary. "Fact Sheet: Women's Preventive Services and Religious Institutions," (Briefing Room, February 10, 2012). https://obamawhitehouse.archives.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions. [accessed on 1/29/2017].

841 The Center for Consumer Information and Insurance Oversight. "Women's Preventive Services Coverage and Non-profit Religious Organizations. Fact Sheet: Women's Preventive Services Coverage, Non-profit Religious Organizations, and Closely-Held For –Profit Entities," https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/womens-preven-02012013.html. [accessed on 1/31/2017].

842 Cornell University Law School. "45 CFR 147.131 – Exemption and Accommodations in Connection with Coverage of Preventive Health Services," https://www.law.cornell.edu/cfr/text/45/147.131. [accessed on 2/1/2017].

843 Pete Yost. "Obamacare Contraception Loophole for Religious Groups is Not Too Restrictive, Court Rules," (Associated Press, November 14, 2014). http://www.pbs.org/newshour/rundown/obamacare-contraception-loophole-religious-groups-restrictive-court-rules/. [accessed on 2/2/2017].

844 Adam Liptak. "Justices, Seeking Compromise, Return contraception Case to Lower Courts," (The New York Times, May 16, 2016). https://www.nytimes.com/2016/05/17/us/supreme-court-contraception-religious-groups.html?_r=0. [accessed 1/2/2017].

845 Laurie Sobel and Alina Saiganicoff. "Round 2 on the Legal Challenges to Contraceptive Coverage: Are Nonprofits "Substantially Burdened" by the "Accommodation"," (The Kaiser Family Foundation, November 9, 2015). http://kff.org/womens-health-policy/issue-brief/round-2-on-the-legal-challenges-to-contraceptive-coverage-are-nonprofits-substantially-burdened-by-the-accommodation/. [accessed 2/2/2017].

846 Institute of Medicine. "Clinical Preventive Services for Women: Closing the Gaps," July 19, 2011. http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. [accessed June 15, 2015].

847 Ann Gerhart. "First Lady Pushes Cause of Reform," (The Washington Post, September 19, 2009). http://www.washingtonpost.com/wp-dyn/content/article/2009/09/18/AR2009091802059.html. [accessed June 14, 2015].

848 United States Census Bureau. "2010 Census Shows Nation's Population is Aging," https://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn147.html. [accessed June 19, 2015].

849 The National Academies. *Women's Health Research: Progress, Pitfalls, and Promise.* Washington, D.C.: The National Academies Press Openbook, 2010, p.15.

850 Harvard Health Publications. Harvard Medical School. "Women's Health,"

http://www.health.harvard.edu/topics/womens-health/. [accessed on 2/4/2017].

851 H. Mead, K. Witkowski, B. Gault, et al. "The Influence of Income, Education, and Work Status on Women's Well Being," *Women's Health Issues* 11, no. 3 [2001]: 160-172.

852 R. Wyn and B. Solis. "Women's Health Issues Across the Lifespan," *Womens Health Issues* 11, no. 3 [2001]: 148-159.

853 Chiara Melloni, Jeffrey Berger, Tracy Wang, et al. "Representation of Women in Randomized Clinical Trials of Cardiovascular Disease Prevention," *Circ Cardiovasc Qual Outcomes* 3 [2010]: 135-142.

854 W. Rosamond, K. Flegal, K. Furie, et al., "Heart Disease and Stroke Statistics: 2008 Update: A Report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee,"*Circulation* 117 [2008]: e25-e146.

855 U. S. Congress House. National Institutes of Health Revitalization Act of 1993. Public Law 103-43. 103d Cong., (June 10, 1993).

856 National Institutes of Health. "NIH Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research," *Fed Reg* 3 [1994]: 143.

857 D. J. Harris and P. S. Douglas. *Enrollment of Women in Cardiovascular Clinical Trials Funded by the National Heart, Lung, and Blood Institute," New England Journal of Medicine* 343 [2000]: 475-480.

858 A. Oliva, E. Pinnow, R. Levin, et al. "Improving Women's Health Through Modernization of Our Bioinformatics Infrastructure," *Clin Pharmacol Ther* 83 [2008]: 192-195.

859 N. M. A. LaPointe, A. Y. Chen, K. P. Alexander, et al. "Enoxaparin Dosing and Associated Risk of In-hospital Bleeding and Death in Patients with Non-ST-segment Elevation Acute Coronary Syndromes," *Arch Inter Med* 167 [2007]: 1539-1544.

860 P. Y. Lee, K. P. Alexander, B. G. Hammill, et al. "Representation of Elderly Persons and Women in Published Randomized Trials of Acute Syndromes," *JAMA* 286 [2001]: 708-713.

861 Lois Downey, Patrick T. Tyree, and William E. Lafferty. "Preventive Screening of Women Who Use Complementary and Alternative Medicine Providers," *Journal of Women's Health* 18 [2009]: 1133-1143.

862 U.S. Preventive Services Task Force. "Screening for Chlamydia Infection: Recommendations and Rationale," *Am J Prev Med* 20 [2001]: 90-94.

863 Centers for Disease Control and Prevention. "Sexually Transmitted Diseases Treatment guidelines, 2006," *MMWR Recomm Rep* 55 [2006]: 1-94.

864 Centers for Disease Control and Prevention. "Breast Cancer," (Last Updated on November 14, 2012).

https://www.cdc.gov/vitalsigns/breastcancer/index.html. [accessed on 2/6/2017].

865 S. W. Fletcher and J. G. Elmore. "Clinical Practice: Mammographic Screening for Breast Cancer," *New England Journal of Medicine* 348 [2003]: 1672-1680.

866 HealthyPeople.Gov. "Breast Cancer Screening: An Update for the U. S. Preventive Services Task Force (Clinical Guide Recommendation),"

https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/screening-breast-cancer-update-us-preventive-services. [accessed on 2/6/2017].

867 ACOG Committee on Practice Bulletins. "ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-gynecologists. Number 45, August 2003. Cervical Cytology Screening (Replaces Committee Opinion 152, March 1995)," *Obstet Gynecol* 102, no. 2 [2003]: 417-427.

868 A. T. O'Meara. "Present Standards for Cervical Screening," *Curr Opin Oncol* 14 [2002]: 505-511.

869 R. A. Smith, V. Cokkinides, and H. J. Eyre. *American Cancer Society Guidelines for the Early Detection of Cancer, 2004," Cancer J Clin* 54 [2004]: 41-52.

870 Elizabeth M. Ozer, John T. Urquhart, and Claire D. Brindis. "Young Adult Preventive Health Care Guidelines: There but Can't be Found," *Arch Pediatr Adolesc Med* 166, no. 3 [2012]: 240-247.

871 L. Steinberg. "A Behavioral Scientist Looks at the Science of Adolescent Brain Development," *Brain Cogn* 72, no. 1 [2010]:160-164.

872 T. P. Mulye, M. J. Park, C. D. Nelson, et al. "Trends in Adolescent and Young Adult Health in the United States," *J Adolesc Health* 45, no. 1 [2009]: 8-24.

873 S. T. Callahan and W. O. Cooper. "Changes in Ambulatory Health Care Use During the Transition to Young Adulthood," *J Adolesc Health* 46, no. 5 [2010]: 407-413.

874 J. Ma, Y. Yang, R. S. Stafford. "U. S. Adolescents Receive Suboptimal Preventive Counselling During Ambulatory Care," *J Adolesc Health* 36, no. 5 [2005]: 441.

875 R. J. Fortuna, B. W. Robbins, J. S. Halterman. "Ambulatory Care Among Young Adults in the United States," *Ann Intern Med* 151, no. 6 [2009]: 379-385.

876 Natalia Olchanski, Joshua T. Cohen, and Peter Neumann. "A Role for Research: An Observation on Preventive Services for Women," *American Journal of Preventive Medicine* 44, no 1S1 [2013]: S12-S15.

877 J. L. Luborsky, P. Meyer, M. F. Sowers, et al. "Premature menopause in a multi-ethnic population study of the menopause transition," *Human Reproduction* 18 no. 1, [2003]: 199-206.

878 Eunice Kennedy Shriver National Institute of Child Health and Human Development. "What are Some Common Complications of Pregnancy," (National Institute of Health). https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/complications.aspx. [accessed on 2/9/2017].

879 The American College of Obstetricians and Gynecologists. "Preeclampsia and High Blood Pressure During Pregnancy," http://www.acog.org/~/media/For%20Patients/faq034.pdf?dmc=1&ts=20120730T1500377195. [accessed on 2/9/2017].

880 L. Leeman and P. Fontaine. "Hypertensive Disorders of Pregnancy," *American Family Physician* 78 [2008]: 93-100.

881 P. J. Meis, , M. Klebanoff, and E. Thom, et al. "Prevention of Recurrent Preterm Delivery by 17 Alpha-hydroxyprogesterone Caproate," *New England Journal of Medicine* 348 [2003]: 2379-2385.

882 L. Leeman and P. Fontaine. "Hypertensive Disorders of Pregnancy," *American Family Physician* 78 [2008]: 93-100.

883 National Organization for Rare Disorders (NORD). "Hyperemesis Gravidarum," https://rarediseases.org/rare-diseases/hyperemesis-gravidarum/. [accessed on 2/9/2017].

884 S. S. Hassan, R. Romero, D. Vidyadhari, et al. "Vaginal Progesterone Reduces the Rate of Preterm Birth in Women with a Sonographic Short Cervix: A Multicenter, Randomized, Double-blind, Placebo-controlled Trial," *Ultrasound in Obstetrics & Gynecology* 38 [2011]: 18-31.

885 Royal College of Psychiatrists. "Mental Health in Pregnancy," (Last Update in November 2012).

http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/mentalhealthinpregnancy.aspx. [accessed on 2/9/2017].

886 Eunice Kennedy Shriver National Institute of Child Health and Human Development. "What are the Factors That Put a Pregnancy at risk?," (National Institute of Health). https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo/pages/factors.aspx. [accessed on 2/9/2017].

887 Healthy Children.Org. "Teenage Pregnancy," (From the American Academy of Pediatrics, last updated on 11/21/2015). https://www.healthychildren.org/English/ages-stages/teen/dating-sex/pages/Teenage-Pregnancy.aspx. [accessed on 2/9/2017].

888 MedlinePlus. "Women's Health," (Page last updated on February 8, 2017). https://medlineplus.gov/womenshealth.html. [accessed on 2/8/2017].

889 Thomas W. Concannon, John L. Griffith, David M. Kent. "Elapsed Time in Emergency Medical Services for Patients with Cardiac Complaints: Are Some Patients at Greater Risk for Delay," *Circ Cardiovasc Qual Outcomes* 2 [2009]: 9-15.

890 Todd M. Brown, Dhananjay Vaidya, William J. Rogers, et al. "Does Prevalence of the Metabolic Syndrome in Women with Coronary Artery Disease Differ by the ATP III and IDF Criteria," *Journal of Women's Health* 17, no. 5 [2008]: 841-847.

891 World Health Organization. "Mental Health," http://www.who.int/mental_health/prevention/genderwomen/en/. [accessed on 2/8/2017].

892 National Cancer Institute. "Breast Cancer Risk in American Women," (Page last reviewed on September 24, 2012). https://www.cancer.gov/types/breast/risk-fact-sheet. [accessed on 2/8/2017].

893 National Cancer Institute. "Male Breast Cancer Treatment (PDQ)-Patient Version," (Page Updated on July 18, 2016). https://www.cancer.gov/types/breast/patient/male-breast-treatment-pdq. [accessed on 2/8/2017].

894 National Institute on Alcohol Abuse and Alcoholism. "Women and Drinking," https://pubs.niaaa.nih.gov/publications/brochurewomen/women.htm. [accessed on 2/8/2017].

895 U. S. Preventive Services Task Force. "Aspirin for the Prevention of Cardiovascular Disease: U. S. Preventive Services Task Force Recommendation Statement," *Annals of Internal Medicine* 150 no. 6 [March 2009]: 396-404.

896 National Stroke Association. "Women and Stroke," http://www.stroke.org/understand-stroke/impact-stroke/women-and-stroke. [accessed on 2/8/2017].

897 Eunice Kennedy Shriver National Institute of Child Health and Human Development. "What Health Issues or Conditions Affect Women Differently than Men?,"(National Institute of Health). https://www.nichd.nih.gov/health/topics/womenshealth/conditioninfo/pages/howconditions.aspx. [accessed 2/8/2017].

898 National Institute of Diabetes and Digestive and Kidneys Diseases. "Urinary Tract Infections (UTIs)," https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-tract-infections-utis. [accessed on 2/8/2017].

899 United States Conference of Catholic Bishops. "U.S. Bishops Vow to fight HHS Edict," http://www.usccb.org/news/2012/12-012.cfm. [accessed June 8, 2015].

900 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care*

Ethics. Washington D.C.: Georgetown University Press, 2013, pp. 282-283.

901 National Archives. "The Bill of Rights: A Transcription," (Paged was Last Reviewed on October 6, 2016). https://www.archives.gov/founding-docs/bill-of-rights-transcript. [accessed on 2/9/2017].

902 Luther.de. "Luther at the Imperial Diet of Worms (1521)," http://www.luther.de/en/worms.html. [accessed on 2/10/2017].

903 Catholic Journal. "The Rise and Eclipse of Religious Liberty in America," http://www.catholicjournal.us/2016/05/28/rise-eclipse-religious-liberty-america/. [accessed on 2/9/2017].

904 Catholic Journal. "The Rise and Eclipse of Religious Liberty in America," http://www.catholicjournal.us/2016/05/28/rise-eclipse-religious-liberty-america/. [accessed on 2/11/2017].

905 The Washington Library. "George Washington's Prayer for his Country and Remarks of the Regent at a Naturalization Ceremony at Mount Vernon," http://catalog.mountvernon.org/cdm/ref/collection/p16829coll4/id/96. [accessed on 2/12/2017].

906 Louis J. Sirico. "Benjamin Franklin, Prayer, and the constitutional Convention: History as Narrative," *Legal Communication & Rhetoric: JALWD* 10 [2013]: 89-124.

907 Cornell University Law School. "U. S. Constitution: First Amendment," https://www.law.cornell.edu/constitution/first_amendment. [accessed on 2/11/2017].

908 Congress.Gov. "H. R. 1308 – Religious Freedom Restoration Act of 1993," https://www.congress.gov/bill/103rd-congress/house-bill/1308. [accessed on 2/11/2017].

909 United States Catholic Conference. *Catechism of the Catholic Church.* New York, New York: Doubleday, 1994, no.1.

910 Mary J. McDonough. *Can a Health Care Market Be Moral?; A Catholic Vision.* Washington D.C.: Georgetown University Press, 2007, pp. 18-19.

911 Catechism of the Catholic Church. "Moral Conscience," http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c1a6.htm. [accessed on 2/11/2017].

912 Catholic United for the Faith. "The Church's Teaching on Moral Conscience," (Last Edited on 8/20/1999). http://www.cuf.org/2004/04/going-gods-way-the-churchs-teaching-on-moral-conscience/. [accessed on 2/11/2017].

913 United States Conference of Catholic Bishops. "Cardinal Dolan and Archbishop Lori to Congress: Support the Conscience Protection Act of 2017," (February 10, 2017). http://www.usccb.org/news/2017/17-038.cfm. [accessed on 2/11/2017].

914 Daniel Sokol. "A Guide to the Hippocratic Oath," (BBC News, page last updated on October 26, 2008). http://news.bbc.co.uk/2/hi/health/7654432.stm. [accessed on 2/11/2017].

915 Richard McCormick. *Corrective Vision.* Kansas City, MO: Sheed & Ward, 1994, p.11.

916 Kelly et al. *Contemporary Catholic Health Care Ethics.* Washington D. C.: Georgetown University Press, 2013, p.95.

917 Charles J. McFadden. *Medical Ethics.* Philadelphia, PA: F. A. Davis, 1955, p. 128.

918 PBS.Org. "American Experience: The Pill," http://www.pbs.org/wgbh/amex/pill/peopleevents/e_church.html. [accessed on 2/14/2017].

919 United States Conference of Catholic. "Human Sexuality from God's Perspective: Humanae Vitae 25 Years Later," http://www.usccb.org/issues-and-action/marriage-and-family/natural-

family-planning/catholic-teaching/upload/Human-Sexuality-from-God-s-Perspective-Humanae-Vitae-25-Years-Later.pdf. [accessed on 2/14/2017].

920 The Pontifical Council for the Family. "The Truth and Meaning of Human Sexuality," (Vatican City, December 8, 1995). http://www.vatican.va/roman_curia/pontifical_councils/family/documents/rc_pc_family_doc_08121995_human-sexuality_en.html. [accessed 2/16/2017].

921 United States Conference of Catholic Bishops, Natural Family Planning Program. "Human Sexuality," http://www.usccb.org/issues-and-action/marriage-and-family/natural-family-planning/catholic-teaching/upload/Human-sexuality.pdf. [accessed 2/16/2017].

922 Kristiaan Depoortere. *A Different God: A Christian View of Suffering.* Louvian Theological & Pastoral Monographs 17. Louvain, Belgium: Peeters Press, 1995.

923 Mary J. McDonough. *Can a Health Care Market Be Moral?; A Catholic Vision.* Washington D.C.: Georgetown University Press, 2007, pp. 55-57.

924 Catechism of the Catholic Church. "Part Three: Life in Christ, Section Two: The Ten Commandments, Chapter Two: "You Shall Love Your Neighbor as Yourself", Article 5: The Fifth commandment," http://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm. [accessed on 2/16/2017].

925 Genesis 9: 5-6 (New American Standard Bible).

926 Gerard Magill. "A Moral Compass for Cooperation with Wrongdoing," In *Voting and Holiness. Catholic Perspectives on Political Participation,* ed. Nicholas P. Cafardi. New York: Paulist Press, 2012, pp. 135-57.

927 US Conference of Catholic Bishops. "Forming Consciences for Faithful Citizenship: A Call to Political Responsibility from the Catholic Bishops of the United States with Introductory Note," http://www.usccb.org/issues-and-action/faithful-citizenship/upload/forming-consciences- for-faithful-citizenship.pdf. [accessed on 2/20/2017].

928 Catechism of the Catholic Church. "Part One: The Profession of Faith. Section Two: The Profession of the Christian Faith. Chapter Three: I believe in the Spirit. Article 9: “I Believe in the Holy Catholic Church”," http://www.vatican.va/archive/ccc_css/archive/catechism/p123a9p1.htm. [accessed on 2/17/2017].

929 Catechism of the Catholic Church. "Part One: The Profession of Faith, Section Two: the Profession of the Christian Faith, Chapter Two: I believe in Jesus Christ, The Only Son of God, Article 2: “And in Jesus Christ, His Only Son, Our Lord,”" http://www.vatican.va/archive/ccc_css/archive/catechism/p1s2c2a2.htm. [accessed on 2/20/2017].

930 Peter Stanford. "Introduction and the Church in Britain: The Roman Catholic Church," (BBC, last updated on June 29, 2011). http://www.bbc.co.uk/religion/religions/christianity/catholic/catholic_1.shtml. [accessed on 2/20/2017].

931 Leo XIII. "Rerum Novarum: Encyclical of Pope Leo XIII on capital and Labor," (Given at St. Peter’s in Rome on May 15, 1891). http://w2.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html. [accessed on 2/20/2017].

932 Catechism of the Catholic Church. "Part One: The Profession of Faith. Section Two: The Profession of the Christian Faith. Chapter Three: I believe in the Spirit. Article 9: “I Believe in the Holy Catholic Church”," http://www.vatican.va/archive/ccc_css/archive/catechism/p123a9p1.htm. [accessed on 2/17/2017].

933 Catholic News Agency (CNA). "Catholic Church’s Mission is to Continue Work of Jesus Christ, Archbishop Niendstedt," (St. Paul, Minn., February 12, 2010). http://www.catholicnewsagency.com/news/catholic_churchs_mission_is_to_continue_work_of_jesus_christ_archbishop_niendstedt_explains/. [accessed 2/19/2017].

934 Carl R. Olson. "The Church’s Essential and Ultimate Mission: Is the Paramount Duty of the Church and Its Faithful to Aid Those in Need?," (The Catholic World Report, August 22, 2014). http://www.catholicworldreport.com/Item/3327/the_churchs_essential_and_ultimate_mission.aspx. [accessed on 2/17/2017].

935 Thomas C. Fox. "Francis to Korean Bishops: ‘Be One with the Poor’," (National Catholic Reporter, August 14, 2014). https://www.ncronline.org/blogs/ncr-today/francis-korean-bishops-be-one-poor. [accessed on 2/17/2017].

936 Pope John Paul II. "Redemptoris Missio: On the Permanent Validity of the Church’s Missionary Mandate," (Given in Rome, at St. Peter’s, on December 7, 1990). http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_07121990_redemptoris-missio.html. [accessed 2/19/2017].

937 Carl R. Olson. "The Church’s Essential and Ultimate Mission: Is the Paramount Duty of the Church and Its Faithful to Aid Those in Need?," (The Catholic World Report, August 22, 2014).

http://www.catholicworldreport.com/Item/3327/the_churchs_essential_and_ultimate_mission.aspx. [accessed on 2/17/2017].

938 Ioannes Paulus PP. II (John Paul II). "Evangelium Vitae on the Value and Inviolability of Human Life," (Given in Rome on March 25, 1995). http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html. [accessed on 2/20/2017].

939 United States Conference of Catholic Bishops. "Forming Consciences for Faithful Citizenship. A Call to Political Responsibility from the Catholic Bishops of the United States with Introductory Notes," http://www.usccb.org/issues-and-action/faithful-citizenship/upload/forming-consciences- for-faithful-citizenship.pdf. [accessed on 2/20/2017].

940 Pope Francis. "Encyclical Letter Laudato Si on Care for Our Common Home," (Given in Rome at Saint Peter's on May 24, 2015). http://w2.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si.html. [accessed on 2/20/2017].

941 Francis. "Apostolic Exhortation Evangeli Gaudium of the Holy Father on the Proclamation of the Gospel in Today's World," (Given in Rome on November 24, 2013). https://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html. [accessed on 2/20/2017].

942 Benedict XVI. "Encylical Letter Caritas in Veritate on Integral Human Development in Charity and Truth," (Given in Rome at Saint Peter's on June 29, 2009). http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate.html. [accessed on 2/20/2017].

943 Pope Paul VI. "Pastoral Constitution on the Church in the Modern World Gaudium et Spes," (Promulgated on December 7, 1965). http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html. [accessed on 2/20/2017].

944 Benedict XVI. "Encyclical Letter Deus Caritas Est on Christian Love," (Given in Rome on December 25, 2005). http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est.html. [accessed on 2/20/2017].

945 United States Conference of Catholic Bishops. "Forming Consciences for Faithful Citizenship: A Call to Political Responsibility from the Catholic Bishops of the United States with Introductory Note," http://www.usccb.org/issues-and-action/faithful-citizenship/upload/forming-consciences-for-faithful-citizenship.pdf. [accessed on 2/20/2017].

946 Ioannes Paulus PP. II (John Paul II). "Evangelium Vitae on the Value and Inviolability of Human Life," (Given in Rome on March 25, 1995). http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html. [accessed on 2/20/2017].

947 Benedict XVI. "Post-Synodal Apostolic Exhortation Sacramentum Caritatis on the Church's Life and Mission," (Given in Rome on February 22, 2007). http://w2.vatican.va/content/benedict-xvi/en/apost_exhortations/documents/hf_ben-xvi_exh_20070222_sacramentum-caritatis.html. [accessed on 2/20/2017].

948 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics,* 2013, p 278.

949 Exodus 20:13 (New American Standard Bible).

950 United States Conference of Catholic Bishops. "Living the Gospel of Life: A Challenge to American Catholics," (A statement by the Catholic Bishops of the United States, 1998). http://www.usccb.org/issues-and-action/human-life-and-dignity/abortion/living-the-gospel-of-life.cfm. [accessed on 2/21/2017].

951 Pope Paul VI. "Pastoral Constitution on the Church in the Modern World Gaudium et Spes," (Promulgated on December 7, 1965). http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_cons_19651207_gaudium-et-spes_en.html. [accessed on 2/21/2017].

952 Lawrence Mary. "Catholic Teaching Concerning a Just War," (Catholicism. Org, February 21, 2006). http://catholicism.org/catholic-teaching-just-war.html. [accessed on 2/21/2017].

953 Exodus 23:7 (New American Standard Bible).

954 Jerry Herda. "Is Killing Enemy on Battlefield a Sin?," (Catholic Herald, September 19, 2013). http://catholicherald.org/special-sections/myfaith/is-killing-enemy-on-battlefield-a-sin/. [accessed on 2/21/2017].

955 Barbra Mann Wall. “Conflict and Compromise: Catholic and Public Hospital Partnership," *Nurs Hist Rev* 18 [2010]: 100-117.

956 United States Conference of Catholic Bishops. *Ethical and Religious Directives for Catholic Health Care Services.* Washington, D. C.: USCCB, 1994.

957 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.,*2013, pp. 278-279.

958 David Kelly. *Contemporary Catholic Health Care Ethics.* Washington D. C.: Georgetown University Press, 2004, pp. 3-9.

959 Richard McCormick. *Corrective Vision: Explorations in Moral Theology.* Kansas City, MO: Sheed & Ward, 1994, p.134.

960 Tom Beauchamp. *Philosophical Ethics: An Introduction to Moral Philosophy.* New York, NY: McGraw-Hill, Inc., 1991.

961 Charles Curran and Richard MeCormick. "Foreword," in *Readings in Moral Theology No.2: The Distinctiveness of Christian Ethics,* edited by Charles Curran and Richard McCormick. New York, NY: Paulist Press, 1980, p.1.

962 Lisa Sowle Cahill. "Christian Character, Biblical Community, and Human Values," in C*haracter and Scripture: Moral Formation, Community, and Biblical Interpretation* edited by William P. Brown. Grand Rapids, Michigan: William B Eerdmans Publishing Company, 2002.

963 William E. May. *Catholic Bioethics and the Gift of Human Life.* Huntington, IN: Our Sunday Visitor Publishing Division, Inc., 2000.

964 Peter J. Cataldo and John M. Haas. "Institutional Cooperation: The ERDs," (Catholic Health Association, November-December 2002). https://www.chausa.org/publications/health-progress/article/november-december-2002/institutional-cooperation-the-erds. [accessed on 2/22/2017].

965 Peter Cataldo. "Applying the Principle of Cooperation to Collaborative Arrangements," in *Walk as Children of Light: The Challenge of Cooperation in a Pluralistic Society* edited by Edward Furton and Louise Mitchell. Boston, MA: The National Catholic Bioethics Center, 2003. p.138.

966 Anthony Fisher. "Cooperation in Evil: Understanding the Issues," in *Cooperation, Complicity and Conscience* edited by Helen Watt. London: The Linacre Centre, 2005.

967 John Tuohey. "Partnering for More Than the Survival of a Catholic Presence in Healthcare," *New Theology Review* 12, no.1 [1999]: 52-59.

968 John Boyle. *The Sterilization Controversy: A New Crisis for the Catholic Hospital.* New York, NY: Paulist Press, 1977.

969 Peter Cataldo and John M. Haas. "Institutional cooperation: The ERDs," (Catholic Health Association, November-December 2002). https://www.chausa.org/publications/health-progress/article/november-december-2002/institutional-cooperation-the-erds. [accessed on 2/23/2017].

970 The National Catholic Bioethics Center. "Cooperating with Non-Catholic Partners," (Published in *Ethics and Medics,* November 1998). http://www.dcnhs-ec.org/assets/docs/Cooperating_with_Non-Catholic_Partners.pdf. [accessed on 2/23/2017].

971 John A. McHugh and Charles J. Callan. *Moral Theology: A Complete Course Based on St. Thomas Aquinas and the Best Modern Authorities.* Revised and Enlarged by Edward P. Farrell. New York city, NY: Joseph Wagner, Inc., 1958.

972 Thomas Kopfensteiner. "The Meaning and Role of Duress in the Cooperation in Wrongdoing," *The Linacre Quarterly* 70, no. 2, Article 7 [2003]: 150-158.

973 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics.,*2013, pp. 280-282.

974 Department of the Treasury, Department of Labor, Department of Health and Human Services. "Coverage of Certain Preventive Services Under the Affordable Care Act; Final Rules," *Federal Register* 78, no. 127 [July 2,2013]: 39869- 39899.

975 Federal Register. "Coverage of Certain Preventive Services Under the Affordable Care Act," (A Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department on 8/27/2014). https://www.federalregister.gov/documents/2014/08/27/2014-20252/coverage-of-certain-preventive-services-under-the-affordable-care-act. [accessed on 2/25/2017].

976 Adam Sonfield. "The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost Sharing," (Guttmacher Policy Review, Volume 14, Issue 1). https://www.guttmacher.org/gpr/2011/03/case-insurance-coverage-contraceptive-services-and-supplies-without-cost-sharing. [accessed on 2/25/2017].

977 J. D. Gipson, M. A. Koeing, and M. J. Hindin. "The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature," *Studies on Family Planning* 39, no. 1 [2008]: 18-38.

978 Claudia Goldin and Lawrence F. Katz. "Career and Marriage in the Age of the Pill," *The American Economic Review* 90, no. 2 [2000]: 461-465.

979 Claudia Goldin and Lawrence F. Katz. "The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions," *Journal of Political Economy* 110, no. 4 [2002]: 730-770.

980 Catholic Health Association of the United States. "Overview of Final Rules on Contraceptive Coverage for Religious Employers and Other Religious Organizations Issued June 28, 2013,"

https://www.chausa.org/docs/default-source/advocacy/130628hhs_summary_final_rule.pdf?sfvrsn=2. [accessed on 2/24/2017].

981 The Center for Consumer Information & Insurance Oversight. "Women's Preventive Services Coverage and Non-Profit Religious Organizations," https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/womens-preven-02012013.html. [accessed on 2/24/2017].

982 Department of the Treasury, Department of Labor, Department of Health and Human Services. "Coverage of Certain Preventive Services Under the Affordable Care Act; Final Rules," *Federal Register* 78, no. 127 [July 2,2013]: 39869- 39899.

983 Catholic News Agency. "Catholic Health Group Approves of Mandate Despite Bishops," (Washington D. C., July 9, 2013). http://www.catholicnewsagency.com/news/catholic-health-association-approves-of-mandate-despite-bishops/. [accessed on 2/25/2017].

984 David Gibson. "Catholic Hospitals and Birth Control: CHA at Odds with Catholic Bishops on Contraception Mandate," (The Huffington Post, 7/10/2013). http://www.huffingtonpost.com/2013/07/10/catholic-hospitals-birth-control_n_3568874.html. [accessed on 2/26/2017].

985 Scribd. "Summary of Final Rule for CHA Members," (Overview of Final Rules on Contraceptive Coverage for Religious Employers and Other Religious Organizations Issued June 28, 2013). https://www.scribd.com/document/152673086/Summary-of-Final-Rule-for-CHA-members. [accessed on2/26/2017].

986 David Gibson. "Catholic Hospitals and Birth Control: CHA at Odds with Catholic Bishops on Contraception Mandate," (The Huffington Post, 7/10/2013). http://www.huffingtonpost.com/2013/07/10/catholic-hospitals-birth-control_n_3568874.html. [accessed on 2/26/2017].

987 David Kelly, Gerard Magill, and Henk ten Have. *Contemporary Catholic Health Care Ethics,* 2013, pp. 283-284.

988 Luke 4:18. (New American Standard Version).

989 Matthew 25:44-45. (New American Standard Version).

990 United States Conference of Catholic Bishops. "Catholic Social Teaching," http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/. [accessed on 2/26/2017].

991 United States Conference of Catholic Bishops. "Seven Themes of Catholic Social Teaching," http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/seven-themes-of-catholic-social-teaching.cfm. [accessed on 2/26/2017].

992 The Offices of the Congregation for the Doctrine of the Faith. "Instruction Dignitas Personae on Certain Bioethical Questions," (Rome, September 8, 2008). http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html. [accessed on 2/27/2017].

993 Pope Leo XIII. "Rerum Novarum on Capital and Labor," (Given at St. Peter's in Rome, May 15, 1891). http://w2.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html. [accessed on 22/27/2017].

994 Pope Paul VI. "Populorum Progressio on the Development of Peoples," (Given in Rome at St. Peter's on March 26, 1967). http://w2.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_26031967_populorum.html. [accessed on 2/27/2017].

995 Pope Francis. "Encyclical Letter: Laudato Si on Care for Our Common Home," (Given in Rome at Saint Peter's on May 24, 2015). http://w2.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si.html. [accessed on 2/27/2017].

996 Pope John Paul II. "Sollicitudo Rei Socialis," (Given in Rome, at St. Peter's on December 30, 1987). http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_30121987_sollicitudo-rei-socialis.html. [accessed on 2/28/2017].

997 M. J. Sheridan, R. K. Bulls, C. R. Adcock, et al. "Practitioners' Personal and Professional Attitudes and Behaviors Towards Religion and Spirituality: Issues for Education and Practice," *Journal of Social Work Education* 28, no. 2 [1992]: 190-203.

998 R. K. Bullis. *Spirituality in Social Work Practice.* Washington, D. C.: Taylor & Francis, 1996.

999 Philip R. Popple and Leslie Leighninger. *Social Work, Social Welfare, and American Society.* Boston, MA: Allyn and Bacon Inc., 1996.

1000 Brenda DuBois and Karla Krogsrud Miley. *Social Work: An Empowering Profession.* Boston, MA: Allyn and Bacon, Inc. 1996.

1001 Robert M. Netting. *Cultural Ecology.* Long Grove, IL: Waveland Press Inc., 1986.

1002 J. W. Ellor, F. E. Netting, and J. M. Thibault. *Understanding Religious and spiritual Aspects of Human Service Practice.* Columbia, SC: University of South Carolina Press, 1999.

[1003] Philip R. Popple and Leslie Leighninger. *Social Work, Social Welfare, and American Society.* Boston, MA: Allyn and Bacon Inc., 1996.

[1004] William P. Barrett. "The Largest U. S. Charities for 2013," (Forbes, November 25, 2013). https://www.forbes.com/sites/williampbarrett/2013/11/25/the-largest-u-s-charities-for-2013/#513f923239e3. [accessed on 2/28/2017].

[1005] Catholic Charities USA. "What We Do," https://catholiccharitiesusa.org/what-we-do. [accessed on 2/28/2017].

[1006] Catholic Health Association (CHA). "Facts-Statistics: Catholic Health Care in the United States," (Updated January 2016). https://www.chausa.org/about/about/facts-statistics. [accessed on 2/28/2017].

Chapter Six

Conclusion

A historical change in the United States healthcare system occurred on March 23, 2010 when Affordable Care Act (ACA) was signed into law. The new healthcare system sharply divided this nation with proponents and opponents argued the validity of their positions. Adding to the complexity of the issue is the religious objection to contraceptive mandate. First of all, the public argued whether it was right to have a national healthcare system. Secondly, religious group agreed with healthcare provision for all but opposed to the contraceptive mandate. Despite strong oppositions, the government pushed forward to swiftly implement the new healthcare system while attempting to find resolutions. The concept of a national healthcare system, in this case is the ACA, can be justified using the four standard ethical principles (known as principlism). The principles of autonomy, non-maleficence, beneficence, and justice have been applied in analyzing various clinical issues in healthcare. They address the morality of obligation, rights, and actions that are bound within the rules of these principles, and they are appropriate for use to justify the right to healthcare in a specifically distinct manner, as established in the ACA.

United States is one of the wealthy countries in the world. However, more than 44.8 million Americans did not have healthcare benefits according to the national health survey in 2013. Many people receive health insurance through employment; however, when their employment ends so does their health insurance. Another problem, on the national level, is the unaffordability for the vulnerable populations to purchase healthcare. The issue of affordability raises the question whether there is a right to treatment and a right to basic healthcare. Similar

concerns were raised previously and resulted in Medicare and Medicaid programs that signed into law in 1960s. Both programs aim at providing healthcare for the elderly and individuals in poverty. Hence, Americans have been familiar with the idea of helping those who cannot afford healthcare. In agreeing to provide healthcare for the old and poor, there is a sense of rightness to serve the vulnerable populations in this nation.

Human dignity is known as the foundation of human rights. Dignity is not earned or gained by labor or achievement; it is simply related to being humans who naturally inherit rights to all necessities to sustain living. It then provides human rights with the protection of life, freedom, against oppression, and against unequal treatment. Based on personal autonomy, an autonomous person has the freedom to act on his own values and carry out his self-chosen plan without the interference by others. It indicates the natural free will to determine action for self. Immanuel Kant explains more clearly, to be a moral agent is to take responsibility for one's own actions; to be a responsible agent is to be able to choose freely; to choose freely is to be autonomous. This concept of human determination is significant in individuals' decision-making regarding healthcare choices. It reflects the state of independent self-governance as being able to consider the good of healthcare and make the decision to obtain it without the controlling interference of others. This is the nature of autonomy applied in healthcare. According to Kant, taking away a person's autonomy is to treat him as a means. Norman Daniels asserts respect for autonomy allows individuals to decide for themselves that they choose to have healthcare. Not receiving healthcare service during illness restricts autonomy. Respect for autonomy demands maintaining people's autonomous choice and eliminate conditions that destroy autonomous action.

Beneficence stresses the moral obligations to act for the benefit of others. The core element of the moral theory demands obligatory actions to give benefit, to prevent and remove harms, and to consider the goods and harms of an action. These obligations can apply to support the provision of healthcare to everyone securing basic protection of treatment. The act of beneficence is particularly pronounced when giving healthcare access to those who cannot afford it. When only some Americans, and not all, have health insurance coverage, there occurs partiality which is against moral rules. Setting up a healthcare practice that provides health insurance solely based on financial means is showing partiality that violates the moral rules of "Do not cause pain," "Do not disable," "Do not deprive of freedom," and "Do your duty." It is partial because favor is shown to those who have financial means, and the judgment causes pain to those who cannot afford it. The value of life and health should be respected in the same manner across all economic levels, and the exercise of freedom to choose health must be impartial. Providing healthcare for all Americans regardless of socioeconomic status is an act of judging impartially. This is reflected in ACA policy.

Nonmaleficence ensures the autonomous right of the patient regarding acceptance and refusal of treatment. Providers are to honor patients' medical wishes to treat if treatment is requested and not to treat when treatment is refused. The failure of executing both conditions violates moral principles. The patient's "right to die" is part of the patient's right to self-determination under the Self-Determination Act. Often, end-of-life decisions raise the concern for possible harm. The patient's choice and the physician's actions are often intertwined creating controversies. ACA policies requires practitioners to explain end-of-life services including palliative care, hospice, and life-sustaining treatment. This is to ensure patients are informed of their rights to make their final medical decisions and to avoid having physicians decide whether

to treat or not to treat which can lead to moral concerns. Hence, the Self-Determination Act respects the patient's wishes and ensures physicians' practice of nonmaleficence.

Justice is the reason for supporting healthcare for every member in society. Health ensures normal functioning which protects opportunity resulting in achieving life goals, and the need for normal functioning is worth supporting because it is the prerequisites for happiness. On the contrary, the impairment of normal functioning directly impacts capabilities by reducing their potential resulting in unfulfilled life goals. Rawls' theory of justice as fairness addresses fair equality of opportunity so that each person will have a fair share of the normal opportunity range. Fair share of opportunity cannot be achieved without normal functioning, and normal functioning for the general public is obtained through the provision of public healthcare. Clearly, there is the inter-connectedness among equal opportunity, normal functioning, and healthcare access. Based on distributive justice, healthcare as social goods is justified for fair distribution. When acquiring health services is burdensome to some and not others, it is considered social injustice. The moral right to healthcare advocates health for all member in society in support of fair opportunity. This is only possible through a national health system.

The Catholic Church has always supported healthcare and social work in the United States and abroad. As a matter of fact, every one in six patients in the United States is treated in a Catholic hospital. The contribution of Catholic healthcare is significant in the United States. It provides healthcare services when public hospitals refuse to treat. The commitment to treat the poor and uninsured demonstrates the dedication of the Catholic social belief in serving the common good. Moreover, the public has noted the relationship between religious values and social work. Even in facing the conflict with secular policies, Catholic teaching allows voting for law that support forbidden practices as long as the legislator who votes for a law that permits

forbidden practices has the intention to limit the harm done by legislation regarding those practices. In this case of contraceptive mandate, the principle of cooperation can be used as a compromise. For the purpose of the greater good, the potential to provide millions of uninsured people with basic healthcare services, the aim can be focused on a workable solution from the perspective of legality and theology so that the work of Catholic ministries can continue to serve the poor and the needy.

Bibliography

ACOG Committee on Practice Bulletins. "ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-gynecologists. Number 45, August 2003. Cervical Cytology Screening (Replaces Committee Opinion 152, March 1995)." *Obstet Gynecol* 102, no. 2 [2003]: 417-427.

Adleman, Andrea. "Will Obamacare Affect Medicare?: Myths and Facts." Health, U.S. News, November 14, 2014. http://health.usnews.com/health-news/health-insurance/articles/2014/11/14/will-obamacare-affect-medicare-myths-and-facts. [accessed 2/22/2016].

Administration for Community Living. "Administration on Aging (AOA): Aging Statistics." Last modified on 5/24/2016. https://aoa.acl.gov/Aging_Statistics/index.aspx. [accessed on 12/27/2016].

Administration for Community Living. "Profile of Older Americans: 2015, Disability and Activity Limitations." Last modified on 5/23/2016. https://aoa.acl.gov/Aging_Statistics/Profile/2015/16.aspx. [accessed on 12/27/2016].

Administration for Community Living. "Profile of Older Americans: 2015, The Older Population." Last modified on 5/23/2016. https://aoa.acl.gov/Aging_Statistics/Profile/2015/3.aspx. [accessed on 12/27/2016].

Administration on Aging. "Administration for Community Living." U. S. Department of Health and Human Services. http://www.aoa.gov. [accessed 4/2/2016].

Administrative Committee of the United States Conference of Catholic Bishops. "March 14 Statement on Religious Freedom and HHS Mandate: United for Religious Freedom".

http://www.usccb.org/issues-and-action/religious-liberty/march-14-statement-on-religious-freedom-and-hhs-mandate.cfm. [accessed July 5, 2015].

ADP Research Institute. "Planning for Health Care Reform: How Income Impacts Employee Health Benefits Participation." http://www.adp.com/~/media/RI/pdf/Benefits%20Planning%20For%20Health%20Care%20Reform%20How%20Income%20Impacts%20Employee%20Health%20Benefits%20Participation%20White%20Paper.ashx. [accessed 2/29/2016].

Agency for Healthcare Research and Quality. "2004 National Healthcare Disparities Report." AHRQ Publication, December 2004. https://archive.ahrq.gov/qual/nhdr04/nhdr2004.pdf. [accessed 12/27/2016].

Agency for Healthcare Research and Quality. "Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimate of Cost Savings and Deaths Averted From 2010 to 2013." http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/interimhacrate2013.pdf. [accessed 4/9/2016].

Agrawal, S., Bhupinderjit, A., Bhutani, M. S., et al. "Colorectal Cancer in African Americans." *Am J Gastroenterol* 100 no. 3 [2005]: 515-523.

The American College of Obstetricians and Gynecologists. "Preeclampsia and High Blood Pressure During Pregnancy." http://www.acog.org/~/media/For%20Patients/faq034.pdf?dmc=1&ts=20120730T1500377195. [accessed on 2/9/2017].

American Public Health Association. "People With Disability in National Health Care Reform." Policy Statement, no. 9307. Washington D.C.: APHA, 1994.

Americas Health Rankings (United Health Foundation). "A Call to Action for Individuals

and Their Communities." 25th Anniversary Edition, 2014. https://www.apha.org/~/media/files/pdf/pubs/ahr_2014.ashx. [accessed on 1/24/2016].

Anand, Sudhir, Peter, Fabienne, and Sen, Amartya. *Public Health, Ethics, and Equity.* Oxford, NY: Oxford University Press, 2004.

Anderson, G. "Chronic Care: Making the Case for Ongoing Care." Robert Wood Johnson Foundation, 2010. http://www.rwjf.org/en/library/research/2010/01/chronic-care.html. [accessed on 12/26/2016]. "

Anderson, Lynda A., Goodman, Richard A., and Holtzman, Deborah, et al. "Aging in the United States: Opportunities and Challenges for Public Health." *Am J Public Health* 102 no. 3 [2012]: 393-395.

Andersen, R. and Aday, L. A. "Access to Medical Care in the US: Realized and Potential." *Medical Care* 16, no. 7 [1978]: 533-546.

Andorno, Roberto. "Article 3: Human dignity and Human Rights." In *UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles, and Application* edited by Henk A.M.J. ten Have and Michele S. Jean. Paris, France: UNESCO, 2007.

Aquinas, Thomas. *Summa Theologiae.* I-II q.91, a.1-2; q.94, a. 2; in Blackfriars ed., vol. 28, trans. Thomas Gilby. New York: McGraw-Hill and London: Eyre and Spottiswoode, 1966.

Arcury, Thomas A., Precisser, J. S., and Gesler, W. M., et al. "Access to Transportation and Health Care Utilization in a Rural Region." *The Journal of Rural Health* 21 [2005]: 31-40.

Aristotle. *Nicomachean Ethics.* Translated by Martin Ostwald. Englewood Cliffs, NJ: Prentice Hall, 1962.

Arnason, Vilhjalmut, Li, Hongwen, and Cong, Yali. "Informed Consent." In *The SAGE Handbook of Healthcare Ethics: Core and Emerging Issues* edited by Ruth Chadwick, Henk ten Have, and Eric Meslin. Los Angeles, CA: Sage, 2011.

Arons, Jessica and Walden, Alex. "HHS: Contraception is Prevention." Posted on August 3, 2011. https://www.americanprogress.org/issues/women/news/2011/08/03/10133/hhs-contraception-is-prevention/. [accessed on 1/31/2017].

Artiga, Samantha, Rudowitz, Robin, and Gates, Alexandra, et al. "Recent Trends in Medicaid and CHIP Enrollment as of January 2015: Early Findings from the CMS Performance Indicator Project." March 31, 2015. http://kff.org/medicaid/issue-brief/recent-trends-in-medicaid-and-chip-enrollment-as-of-january-2015-early-findings-from-the-cms-performance-indicator-project/. [accessed 2/15/2016].

Aristotle. *Nicomachean Ethics.* Translated by Martin Ostwald. Englewood Cliffs, NJ: Prentice Hall, 1962.

Asch, S. M., Kerr, E. A., and Keesey, J., et al. "Who is at Greatest Risk for Receiving Poor-quality Health Care?" *New England Journal of Medicine* 354, no. 11 [2006]: 1147-1156.

Ashcroft, Richard. "The Declaration of Helsinki." In *The Oxford Textbook of clinical Research Ethics* edited by Ezekiel J. Emmanuel, Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010.

Ashley, Benedict M. "Reactions of Various Scholars and Their Comments on the

Working Paper, No. 1." In *A Report to the Congregation for the Faith "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons."* Braintree, MA: Pope John XXIII Medical-Moral Research and Education Center, 1988.

Ashley, Benedict M. and O'Rourke, Kevin D. *Health Care Ethics: A Theological Analysis.* Washington, D.C.: Georgetown University Press, 1997.

Ayres, Chris. "When IVF Turns into an IQ Test." *The Times,* December, 11, 2007.

Beauchamp, Tom L. and Childress, James F. *Principles of Biomedical Ethics.* Oxford, NY: Oxford University Press, Inc., 2009.

Bach, P. B., Pham, H. H., Schrag, D., et al. "Primary Care Physicians Who Treat Blacks and Whites." *New England Journal of Medicine* 351, no. 6 [2004]: 575-84.

Barber, Benjamin R. "Justifying Justice: Problem of Psychology, Politics, and Measurement in Rawls." In *Reading Rawls*, edited by Norman Daniels. New York: Basic Books, 1989.

Barrett, William P. "The Largest U. S. Charities for 2013." Forbes, November 25, 2013. https://www.forbes.com/sites/williampbarrett/2013/11/25/the-largest-u-s-charities-for-2013/#513f923239e3. [accessed on 2/28/2017].

Beauchamp, Tom. *Philosophical Ethics: An Introduction to Moral Philosophy.* New York, NY: McGraw-Hill, Inc., 1991.

Beauchamp, Tom L. and James F. Childress, *Principles of Biomedical Ethics*. New York, NY: Oxford University Press, 2001.

Beauchamp, Tom L. and Childress, James F. *Principles of Biomedical Ethics.* 6th Ed. Oxford, NY: Oxford University Press, 2009.

Bellone, J. M., Barner, J. C., and Lopez, D. A. "Postdischarge Interventions by

Pharmacists and Impact on Hospital Readmission Rates." *Journal of the American Pharmacists Association* 52, no.3 [2012]: 358-362.

Benedict XVI. "God is Love." *Deus Caritas Est.* 2005, nos. 20-23. http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est.html. [accessed July 5, 2015].

Bentham, Jeremy. "The Works of Jeremy Bentham, published under the Superintendence of his Executor, John Bowring." Edinburgh: William Tait, 1838-1843, 11 vols. http://oll.libertyfund.org/titles/bentham-works-of-jeremy-bentham-11-vols. [accessed on 11/5/2016].

Bernagiano, G. and von Hertzen, H. "Towards More Effective Emergency Contraception?" The *Lancet* 375 [February 13, 2010]: 527-28.

Berry, J., Caplan, L., Davis, S., et al. "A Black-white Comparison of the Quality of Stage-Specific Colon Cancer Treatment." *Cancer* 116, no 3 [2010]: 713-722.

Betancourt, Joseph R., Green, Alexander R., and Carrilio, J. Emilio, et al. "Defining Cultural Competnce: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care." *Public Health Reports* 118 [2003]: 293- 302.

Blum, Jonathan. "Post-acute Care in the Medicare Program." Testimony before House Committee on Ways and Means Subcommittee on Health, June 14, 2013. http://www.hhs.gov/asl/testify/2013/06/4481.html. [accessed 2/17/2016].

Blumberg, Linda J. "The Affordable Care Act: What Does it Do For Low-income Families? Institute for Research on Poverty, December 2012. http://www.irp.wisc.edu/publications/fastfocus/pdfs/FF15-2012.pdf. [accessed 7/14/2106].

Blumenthal, David, Abrams, Melinda, and Nuzum, Rachel. "The Affordable Care Act at 5 Years." *New England Journal of Medicine* 372, [2015]: 2451-2458.

Bobak, M. and Marmot, M. "East-West Mortality Divide and its Potential Explanation: Proposed Research Agenda." *British Medical Journal* 312 [1996]: 421-5.

Bodenheimer, T. and Berry-Millett, R. *Care Management of Patients with Complex Health Care Needs: Research Synthesis Report, No 19.* Princeton, NJ: Robert Wood Johnson Foundation, 2009.

Bognetti, Giovanni. "The Concept of Human Dignity in European and U.S. Constitutionalism." In *European and US constitutionalism,* Foreworded by G. Nolte. *Science and Technique of Democracy* no. 37 [2003]: 75.

Boston Medical Center, Boston University School of Medicine. "Project RED (Re-engineered Discharge)." http://www.bu.edu/fammed/projectred/index.html. [accessed 4/3/2016].

Boyle, John. *The Sterilization Controversy: A New Crisis for the Catholic Hospital.* New York, NY: Paulist Press, 1977.

Brault, Matthew W. "Americans with disability: 2010." United States Census Bureau. https://www.census.gov/prod/2012pubs/p70-131.pdf. [accessed May 23, 2015].

Brenner, M. H. "Mortality and the National Economy." *Lancet* 2 [1979]: 568-573.

British Library. "Mary Wollstonecraft, A Vindication of the Rights of Woman." http://www.bl.uk/collection-items/mary-wollstonecraft-a-vindication-of-the-rights-of-woman. [accessed on 6/16/2016].

Brock, Dan. "Public Policy and Bioethics." In *Encyclopedia of Bioethics* edited by W. T. Reich. New York, NY: Macmillan Reference, 1995, pp. 2181-8.

Brooks, Dan. *The Ultimate Medicare Decision-Making Formula: Consumer Guide to Medicare Supplement, Medicare Advantage, and Part D Plans.* eBook, 2013.

Brooks, W., Jordan, J., Divine, G., et al. "The Impact of Psychologic Factors on Measurement of Functional Status: Assessment of the Sickness Impact Profile." *Medical Care* 28, no. 9 [1990]: 793-804.

Brown, Todd M., Vaidya, Dhananjay, Rogers, William J., et al. "Does Prevalence of the Metabolic Syndrome in Women with Coronary Artery Disease Differ by the ATP III and IDF Criteria?" *Journal of Women's Health* 17, no. 5 [2008]: 841-847.

Brown, R. S., Peikes, S., Peterson, G., et al. "Six features of Medicare Coordinated Care Demonstration Programs that Cut Hospital Admissions of High-risk Patients." *Health Affairs (Project Hope)* 31, no. 6 [2012]: 1156-1166.

Buchanan, A., Brock, D., Daniels, N., et al. *From Chance to Choice: Genetics and Justice.* Cambridge, MA: Cambridge University Press, 2000.

Bullis, R. K. *Spirituality in Social Work Practice.* Washington, D. C.: Taylor & Francis, 1996.

Burchardt, T. "The Dynamics of Being Disabled." *Journal of Social Policy* 29 no. 4 [2000]: 645-668.

Burchardt, T. *The Education and Employment of Disabled Young People: Frustrated Ambition.* Bristol: Policy Press, 2005.

Burke, Amy and Simmons, Adelle. "Increased Coverage of Preventive Services with Zero Cost Sharing Under the Affordable Care Act." *ASPE Issue Brief,* June 27, 2014. https://aspe.hhs.gov/sites/default/files/pdf/76901/ib_PreventiveServices.pdf. [accessed 1/18/2016].

Burt, Robert A. *Death is That Man Taking Names.* Berkeley, CA: University of

California Press, 2002.

Butow, P. Maclean, M., S Dunn, S. et al. "The Dynamics of Change: Cancer Patients' Preferences for Information, Involvement and Support." *Ann Oncol.* 8 [1997]: 857-63.

Cahill, Lisa Sowle. "Christian Character, Biblical Community, and Human Values." In C*haracter and Scripture: Moral Formation, Community, and Biblical Interpretation* edited by William P. Brown. Grand Rapids, Michigan: William B Eerdmans Publishing Company, 2002.

Callahan, Daniel. "Adequate Health Care and an Aging Society: Are They Morally Compatible?" *Daedalus* 115 [1982]: 247-67.

Callahan, S. T. and Cooper, W. O. "Changes in Ambulatory Health Care Use During the Transition to Young Adulthood." *J Adolesc Health* 46, no. 5 [2010]: 407-413.

Calle, E. E., Thun, M. J., Petrelli, J. M., et al. "Body-mass Index and Mortality in a Prospective Cohort of U.S. Adults." *New England Journal Medicine* 341, no 15 [1999]: 1097-105.

Campbell, J., Jones, A. S., and Dienemann, J., et al. "Intimate Partner Violence and Physical Health Consequences." *Archives of Internal Medicine* 162 no. 10 [2002]: 1157-1163. http://orwh.od.nih.gov/resources/policyreports/pdf/WoC-Databook-FINAL.pdf. [accessed 3/20/2016].

The Care Transitions Intervention. "What is a Transitions Coach?" http://caretransitions.org/what-is-a-transitions-coach/. [accessed on 4/2/2016].

Carozza, Paolo G. "From Conquest to Constitutions: Retrieving a Latin American Tradition of the Idea of Human Rights." *Human Rights Quarterly* 25 [2003]: 281-313.

Case, A., Lubotsky, D., and Paxson, C. "Economic Status and Health in Childhood: The

Origins of the Gradient." *The American Economic Review* 25, no. 4 [2002]: 1308–1334.

Cassell, Eric J. *The Nature of Suffering and the Goals of Medicine.* Oxford, New York: Oxford University Press, Inc., 2004.

Cataldo, Peter. "Applying the Principle of Cooperation to Collaborative Arrangements."In *Walk as Children of Light: The Challenge of Cooperation in a Pluralistic Society* edited by Furton, Edward and Mitchell, Louise. Boston, MA: The National Catholic Bioethics Center, 2003.

Cataldo, Peter J. and Haas, John M. "Institutional Cooperation: The ERDs." Catholic Health Association, November-December 2002. https://www.chausa.org/publications/health-progress/article/november-december-2002/institutional-cooperation-the-erds. [accessed on 2/22/2017].

Catechism of the Catholic Church. "Moral Conscience." http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c1a6.htm. [accessed on 2/11/2017].

Catechism of the Catholic Church. "Part One: The Profession of Faith. Section Two: The Profession of the Christian Faith. Chapter Three: I believe in the Spirit. Article 9: "I Believe in the Holy Catholic Church."" http://www.vatican.va/archive/ccc_css/archive/catechism/p123a9p1.htm. [accessed on 2/17/2017].

Catechism of the Catholic Church. "Part One: The Profession of Faith, Section Two: the Profession of the Christian Faith, Chapter Two: I believe in Jesus Christ, The Only Son of God, Article 2: "And in Jesus Christ, His Only Son, Our Lord.""

http://www.vatican.va/archive/ccc_css/archive/catechism/p1s2c2a2.htm. [accessed on 2/20/2017].

Catechism of the Catholic Church. "Part Three: Life in Christ, Section Two: The Ten Commandments, Chapter Two: "You Shall Love Your Neighbor as Yourself", Article 5: The Fifth commandment." http://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm. [accessed on 2/16/2017].

Catechism of the Catholic Church. "Part One: The profession of Faith. Section Two The Profession of the Christian Faith. Chapter one Believe in God the Father. Article 1. Paragraph 6, 355-357." http://www.vatican.va/archive/ccc_css/archive/catechism/p1s2c1p6.htm. [accessed on 6/11/2016].

Catholic Charities USA. "What We Do." https://catholiccharitiesusa.org/what-we-do. [accessed on 2/28/2017].

Catholic Health Association (CHA). "Facts-Statistics: Catholic Health Care in the United States." Updated January 2016. https://www.chausa.org/about/about/facts-statistics. [accessed on 2/28/2017].

Catholic Health Association of the United States. "Overview of Final Rules on Contraceptive Coverage for Religious Employers and Other Religious Organizations Issued June 28, 2013." https://www.chausa.org/docs/default-source/advocacy/130628hhs_summary_final_rule.pdf?sfvrsn=2. [accessed on 2/24/2017].

The Catholic Health Association of the United States. *With Justice for All?: The Ethics of*

Healthcare Rationing. Lt. Louis, MO: The Catholic Health Association of the United States, 1991.

Catholic News Agency (CNA). "Catholic Church's Mission is to Continue Work of Jesus Christ, Archbishop Niendstedt." St. Paul, Minn., February 12, 2010. http://www.catholicnewsagency.com/news/catholic_churchs_mission_is_to_continue_work_of_jesus_christ_archbishop_niendstedt_explains/. [accessed 2/19/2017].

Catholic News Agency. "Catholic Health Group Approves of Mandate Despite Bishops." Washington D. C., July 9, 2013. http://www.catholicnewsagency.com/news/catholic-health-association-approves-of-mandate-despite-bishops/. [accessed on 2/25/2017].

Catholic Journal. "The Rise and Eclipse of Religious Liberty in America." http://www.catholicjournal.us/2016/05/28/rise-eclipse-religious-liberty-america/. [accessed on 2/9/2017].

Catholic United for the Faith. "The Church's Teaching on Moral Conscience." Last edited on 8/20/1999. http://www.cuf.org/2004/04/going-gods-way-the-churchs-teaching-on-moral-conscience/. [accessed on 2/11/2017].

The Center for Consumer Information and Insurance Oversight. "Women's Preventive Services Coverage and Non-profit Religious Organizations. Fact Sheet: Women's Preventive Services Coverage, Non-profit Religious Organizations, and Closely-Held For-Profit Entities." https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/womens-preven-02012013.html. [accessed on 1/31/2017].

Center for Disease Control and Prevention. "About Adult BMI." Page last updated on

May 15, 2015. http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/#trends. [accessed 1/21/2016].

Centers for Disease Control and Prevention. "Breast Cancer." Last updated on November 14, 2012. https://www.cdc.gov/vitalsigns/breastcancer/index.html. [accessed on 2/6/2017].

Center for Disease Control and Prevention. "National Prevention Strategy: America's Plan for Better Health and Wellness." Last updated January 17, 2014. http://www.cdc.gov/Features/PreventionStrategy/. [accessed on 1/24/2016].

Centers for Disease Control and Prevention. "Prevention and Public Health Fund." Last reviewed September 29, 2015. http://www.cdc.gov/funding/pphf/index.html. [accessed 1/19/2016].

Centers for Disease Control and Prevention. "Racial and Ethnic Approaches to Community Health (REACH 2010): Addressing Disparities in Health at a Glance 2004." http://www.cdc.gov/nccdphp/aag/aag_reach.htm. [accessed 3/20/2016].

Centers for Disease Control and Prevention. "Sexually Transmitted Diseases Treatment Guidelines, 2006." *MMWR Recomm Rep* 55 [2006]: 1-94.

Centers for Medicare & Medicaid Services. "Community-based Care Transitions Program."http://innovation.cms.gov/index.html. [accessed on April 11, 2015]

Center for Medicare & Medicaid Services. "Comprehensive Primary Care Initiative." Last updated March 22, 2016. https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/. [accessed 4/11/2016].

Centers for Medicare & Medicaid Services. "Emergency Medical Treatment & Labor Act (EMTALA)." Last modified March 26, 2012. https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/. [accessed on 1/8/2017].

Centers for Medicare and Medicaid Services. "Public Use File: New Data on Geographic Variation, 2015."http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html. [accessed 4/9/2016].

Center for Medicare and Medicaid Services. "Solicitation for Applications: Community-based Care Transitions Program."https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CCTP_Solicitation.pdf. [accessed 3/20/2016].

Centers for Medicare & Medicaid Services. "Trustees Report & Trust Funds." Last modified on 7/22/2015. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/. [accessed on 2/22/2016].

Center for Medicare & Medicaid Services. "Women's Preventive Services Coverage and Non-Profit Religious Organizations." http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html. [accessed September 9, 2015].

Center for Prevention and Health Services. "Eliminating Racial and Ethnic Health Disparities; A Business Case Update for Employers." Issue Brief, February 2009. https://minorityhealth.hhs.gov/Assets/pdf/checked/1/Eliminating_Racial_Ethnic_Health_Disparities_A_Business_Case_Update_for_Employers.pdf. [accessed 12/27/2016].

Chen, Edith, Strunk, Robert C., Trethewey, Alexandra, et al. "Socioeconomic Status and Inflammatory Processes in Childhood Asthma: The Role of Psychological Stress." *Journal of Allergy and Clinical Immunology* 117, no. 5 [2006]: 1014-1020.

Christopher, Andrea S. and Caruso, Dominic. "Promoting Health as a Human Right in the Post-ACA United States." *AMA Journal of Ethics* 17, no. 10 [2015]: 958-965.

Chua, Kao-Ping, and Sommers, Benjamin D. "Changes in Health and Medical Spending Among Young Adults Under Health Reform." JAMA 311, no. 23 [2014]: 2437-2439.

Churchhill, Larry R. *Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone*. Cambridge, MA: Harvard University Press, 1994, p. 35.

Clayton, Janine A., Brooks, Claudette E., Kornstein, Susan G. "Toward More Individualized Medicine: Introducing the Women of Color Health Data Book, Fourth Edition."http://orwh.od.nih.gov/resources/policyreports/pdf/WoC-Databook-FINAL.pdf. [accessed 3/20/2016].

Cohen, Robin A. and Kirzinger, Whitney K. "Financial Burden of medical Care: A Family Perspective." January 2014. http://www.cdc.gov/nchs/data/databriefs/db142.pdf. [accessed 2/13/2016].

Cohen, Robin A. and Martinez, Michael E. "Health Insurance coverage: Early Release of Estimates from the National Health Interview Survey." Division of Health Interview Statistics, National Center for Health Statistics, January-March 2015. http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf. [accessed 2/15/2016].

Coleridge, P. "Disabled People and 'Employment' in the Majority World: Policies and Realities." In *Working futures? Disabled People, Policy and Social Inclusion*, edited by Roulstone, A. and Barnes, C. Bristol: Policy Press, 2005.

Collins, Sara R., Doty, Michelle M., Robertson, Ruth, et al. "Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief- Findings from the Commonwealth Fund Biennial Health

Insurance Survey of 2010." March 2011. http://www.commonwealthfund.org/publications/fund-reports/2011/mar/help-on-the-horizon. [accessed 2/8/2016].

Concannon, Thomas W., Griffith, John L., Kent, David M, et al. "Elapsed Time in Emergency Medical Services for Patients with Cardiac Complaints: Are Some Patients at Greater Risk for Delay?" *Circ Cardiovasc Qual Outcomes* 2 [2009]: 9-15.

Congress.Gov. "H. R. 1308 – Religious Freedom Restoration Act of 1993." https://www.congress.gov/bill/103rd-congress/house-bill/1308. [accessed on 2/11/2017].

Congressional Budget Office. "CBO Memorandum: Projections of Expenditures for Long-Term Care Services for the Elderly." March 1999. https://www.cbo.gov/sites/default/files/106th-congress-1999-2000/reports/ltcare.pdf. [accessed on 1/6/2017].

The Constitution of the World Health Organization. "Basic Documents." Forty-fifth edition, Supplement, October 2006. http://www.who.int/governance/eb/who_constitution_en.pdf. [accessed 10/31/2016].

Conti, Carolyn Ann. "American Health Care: Justice, Policy, Reform." PhD diss., Duquesne University, 2010.

Cornell University Law School. "45 CFR 147.131 – Exemption and Accommodations in Connection with Coverage of Preventive Health Services." https://www.law.cornell.edu/cfr/text/45/147.131. [accessed on 2/1/2017].

Cornell University Law School. "U. S. Constitution: First Amendment." https://www.law.cornell.edu/constitution/first_amendment. [accessed on 2/11/2017].

Cowley, Stacy. "Many Low-Income Workers Say 'No' to Health Insurance." *The New York Times*, October 19, 2015, under "Business Day." http://www.nytimes.com/2015/10/20/business/many-low-income-workers-say-no-to-health-insurance.html?_r=0. [accessed 2/28/2015].

Cruzan v. Director, Missouri Department of Health. 1105. CT, 1990, pp. 2843, 2851-2852.

Curran, Charles and MeCormick, Richard. "Foreword." In *Readings in Moral Theology No.2: The Distinctiveness of Christian Ethics,* edited by Charles Curran and Richard McCormick. New York, NY: Paulist Press, 1980.

Curran, G. M., Sullivan, G., Williams, K., et al. "Emergency Department Use of Persons with Comorbid Psychiatric and Substance Abuse Disorders." *Annals of Emergency Medicine* 41 no. 5 [2003]: 659-667.

Daemmrich, Arthur. U.S. Healthcare Reform and the Pharmaceutical Industry. Harvard Business School. Harvard Business School, 2011. http://www.hbs.edu/faculty/Publication%20Files/12-015.pdf. [accessed March 15, 2015].

D'Amato, Anthony. "International Law and Rawls' Theory of Justice." Faculty Working Papers, Paper 119. http://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=1118&context=facultyworkingpapers. [accessed on 11/9/2016].

Damiano, P. C., Willard, J. C., Momany, E. T., et al. "The Impact of the Iowa S-SCHIP Program on Access, Health Status, and the Family Environment." *Ambulatory Pediatrics* 3, no. 5 [2003]: 63–9.

D'Angelo, Denise. "Patterns of Health Insurance Coverage Around the Time of

Pregnancy Among Women with Live-born Infants-Pregnancy Risk Assessment Monitoring System, 29 States, 2009." *Morbidity and Mortality Weekly Report (MMWR)* 64, no. SS04 [2015]: 1-19.

Daniels, Norman. "Equal liberty and unequal worth of liberty." In *Reading Rawls*, edited by Norman Daniels. New York: Basic Books, 1975.

Daniels, Norman. *Just Health Care.* Oxford, NY: Oxford University Press, 1985.

Daniels, Norman. *Reading Rawls: Critical Studies on Rawls' 'A Theory of Justice.'* Stanford, CA: Stanford University Press, 1989.

Daniels, Norman. *Just Health.* Cambridge, NY: Cambridge University Press, 2008.

Daniels, Norman. *Seeking Fair Treatment: From the AIDS Epidemic to National Health Care Reform.* Oxford, NY: Oxford University Press, 1995.

Daniels, Norman. *Am I Parents' Keeper?: An Essay on Justice Between the Young and the Old.* Oxford, NY: Oxford University Press, 1988.

Daniel, N., Kennedy, B., and Kawachi, I. "Health and Inequality, or Why Justice is Good for Our Health." In *Public Health, Ethics, and Equity* edited by Anand, S., Peter, F. and Sen, A. Oxford, New York: Oxford University Press, 2004.

Daniels, N. and Sabin, J. E. "The Ethics of Accountability and the Reform of Managed Care Organizations." *Health Affairs* 17, no. 5 [1997]: 50-69.

Daniels, N. and Sabin, J. E. "Limits to Health Care: Fair Procedures, Democratic Deliberation and the Legitimacy Problem for Insurer." *Philosophy and Public Affairs* 26 [1998]: 303-50.

Daniels, Norman and Sabin James E. *Setting Limits Fairly: Can We learn to Share Medical Resources?* Oxford, NY: Oxford University Press, 2002.

Daniels, Norman. *Just Health: Meeting Health Care Needs Fairly.* Cambridge, NY: Cambridge University Press, 2008.

Data.CMS.gov. "BPCI Initiative Filtered View." https://data.cms.gov/dataset/BPCI-Initiative-Filtered-View/e5a5-c768. [accessed on 4/10/2016].

Davidoff, A. "Insurance for Children with Special Health Care Needs: Patterns of Coverage and Burden on Families to Provide Adequate Insurance." *Pediatrics* 114 [2004]: 394-403.

Deane-Drummond, Celia. *Genetics and Christian Ethics: New Studies in Christian Ethics.* Cambridge. NY: Cambridge University Press, 2006.

Debruin, D. "Justice and the Inclusion of Women in Clinical Studies." *Kennedy Institute of Ethics Journal* 4 [1994]: 117-46.

Democratic Policy & Communications Center. Affordable Care Act: Section-by-Section Analysis with Changes Made by Title X and Reconciliation. http://www.dpc.senate.gov/healthreformbill/healthbill96.pdf. [accessed March 14,2015]

Democratic Policy& Communications Center. The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act Detailed Summary. http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. [accessed March 14, 2015]

DeNavas-Walt, Carmen, Proctor, Bernadette D., and Smith, Jessica C. "Income, Poverty, and Health Insurance coverage in the United States: 2012." U. S. Census Bureau. https://www.census.gov/prod/2013pubs/p60-245.pdf. [accessed May 24, 2015].

Department of Health & Human Services/Centers for Medicare & Medicaid Services.

"Re: Health Homes for Enrollees with Chronic Conditions, November 16, 2010." http://downloads.cms.gov/cmsgov/archiveddownloads/SMDL/downloads/SMD10024.pdf . [accessed April 11, 2015]

Department of Health and Human Services. Centers for Medicare & Medicaid Services. "The ABCs of the Annual Wellness Visit (AWV)." January 2015. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf. [accessed 1/18/2016].

Department of the Treasury, Department of Labor, Department of Health and Human Services. "Coverage of Certain Preventive Services Under the Affordable Care Act; Final Rules." *Federal Register* 78, no. 127 [July 2, 2013]: 39869- 39899.

Depoortere, Kristiaan. *A Different God: A Christian View of Suffering.* Louvian Theological & Pastoral Monographs 17. Louvain, Belgium: Peeters Press, 1995.

Dickman, R. "Operationalizing Respect for Persons: A Qualitative Aspect of the Right to Health Care." In *In Search of Equity: Heath Needs and the Health Care System* edited by Bayer R, Caplan, A, and Daniel, N. New York, NY: Plenum, 1983.

Donabedian, A. "The Quality of Medical Care: A Concept in Search of a Definition." *Journal of Family Practice* 9 no. 2 [1979]: 277-284.

Dorff, Elliot N. *Matters of Life and Death: A Jewish Approach to Modern Medical Ethics.* Philadelphia, PA: Jewish Publication Society, 1998.

Doty, Michelle M. Collins, Sara R. Nicholson, Jennifer. L. et. al. "Failure to Protect: Why the Individual Insurance Market is Not a Viable Option for Most US Family." The Commonwealth Fund, July 2009.

http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf. {accessed 1/11/2016].

Dougherty, Charles J. *American Health Care: Realities, Rights, and Reforms*. New York, NY: Oxford University Press, 1988.

Downey, Lois, Tyree, Patrick T., and Lafferty, William E. "Preventive Screening of Women Who Use Complementary and Alternative Medicine Providers." *Journal of Women's Health* 18 [2009]: 1133-1143.

Drever, F., Whitehead, M., and Roden, M. "Current Patterns and Trends in Male Mortality by Social Class (Based on Occupation)." *Population Trends* 86 [1996]:15-20.

Driscoll, Anne K. and Bernstein, Amy B. "Health and Access to Care Among Employed and Unemployed Adults: United States, 2009-2010." National Center for Health Statistics, no. 83, January 2012. https://www.cdc.gov/nchs/data/databriefs/db83.pdf. [accessed 1/8/2017].

DuBois, Brenda and Miley, Karla Krogsrud. *Social Work: An Empowering Profession.* Boston, MA: Allyn and Bacon, Inc. 1996.

Dworkin, Ronald. "What is equality? Part 1: Equality of Welfare." *Philosophy and Public Affairs* 10, no. 3 [1981]:185-246

Dworkin, Gerald. *The Theory and Practice of Autonomy.* New York, NY: Cambridge University Press, 1988.

Dworkin, Ronald. "Life Past Reason." In *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* edited by Ronald Dworkin. New York: Knopf, 1993.

Eisner, Mark D., Blanc, Paul D., Yelin, Edward H., et al. "COPD as a Systemic Disease:

Impact on Physical Functional Limitations." *American Journal of Medicine* 121, no, 9 [September 2008]: 789-796. http://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=18724969. [accessed May 23, 2015].

Ellor, J. W., Netting, F. E., and Thibault, J. M. *Understanding Religious and Spiritual Aspects of Human Service Practice.* Columbia, SC: University of South Carolina Press, 1999.

Emanuel, Ezekiel J. and Grady, Christine. "What Makes Clinical Research Ethical." *JAMA* 283 [2000]: 2701-11.

Emanuel, E. J., Killen J., Wendler D., and Grady, C. "What Makes Clinical Research In developing Countries Ethical? The Benchmarks of Ethical Research." *Journal of Infectious Diseases* 189 [2004]: 930-7.

Emanuel, Ezekiel J., Christine Grady, Robert A. Crouch, et al. *The Oxford Textbook of Clinical Research Ethics.* Oxford, NY: Oxford University Press, Inc., 2008, p. 149.

Emanuel, Ezekiel J., Wendler, David, and Grady, Christine. "An Ethical Framework for Biomedical Research." In *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel, Ezekiel J., Christine Grady, Robert A. Crouch, Reidar K. Lie, Franklin G. Miller, and David Wendler. Oxford, New York: Oxford University Press, Inc., 2010.

Emanuel, Ezekiel J. *Reinventing American Health Care: How the Affordable Care Act will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error System.* New York, NY: Public Affairs Books, 2014.

Emmett, Tony. "Disability, Poverty, Gender, and Race." In *Disability and Social Change: A South African Agenda* edited by Watermeyer, Brian, Swartz, Leslie, Lorenzo, Theresa, Schneider, Marguerite, and Priestley, Mark. Cape Town: HSRC Press, 2006.

Engelhardt, H. T., Jr. *The Foundations of Bioethics.* Oxford: Oxford University Press, 1996.

Enthoven, Alain. Health Plan: The Practical Solution to the Soaring Cost of Medical Care. Reading, MA: Addison-Wesley Publishing Company, 1980.

Eunice Kennedy Shriver National Institute of Child Health and Human Development. "What Health Issues or Conditions Affect Women Differently than Men?" National Institute of Health. https://www.nichd.nih.gov/health/topics/womenshealth/conditioninfo/pages/howconditions.aspx. [accessed 2/8/2017].

Eunice Kennedy Shriver National Institute of Child Health and Human Development. "What are Some Common Complications of Pregnancy?" National Institute of Health. https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/complications.aspx. [accessed on 2/9/2017].

Eunice Kennedy Shriver National Institute of Child Health and Human Development. "What are the Factors That Put a Pregnancy at risk?" National Institute of Health. https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo/pages/factors.aspx. [accessed on 2/9/2017].

Evans, Donald. "Autonomy and Individual Responsibility." In *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles, and Application,* edited by Henk A.M.J. ten Have and Michele S. Jean. Paris, France: UNESCO, 2007.

Evashwick, C. J. *The Continuum of Long-Term Care.* Albany, NY: Delmar, 2001.

Executive Office of the President Council of Economic Advisers. *The Economic Case for Health Care Reform.* Washington, D.C.: Government Printing Office, June 2009.

The Faculty of Public Health. "What is Public Health?" http://www.fph.org.uk/uploads/about_us_leaflet_2007.pdf. [accessed on 10/31/2016].

Federal Register. "Agency Information Collection Activities; Submission for OMB Review; Comment Request; Summary of Benefits and Coverage and Uniform Glossary Required Under the Affordable Care Act." A Notice by the Labor Department on 2/26/2016. https://www.federalregister.gov/articles/2016/02/26/2016-04314/agency-information-collection-activities-submission-for-omb-review-comment-request-summary-of. [accessed 3/2/2016].

Federal Register. "Coverage of Certain Preventive Services Under Affordable Care Act." A rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department on 7/14/2015. https://www.federalregister.gov/documents/2015/07/14/2015-17076/coverage-of-certain-preventive-services-under-the-affordable-care-act. [accessed on 1/27/2017].

Federal Register. "Coverage of Certain Preventive Services Under the Affordable Care Act." A Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department on 8/27/2014. https://www.federalregister.gov/documents/2014/08/27/2014-20252/coverage-of-certain-preventive-services-under-the-affordable-care-act. [accessed on 2/25/2017].

Feldman, Arthur. *Understanding Health Care Reform: Bridging the Gap between Myth and Reality.* Boca Raton, FL: CRC Press, 2012.

Finkelstein, Amy, Taubman, Sarah, Wright, Bill, et al. and the Oregon Health Study Group. "The Oregon Health Insurance Experiment: Evidence from the First Year." *Q J Econ* 127, no. 3 [2012]: 1057-1106.

Fisher, Anthony. "Cooperation in Evil: Understanding the Issues." In *Cooperation, Complicity and Conscience* edited by Helen Watt. London: The Linacre Centre, 2005.

Fletcher, S. W. and Elmore, J. G. "Clinical Practice: Mammographic Screening for Breast Cancer." *New England Journal of Medicine* 348 [2003]: 1672-1680.

Foley, K. L., Song, E. Y., Klepin, H., et al. "Screening Colonoscopy among Colorectal Cancer Survivors Insured by Medicaid." *American Journal of Clinical Oncology* 35, no 3 [2012]: 205-211.

Fortuna, R. J., Robbins, B. W., J. S. Halterman, J. S. "Ambulatory Care Among Young Adults in the United States." *Ann Intern Med* 151, no. 6 [2009]: 379-385.

Fox News Politics. "Groups Opposed to Contraception Mandate will Push Forward with Lawsuits." Published June 28, 2012. http://www.foxnews.com/politics/2012/06/28/groups-opposed-to-health-care-mandate-to-push-forward-with-lawsuits.html. [accessed 1/30/2017].

Fox, Thomas C. "Francis to Korean Bishops: 'Be One with the Poor'." National Catholic Reporter, August 14, 2014. https://www.ncronline.org/blogs/ncr-today/francis-korean-bishops-be-one-poor. [accessed on 2/17/2017].

Freedman, B. "Scientific Value and Validity as Ethical Requirements for Research." IRB: *A Review of Human Subjects Research* 9, no. 6 [1987]: 7-10.

Furman, Jason and Fiedler, Matt. "4.5 Million Young Adults Have Gained Coverage Since 2010, Improving Access to Care and Benefitting Our Economy." January 29, 2015. https://www.whitehouse.gov/blog/2015/01/29/45-million-young-adults-have-gained-coverage-2010-improving-access-care-and-benefitt. [accessed 12/30/2015].

Gabel, Jon, McDevitt, R., Gandolfo, L., et al. "Generosity and adjusted premiums in job-

based insurance: Hawaii is up, Wyoming is down." *Health Affairs* 25, no. 3 [2006]:832-43.

Galbraith, A., Sinaiko, A., Soumerai, S., et al. "Some families who purchased health coverage through the Massachusetts connector wound up with high financial burdens." *Health Affairs* 32, no. 5 [2013]: 974-983.

Galbraith, Alison, Wong, Sabrina T., Kim, Sue E. et al. "Out-of-pocket Financial Burden for Low-income Families with Children: Socioeconomic Disparities and Effects of Insurance." *Health Serv Res* 40, no. 6 [2005]: 1722-1736.

Gert, Bernard. *Common Morality.* Oxford, NY: Oxford University Press, 2004.

Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A Systematic Approach.* New York, New York: Oxford University Press, 2006.

Gert, Heather. "Viability." In *The Problem of Abortion* edited by Joel Feinberg and Susan Dwyer. Belmont, CA: Wadsworth, 1997.

Gerhart, Ann. "First lady pushes cause of reform." The Washington Post, September 19, 2009. http://www.washingtonpost.com/wp-dyn/content/article/2009/09/18/AR2009091802059.html. [accessed June 14, 2015]

Giannuzzi, Pantaleo, Temporelli, Pier Luigi, Corra, Ugo, et al. "Attenuation of Unfavorable Remodeling by Exercise Training in Postinfarction Patients with Left Ventricular Dysfunction: Results of the Exercise in Left Ventricular Dysfunction (ELVD) Trial." *Circulation* 96, no. 6 [1997]: 1790-7.

Gibson, David. "Catholic Hospitals and Birth Control: CHA at Odds with Catholic Bishops on Contraception Mandate." The Huffington Post, 7/10/2013.

http://www.huffingtonpost.com/2013/07/10/catholic-hospitals-birth-control_n_3568874.html. [accessed on 2/26/2017].

Gillespie, D., Gleason, M., Mshinda, H., et al. "Knowledge into Action for Child Survival." *The Lancet,* 362 [2003]: 323-27.

Gipson, J. D., Koeing, M. A., and Hindin, M. J. "The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature." *Studies on Family Planning* 39, no. 1 [2008]: 18-38.

Goldin, Claudia and Katz, Lawrence F. "Career and Marriage in the Age of the Pill." *The American Economic Review* 90, no. 2 [2000]: 461-465.

Goldin, Claudia and Katz, Lawrence F. "The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions." *Journal of Political Economy* 110, no. 4 [2002]: 730-770.

Grady, Christine. *The Search for an AIDS Vaccine: Ethical Issues in the Development and Testing of a Preventive HIV Vaccine.* Bloomington, IN: Indiana University Press, 1995.

Grogan, Collen M. "Political-Economic Factors Influencing State Medicaid Policy." *Political Research Quarterly* 47 [1994]: 589-622.

Grodin, Michael. "The Nuremberg Code." In *The Oxford Textbook of Clinical Research Ethics,* edited by Emanuel, Ezekiel J., Grady, Christine, Crouch, Robert A., Lie, Reidar K., Miller, Franklin G., and Wendler, David, 136-7. Oxford, New York: Oxford University Press, Inc., 2010.

Gupta, Rita Paul-Sen, de Wit, Margaret L, and McKeown, David. "The Impact of

Poverty on the Current and Future Health Status of Children." *Paediatr Child Health* 12, no. 8, [2007]: 667-672.

Guyer, Paul. "Kant on the Theory and Pracitce of Autonomy." *Social Philosophy and Policy* 20 [2003]: 70-98.

Haas, J. and Swartz, K. "The Relative Importance of Worker, Firm, and Market Characteristics for Racial/Ethnic Disparities in Employer-Sponsored Health Insurance." *Inquiry* 44, no. 3 [2007]: 280-302.

Hadley, J., Holahan, J., and Coughlin, T., et al. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs* 27 no. 5 [2008]: 399-415.

Hall, Mark A. "The Malpractice Standard Under Health Care Cost Containment." *Law, Medicine and Health Care* 17 [1989]: 347-355.

Halpern, Jodi. "What is Clinical Empathy?" *J Gen Intern Med* 18[2003]: 670-674.

Harris, D. J. and Douglas, P. S. "Enrollment of Women in Cardiovascular Clinical Trials Funded by the National Heart, Lung, and Blood Institute." *New England Journal of Medicine* 343 [2000]: 475-480.

Harvard Health Publications. Harvard Medical School. "Women's Health." http://www.health.harvard.edu/topics/womens-health/. [accessed on 2/4/2017].

Hassan, S. S., Romero, R., Vidyadhari, D., et al. "Vaginal Progesterone Reduces the Rate of Preterm Birth in Women with a Sonographic Short Cervix: A Multicenter, Randomized, Double-blind, Placebo-controlled Trial." *Ultrasound in Obstetrics & Gynecology* 38 [2011]: 18-31.

Hawaii State Department of Health. "Hawaii Pregnancy Risk Assessment Monitoring

System (PRAMS) trend report 2000-2008." Family Health Services Division, Maternal and Child Health Branch, 2010. http://health.Hawaii.gov/mchb/files/2013/05/pramstrendreport2010.pdf. [accessed 3/20/2016].

He, Wan, Sengupta, Manisha, Velkoff, Victoria A., et al. "U. S. Census Bureau, Current Population Reports, P23-209, 65+ in the United States: 2005." Washington, DC, U. S. Government Printing Office, 2005. http://www.census.gov/prod/2006pubs/p23-209.pdf. [accessed 12/26/2016].

HealthCare.gov. "Coverage for pre-existing conditions." https://www.healthcare.gov/coverage/pre-existing-conditions/. [accessed 1/15/2016].

HealthCare.gov. "Health Benefits and Coverage: Birth Control Benefits." https://www.healthcare.gov/coverage/birth-control-benefits/. [accessed 1/27/2017].

HealthCare.gov. "How the Affordable Care Act Affects Small Businesses." The Health Care Law & Business. https://www.healthcare.gov/small-businesses/health-care-law-and-business/how-aca-affects-businesses/. [accessed 3/2/2016].

HealthCare.gov. "Introducing the Health Insurance Marketplace." June 21, 2013 https://www.healthcare.gov/blog/introducing-the-health-insurance-marketplace/. [accessed 1/6/2016].

Healthcare.gov. "Preventive Care Benefits for Women." https://www.healthcare.gov/preventive-care-women/. [accessed 3/7/2016].

HealthCare.gov. "The Children's Health Insurance Program (CHIP)." https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/. [accessed 1/6/2016].

HealthCare.gov. "The 'metal' Categories: Bronze, Silver, Gold & Platinum." https://www.healthcare.gov/choose-a-plan/plans-categories/#catastrophic. [accessed 1/6/2016].

HealthyChildren.Org. "Teenage Pregnancy." American Academy of Pediatrics, last updated on 11/21/2015. https://www.healthychildren.org/English/ages-stages/teen/dating-sex/pages/Teenage-Pregnancy.aspx. [accessed on 2/9/2017].

Health Insurance portability and Accountability Act of 1996. HR 3103. Public Law 104-191. 104th Cong. [August 21, 2996].

Health Resources and Services Administration. "Affordable Care Act Maternal, Infant and Early Childhood Home Visiting program." http://www.hrsa.gov/grants/apply/assistance/homevisiting/homevisitingsupplemental.pdf. [accessed 3/22/2016].

Health Policy Priorities. "Partnership for Prevention." Washington, DC, 2005. http://www.prevent.org/images/stories/health_policy.pdf. [accessed 1/23/2016].

HealthyPeople.Gov. "Breast Cancer Screening: An Update for the U. S. Preventive Services Task Force (Clinical Guide Recommendation)." https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/screening-breast-cancer-update-us-preventive-services. [accessed on 2/6/2017].

Hellmich, Nanci. "Obamacare Requires Most Insurers to Tackle Obesity." USA Today, July 4, 2013. http://www.usatoday.com/story/news/nation/2013/07/04/obesity-disease-insurance-coverage/2447217/. [accessed 1/18/2016].

The Henry J. Kaiser Family Foundation. "Key Facts About the Uninsured Population." October 5, 2015.

http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/. [accessed 2/13/2016].

The Henry J. Kaiser Family Foundation. "Overview of Contraceptive Coverage under the ACA and Legal Challenges to the Requirement." https://kaiserfamilyfoundation.files.wordpress.com/2014/02/slides-laurie_sobel-supreme-court-and-contraceptives2.pdf. [accessed 3/28/2016].

The Henry J. Kaiser Family Foundation. "Status of State Acton on the Medicaid Expansion Decision." January 2016. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. [accessed 2/15/2016].

The Henry J. Kaiser family Foundation. "Survey of People who Purchase Their Own Insurance." June 2010. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8077-r.pdf. [accessed 1/12/2016].

The Henry J. Kaiser Family Foundation. "Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women." April 13, 2015 http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/ [accessed 12/31/2015].

Herda, Jerry. "Is Killing Enemy on Battlefield a Sin?" Catholic Herald, September 19, 2013. http://catholicherald.org/special-sections/myfaith/is-killing-enemy-on-battlefield-a-sin/. [accessed on 2/21/2017].

Herman, Barbara. "Mutual Aid and Respect for Persons." *Ethics* 94 [July, 1984]: 577- 602.

Hickey, T., Speers, M. A., and Prohaska, T. R. *Public Health and Aging.* Baltimore, MA: Johns Hopkins University Press, 1997.

Hillman, A. L. "Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?" *The New England Journal of Medicine* 317 [1987]:1747.

Hillman, A. L. "Health Maintenance Organizations, Financial Incentives, and Physicians' Judgments." *Annals of Internal Medicine,* 112 [1990]: 892.

Himmelstein, David U., Thorne, Deborah, Warren, Elizabeth, et al. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Medicine.* 2009; 122: 741-746.

Hippocrates. *The Genuine Works of Hippocrates: The Book of Prognostics,* trans. Francis Adams. Baltimore: Williams and Wilkens Company, 1939.

Hirshfield, Daniel S. *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943.* Cambridge, MA: Harvard University Press, 1970.

Holland, Stephen. *Public Health Ethics.* Malden, MA: Polity Press, 2007.

Iglehart, John. "Medicaid Expansion Offers Solutions, Challenges." *Health Aff* 29, no. 2 [2010]: 2230-2232.

Ingraham, Christopher. "Our Infant Mortality Rate is a National Embarrassment." *The Washington Post,* September 29, 2014*,* under "Wonkblog," https://www.washingtonpost.com/news/wonk/wp/2014/09/29/our-infant-mortality-rate-is-a-national-embarrassment/. [accessed 3/22/2016].

Institute for Healthcare Improvement. "Reducing Avoidable Readmissions by Improving

Transitions in Care." http://www.ihi.org/education/InPersonTraining/ReduceReadmissions/Pages/default.aspx. [accessed 4/3/2016].

Institute of Medicine (IOM). "Care Without Coverage: Too Little, Too Late." May 2002. https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2003/Care-Without-Coverage-Too-Little-Too-Late/Uninsured2FINAL.pdf. [accessed 1/13/2017].

Institute of Medicine. "Clinical Preventive Services for Women: Closing the Gaps." http://iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. [assessed April, 6 ,2015].

Institute of Medicine of the National Academies. "Clinical Preventive Services for Women: Closing the Gaps." Report Brief, July 2011. http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the Gaps/Preventive%20Services%20Women%202011%20Report%20Brief.pdf. [accessed 3/27/2016].

Institute of Medicine. "Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare." March 2002. https://iom.nationalacademies.org/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitieshcproviders8pgFINAL.pdf. [accessed 2/2/2016].

Institution for Work & Health. "What Researchers mean by…Primary, Secondary and

Tertiary prevention." 2006. http://www.iwh.on.ca/wrmb/primary-secondary-and-tertiary-prevention. [accessed on 2/1/2016].

Internal Revenue Service. "Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)." Page last reviewed or updated on 3/3/2016. https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055. [accessed on 3/11/2016].

Ioannes Paulus PP. II (John Paul II). "Evangelium Vitae on the Value and Inviolability of Human Life." Given in Rome on March 25, 1995. http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html. [accessed on 2/20/2017].

Jekel, James F. and Elmore, Joann G. *Epidemiology, Biostatistics, and Preventive Medicine.* Philadelphia, PA: Elsevier Saunders, 2007.

Jencks, S. F., Williams, M. V., and Coleman, E. A. "Rehospitalizations among Patients in the Medicare Fee-for-service Program." *New England journal of Medicine* 360, no.14 [2009]: 1418-1428.

Jha, Ashish K., Varosy, Paul D., Kanaya, Alka M., et al. "Differences in Medical Care and Disease Outcomes Among Black and White Women with Heart Disease." *Circulation* 108, no. 9 [2003]: 1089-94.

Jiamsripong, Panupong, Mookadam, Martina, Honda, Tadaaki, et al. "The Metabolic Syndrome and Cardiovascular Disease: Part I." *Prev Cardiol* 11, no. 3 [2008]: 155-61.

Johnson, Kay, Posner, Samuel F., Biermann, Janis, et al. "Recommendations to Improve Preconception Health and Health Care-United States." A Report of the

CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. *MMWR* 55, no. RR06 [2006]:1-23.

Joint Center for Political and Economic Studies. "Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Population." July 2010. http://jointcenter.org/sites/default/files/Patient%20Protection%20and%20Affordable%20Care%20Act.pdf. [accessed on 1/6/2017].

Jonsen, Albert. "Principles for an Ethics of Health Services." In *Social Policy, Social Ethics, and The Aging Society,* edited by B. L. Neugarten and R. J. Havighurst. Washington D.C.: National Science Foundation, 1976.

Jonsen, Albert R. and Toulmin, Stephen. *The Abuse of Casuistry: A History of Moral Reasoning.* Berkeley, CA: University of California Press, 1988.

Kant, Immanuel. "Foundation of the Metaphysics of Moral." trans. Lewis White Beck. Indianapolis, IN: Bobbs-Merrill, 1956.

Kant, Immanuel. "The Doctrine of Virtue, part II of the Metaphysics of Morals." trans. Mary Gregor. Philadelphia: University of Pennsylvania Press, 1964.

Kant, Immanuel. "The Conflict of the Faculties." In *Religion and Rational Theology,* edited by I. Kant, A. W. Wood and G. di Giovanni, trans. M.J. Gregor and R. Anchor. Cambridge, MA: Cambridge University Press, [1798] 1996, 239-327.

Kant, Immanuel. "The Metaphysic of Ethics." Trans. By J. W. Semple. http://oll.libertyfund.org/titles/kant-the-metaphysics-of-ethics. [accessed on 6/12/2016].

Kaplan, G. A., Pamuk, E. R., Lynch, J. W., et al. "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways." *British Medical Journal* 312 [1996]: 999-1003.

Karim, Q. A., Karim, S. S. A., Coovadia, H. M. et al. "Informed Consent for HIV Testing in A South African Hospital: Is It Truly Informed and Truly and Truly Voluntary?" *American Journal of Public Health* 88 [1998]: 637-40.

Kass, Leon. R. "Practicing Ethics: Where's the action?" *Hastings Center Report* 20, no. 1 [1990]: 5-12.

Katz, David L. and Ali, Ather. "Preventive Medicine, Integrative Medicine & the Health of the Public." Commissioned for the Institute of Medicine, February, 2009. http://www.iom.edu/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf. [accessed March 21, 2015].

Katz, Jay. *The Silent World of Doctor and Patient.* New York: Free Press, 1984.

Kelly, David F. *Contemporary Catholic Health Care Ethics.* Washington, D.C.: Georgetown University Press, 2004.

Kelly, David, Magill, Gerard, and ten Have, Henk. *Contemporary Catholic Health Care Ethics.* Washington, D.C.: Georgetown University Press, 2013.

Kennedy, B. P., Kawachi, I., and Prothrow-Stith, D. "Income Distribution and Mortality: Cross Sectional Ecological Study of the Robin Hood Index in the United States." *British Medical Journal* 312 [1996]: 1004-7.

Kjerulff, K. H., Frick, K. D., and Rhoades, J. A., et al. "The Cost of Being a Woman- A

National Study of Health Care Utilization and Expenditure for Female-specific Conditions." *Womens Health Issues* 17, no. 1 [2007]: 13-21.

Kocher, R. P. & Adashi, E. Y. "Hospital Readmissions and the Affordable Care Act Paying for Coordinated Quality Care." *JAMA* 306, no. 16 [2011]: 1794- 1795.

Koch, K. A. "Patient Self-Determination Act." *The Journal of the Florida Medical Association* 79, no 4 [1992]: 240-3.

Koh, Howard K. and Sebelius, Kathleen G. "Promoting Prevention through the Affordable Care Act." *New England Journal of Medicine* 363 [2010]: 1296-1299.

Kopfensteiner, Thomas. "The Meaning and Role of Duress in the Cooperation in Wrongdoing." *The Linacre Quarterly* 70, no. 2, Article 7 [2003]: 150-158.

Kronebusch, K. "Medicaid Politics: Policymaking Contexts and the Politics of Group Differences in the American States." PhD. Diss., Harvard University, 1993.

Ku, B. S., Scott, K. C., Kertesz, S. G., et al. "Factors Associated with Use of Urban Emergency Departments by the U. S Homeless Population." *Public Health Reports* 125, no. 3 [2010]: 398-405.

Kuh, D., Hardy, R., Langenberg, C., et al. "Mortality in Adults Aged 26-54 Years Related to Socioeconomic Conditions in Childhood and Adulthood: Post War Birth Cohort Study." *BMJ* 325, no. 7372 [2002 Nov 9]: 1076-80.

Kukla, Rebecca. "Conscientious Autonomy: Displacing Decisions in Health Care." *Hasting Center Report* 35 [March-April, 2005]: 34-44.

LaPointe, N. M. A., Chen, A. Y., Alexander, K. P., et al. "Enoxaparin Dosing and Associated Risk of In-hospital Bleeding and Death in Patients with Non-ST-segment Elevation Acute Coronary Syndromes." *Arch Inter Med* 167 [2007]: 1539-1544.

Lachs, M. S., Sindelar, J. L., and Horwitz, R . I. "The Forgiveness of Coinsurance: Charity or Cheating." *The New England Journal of Medicine,* 322 [1990]: 1599-1602.

Leavell, H. R. and Clark, E. G. *Preventive Medicine for the Doctor in His Community.* New York: McGraw-Hill Book Company, 1965.

Lebacqz, Karen. *Six Theories of Justice*: *Perspectives from Philosophical and Theological Ethics.* Minneapolis, MN: Augsburg Publishing House, 1986.

Lee, P. Y., Alexander, K. P., Hammill, B. G., et al. "Representation of Elderly Persons and Women in Published Randomized Trials of Acute Syndromes." *JAMA* 286 [2001]: 708-713.

Leeman, L. and Fontaine, P. "Hypertensive Disorders of Pregnancy." *American Family Physician* 78 [2008]: 93-100.

LET (Leadership, Education & Training Program in Maternal & Child Nutrition). "Focus on Prevention: Strategies for Affecting Nutritional Health." University of Minnesota, Last modified in August 2012. http://www.epi.umn.edu/let/nutri/principles/prevent.shtm. [accessed on 1/23/2016].

Levine, R. J. *Ethics and Regulation of Clinical Research.* New Haven, Ct: Yale University Press, 1988.

Levinson, W. and Roter, D. "Physicians' Psychosocial Beliefs Correlate with Their Patient Communication Skills." *Journal of General Internal Medicine* 10 [1995]: 375-9.

Lezzoni, Lisa I. "Public Health Goals for Persons with Disabilities: Looking Ahead to 2020." *Institute for Health Policies*, 2 [2009]: 111-115.

The Library of Congress Thomas. *Patient Self Determination Act of 1990*. H.R..4449. Sec. 2.

Link, Bruce G. and Phelan, J. C. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* Extra Issue [1995]: 80-94.

Link, Bruce G., Northridge, M. E., and Phelan, M. E., et al. "Social Epidemiology and the Fundamental Cause Concept: On the Structuring of Effective Cancer Screens by Socioeconomic Status." *Milbank Quarterly* 76 [1998]: 375-402.

Linn, Margaret W., Sandifer, Richard, and Stein, Shayna. "Effects of Unemployment on Mental and Physical Health." *Am J Public Health* 75, no. 5 [1985]: 502-506.

Liptak, Adam. "Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama." The New York Times, June 28, 2012. http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html. [accessed on 1/30/2017].

Liptak, Adam. "Justices, Seeking Compromise, Return contraception Case to Lower Courts." The New York Times, May 16, 2016. https://www.nytimes.com/2016/05/17/us/supreme-court-contraception-religious-groups.html?_r=0. [accessed 1/2/2017].

Lovett, Frank. *Rawls's a Theory of Justice: A Reader's Guide.* New York, NY: Bloomsbury, 2011. eBook.

Luborsky, J. L., Meyer, P., Sowers, M. F., et al. "Premature Menopause in a Multi-ethnic Population Study of the Menopause Transition." *Human Reproduction* 18 no. 1, [2003]: 199-206.

Lunney, J. R., Lynn, J., and Hogan, C. "Profile of Older Medicare Decedents." *Journal of the American Geriatric Society* 50, no. 6 [2002]: 1108-1112.

Luther.de. "Luther at the Imperial Diet of Worms (1521)." http://www.luther.de/en/worms.html. [accessed on 2/10/2017].

Lyon, Jeff. "Concerns About Women's Health." JAMA Network, January 10, 2017. http://jamanetwork.com/journals/jama/article-abstract/2596274. [accessed 1/25/2017].

Ma, J., Yang, Y., Stafford, R. S. "U. S. Adolescents Receive Suboptimal Preventive Counselling During Ambulatory Care." *J Adolesc Health* 36, no. 5 [2005]: 441.

Maat, Sue Ter, "Preventive Care Coverage a Mystery to Many Patients." American Medical News, March 18, 2013. http://www.amednews.com/article/20130318/business/130319953/6/. [accessed 1/18/2016].

Mackler, Aaron L. *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.* Washington D.C.: Georgetown University Press, 2003.

Magill, Gerard. "A Moral Compass for Cooperation with Wrongdoing." In *Voting and Holiness: Catholic Perspectives on Political Participation* edited by Nicholas P. Cafardi. New York: Paulist Press, 2012.

Manning, W. G., Newhouse, J. R., and Ware, J. E. "The Status of Health in Demand Estimates: Beyond Good, Excellent, Fair, and Poor." In *Economic Aspects of Health,* edited by C. R. Fuchs. Chicago: Chicago University, 1981.

Marcus, S. A. "Trade Unionism for Doctors: An Idea Whose Time Has Come." *The New England Journal of Medicine,* 311 [1984]: 1509.

Maritain, Jacques. "Man and the State." 1951. http://www.panarchy.org/maritain/state.html. [accessed on 6/18/2016].

Marmot, M. and McDowall, M. "Mortality Decline and Widening Social Inequalities." *Lancet* ii [1986]: 274-6.

Marmot, Michael, Smith, D., and Stansfeld, S., et al. "Health Inequalities Among British Civil Servants: The Whitehall II Study." *The Lancet* 337, no. 8754 [1991]:1387-1393.

Marmot, M., Adelstein, A.M., Robinson, N., et al. "The Changing Social Class Distribution of Heart Disease." *British Medical Journal* 2 [1996]: 1109-12.

Marmot, Michael. "Social Causes of Social Inequalities in Health." In *Public Health Ethics, and Equity* edited by Anand, Sudhir, Peter, Fabienne, and Sen, Amartya. Oxford, NY: Oxford University Press, 2006.

Mary, Lawrence. "Catholic Teaching Concerning a Just War." Catholicism.org, February 21, 2006. http://catholicism.org/catholic-teaching-just-war.html. [accessed on 2/21/2017].

Mastroianni, A. C., Faden R. R., and Federmam, D. D. *Women and Health Research: Ethical and Legal Issues of Including Women in Clinical Studies.* Washington D. C.: National Academies Press, 1994.

Mastroianni, Anna C. and Kahn, Jeffrey P. "Risk and Responsibility: Ethics, Grimes v. Kennedy Krieger, and Public Health Research Involving Children." *American journal Public Health* 92, no. 7 [2002]: 1073-1076.

May, J. H. and Cunningham, P. "Tough Trade-offs: Medecial Bills, Family finances and Access to Care." 2004. http://www.hschange.org/CONTENT/689/689.pdf. [accessed 2/12/2016].

May, William E. *Catholic Bioethics and the Gift of Human Life.* Huntington, IN: Our Sunday Visitor Publishing Division, Inc., 2000.

McCormick, Richard A. *Health and Medicine in the Catholic Tradition.* New York: Crossroad, 1987.

McCormick, Richard. *Corrective Vision: Exporations in Moral Theology.* Kansas City, MO: Sheed & Ward, 1994.

McCrudden, Christopher. "Human Dignity and Judicial Interpretation of Human Rights." *Journal of International Law* 19, no. 4 [2008]: 655-724.

McDevitt, R. D. and Savan, J. "Prospects for account-based health plans under the patent protection and affordable care act." *Benefits Quarterly* 27, no. 1 [2011]: 21-25.

McDonough, Mary J. *Can a Health Care Market Be Moral?; A Catholic Vision.* Washington D.C.: Georgetown University Press, 2007.

McFadden, Charles J. *Medical Ethics.* Philadelphia, PA: F. A. Davis, 1955.

McHugh, John A. and Callan, Charles J. *Moral Theology: A Complete Course Based on St. Thomas Aquinas and the Best Modern Authorities.* Revised and Enlarged by Edward P. Farrell. New York city, NY: Joseph Wagner, Inc., 1958.

McWilliams, M., Meara, E., Zaslavsky, M., et al. "Health of Previously Uninsured Adults after Acquiring Medicare Coverage." *Journal of the American Medical Association,* 298 no. 24 [2007]: 2886-2894.

McWilliams, J. Michael. "Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications." *Milbank Q.* 87, no.2 [2009]: 443-494.

Mead, H., Witkowski, K., Gault, B., et al. "The Influence of Income, Education, and Work Status on Women's Well Being." *Women's Health Issues* 11, no. 3 [2001]: 160-172.

Medicaid.gov. "Eligibility." Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/eligibility/index.html. [accessed 1/9/2017].

Medicaid.Gov Keeping America Healthy. "Health Homes."

http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/health-homes/health-homes.html. [accessed April 11, 2015.

Medicare Prescription Drug Coverage. "Closing the Coverage Gap-Medicare Prescription Drugs are Becoming More Affordable." https://www.medicare.gov/Pubs/pdf/11493.pdf. [accessed March 29, 2015]

MedPAC. "Refining the Hospital Readmissions Reduction Program." Report to the Congress: Medicare and the Health Care Delivery System, June 2013. http://www.medpac.gov/documents/reports/jun13_ch04.pdf?sfvrsn=0. [accessed 2/10/2016].

MedPAC Staff. "The Hospital Readmission Penalty: How Well is it Working?" March 24, 2015. http://www.medpac.gov/blog/march-2015/march-2015/2015/03/24/the-hospital-readmission-penalty-how-well-is-it-working-. [accessed 2/20/2016].

MedlinePlus. "Women's Health." Page last updated on February 8, 2017. https://medlineplus.gov/womenshealth.html. [accessed on 2/8/2017].

Meis, P. J., Klebanoff, M., and Thom, E., et al. "Prevention of Recurrent Preterm Delivery by 17 Alpha-hydroxyprogesterone Caproate." *New England Journal of Medicine* 348 [2003]: 2379-2385.

Melloni, Chiara, Berger, Jeffrey, Wang, Tracy, et al. "Representation of Women in Randomized Clinical Trials of Cardiovascular Disease Prevention." *Circ Cardiovasc Qual Outcomes* 3 [2010]: 135-142.

Mercer, Marsha. "Is Your Medicare Safe?" AARP Bulletin, January/February 2014.

http://www.aarp.org/health/medicare-insurance/info-12-2013/medicare-and-affordable-care-act.html. [accessed 2/21/2106].

Merlis, M. "Caring for the Frail Elderly: An International Review." *Health Affairs* 19, no. 3 [200]: 141-149.

Merrick, Janna C. *Death and Dying: The American Experience.* Cambridge. Massachusetts: The MIT Press, 2005.

Mezey, M. and Fulmer, R. "Quality Care for the Frail Elderly." *Nursing Outlook* 46, no. 6 [1998]: 291-292.

Milani, R. V. and Lavie, C. J. "Impact of Cardiac Rehabilitation on Depression and its Associated Mortality." *Am J Med* 120, no. 9 [2007]: 799-806.

Mill, John Stuart. *Utilitarianism.* New York: Bobbs-Merrill, 1957.

Mill, John Stuart. *Utilitarianism.* London, 1863.

Mill, John Stuart. *Utilitarianism.* New York: Bobbs-Merrill, 1957.

Mill, John Stuart. "On Liberty." In *On Liberty and Other Essays*, edited by Collini, S. Cambridge: Cambridge University Press, 1989.

Mill, John Stuart. *Utilitarianism.* ebook edition, 2004, [ebook #11224]. http://www.gutenberg.org/ebooks/11224. [accessed on 11/6/2016].

Mill, John Stuart. "Utilitarianism." https://www.utilitarianism.com/mill2.htm. [accessed 11/5/2016].

Miller-Terkuile, Elena. "Elena's #GetCovered Story: Pursuing Her Dream to Farm." January 6, 2015. http://wayback.archive-it.org/3909/20150925135952/ http://www.hhs.gov/healthcare/facts/blog/2015/01/e lenas-getcovered-story-pursuing-her-dream-farm.html. [accessed on 9/28/2016].

Minnesota Association for Children's Mental Health. "Key Features of the Affordable Healthcare Act Law." http://www.macmh.org/2012/08/key-features-of-the-affordable-healthcare-act-law/. [accessed March 14,2015].

Miranda, Pico Della. *On the Dignity of Man.* Trans. by Glenn Walls. Indianapolis, IN: Hackett Publishing Company, 1965.

Mitchell, Alison, Congressional Research Service Report for Congress. "Medicaid Financing and Expenditures." December 14, 2015. https://www.fas.org/sgp/crs/misc/R42640.pdf. [accessed 12/31/2015].

Morgan, J. N. "The Ethical Basis of the Economic Claims of the Elderly." In *Social Policy, Social Ethics, and the Aging Society* edited by B. L. Neugarten and R. J. Havighurst. Washington D.C.: National Science Foundation, 1976.

Morreim, E. Haavi. *Balancing Act: The New Medical Ethics of Medicine's New Economics.* Washington DC: Georgetown University Press, 1995.

Mullins, C. D., Blatt, L., Gbarayor, C. M., et al. "Health Disparities: A Barrier to High-Quality Care." *Am J Health Syst. Pharm* 62, no. 18 [2005]: 1873-1882.

Mulye, T. P., Park, M. J., Nelson, C. D., et al. "Trends in Adolescent and Young Adult Health in the United States." *J Adolesc Health* 45, no. 1 [2009]: 8-24.

Murray, C.J.L., Michaud, C.M., M.T. McKenna, M.T., et al. *US Pattern of Mortality by County and Race:* 1965-94. Cambridge, MA: Harvard Center for Population and Development Studies, 1998.

Must, A., Spadnao, J., Coakley, E.H., et al. "The Disease Burden Associated with Overweight and Obesity." *JAMA* 282 no 16 [1999]: 1523-9.

The National Academies. *Women's Health Research: Progress, Pitfalls, and Promise.*

Washington, D.C.: The National Academies Press Openbook, 2010.

The National Academies of Sciences, Engineering, and Medicine. "Clinical Preventive Services for Women: Closing the Gaps." Report released on July 19, 2011. http://iom.nationalacademies.org/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx. [assessed July 4, 2015].

The National Academies of Sciences Engineering Medicine. "Geographic Variation in Health Care Spending and Promotion of High-Value Care." Interim Report, March 22, 2013. http://iom.nationalacademies.org/Reports/2013/Geographic-Variation-in-Health-Care-Spending-and-Promotion-of-High-Care-Value-Interim-Report.aspx. [accessed 2/17/2016].

The National Academies of Sciences, Engineering, and Medicine. "IOM Report Recommends Eight Additional Preventive Health Services to Promote Women's Health." For immediate release July 19, 2011. http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=13181. [assessed on July 4, 2015].

National Archives. "The Bill of Rights: A Transcription." Page last reviewed October 6, 2016. https://www.archives.gov/founding-docs/bill-of-rights-transcript. [accessed on 2/9/2017].

National Association of Social Workers. "Reproductive Health Disparities for Women of Color." Health Disparities Practice Update. December 2004.

National Cancer Institute. "Breast Cancer Risk in American Women." Page last reviewed on September 24, 2012. https://www.cancer.gov/types/breast/risk-fact-sheet. [accessed on 2/8/2017].

National Cancer Institute. "Male Breast Cancer Treatment (PDQ)-Patient Version." Page updated July 18, 2016. https://www.cancer.gov/types/breast/patient/male-breast-treatment-pdq. [accessed on 2/8/2017].

The National Catholic Bioethics Center. "Cooperating with Non-Catholic Partners." *Ethics and Medics,* November 1998. http://www.dcnhs-ec.org/assets/docs/Cooperating_with_Non-Catholic_Partners.pdf. [accessed on 2/23/2017].

National Conference of Catholic Bishops. "Ethical and Religious Directives for Catholic Health Care Services." *Origin* 24 [1994]: 452, citing Genesis 1:26.

National Conference of Catholic Bishops. "Pastoral Letter on Health and Health Care." *Origin* 11 [1981]: 396-402.

National Conference of State Legislatures. "Medical Loss Ratios for Health Insurance." http://www.ncsl.org/research/health/health-insurance-medical-loss-ratios.aspx. [accessed 3/6/2016].

National Conference of State Legislatures. "Preventive Services Covered Under the Affordable Care Act." June 30, 2014. http://www.ncsl.org/research/health/american-health-benefit-exchanges-b.aspx. [accessed 1/18/2016].

National Conference of States Legislatures. "States Implement Health Reform: Medicaid and the Affordable Care Act." http://www.ncsl.org/documents/health/HRMedicaid.pdf. [accessed March 17, 2015]

National Conference of State Legislatures. "The Medical Home Model of Care." Updated in September, 2012. http://www.ncsl.org/research/health/the-medical-home-model-of-care.aspx. [accessed on 4/4/2016].

National Council on Aging (NCOA). "Economic security for Seniors Facts." https://www.ncoa.org/news/resources-for-reporters/get-the-facts/economic-security-facts/. [accessed 11/26/2016].

National Health Interview Survey Early Release Program. "Early Release of Selected Estimates Based on Data from the 2013 National Health Interview Survey." http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201406.pdf. [accessed March 7, 2015].

National Institute of Diabetes and Digestive and Kidneys Diseases. "Urinary Tract Infections (UTIs)." https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-tract-infections-utis. [accessed on 2/8/2017].

National Institutes of Health. "NIH Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research." *Fed Reg* 3 [1994]: 143.

National Institutes of Health Revitalization Act of 1993. Public Law 103-43. 103d Cong., June 10, 1993.

National Institute on Alcohol Abuse and Alcoholism. "Women and Drinking." https://pubs.niaaa.nih.gov/publications/brochurewomen/women.htm. [accessed on 2/8/2017].

National Organization for Rare Disorders (NORD). "Hyperemesis Gravidarum." https://rarediseases.org/rare-diseases/hyperemesis-gravidarum/. [accessed on 2/9/2017].

National Service Center for Environmental Publications (NSCEP). "Older Americans 2010: Key Indicators of Well-Being." https://nepis.epa.gov/Exe/ZyPURL.cgi?Dockey=P10081CP.txt. [accessed 12/26/2016].

National Stroke Association. "Women and Stroke." http://www.stroke.org/understand-stroke/impact-stroke/women-and-stroke. [accessed on 2/8/2017].

Naylor, M. D., Aiken, L. H., Kurtzman, E. T., et al. "The Care Span: The Importance of Transitional Care in Achieving Health Reform." *Health Affairs* 30, no. 4 [2011]: 746-754.

Ndebele, Paul. "Research Ethics." In *The SAGE Handbook of Healthcare Ethics: Core and Emerging Issues* edited by Chadwick, Ruth Chadwick, ten Have, Henk, and Meslin, Eric. Los Angeles, CA: Sage, 2011.

Nelson, Charles and Short, Kathleen. "Health Insurance Coverage – 1986- 1988." Bureau of The Census, U.S. Department of Commerce, current Population Reports, Household Economic Studies, series P-70, no. 17, March 1990.

Netting, Robert M. *Cultural Ecology.* Long Grove, IL: Waveland Press Inc., 1986.

Neves, Maria Patrao. "Respect for Human Vulnerability and Personal Integrity." In *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles, and Application,* edited by Henk A.M.J. ten Have and Michele S. Jean. Paris, France: UNESCO, 2007.

Nies, Leslie K., Cymbala, Alicia A.,Kasten, Sheila L., et al. "Complementary and Alternative Therapies for the Management of Dyslipidemia." *Ann. Pharmacotherapy* 40, no. 11 [2006]: 1984-92.

Niewczyk, Paulette M. and Lwebuga-Mukasa, Jamson S. "Is Poverty the Main Factor Contributing to Health Care Disparities? An Investigation of Individual Level Factors

Contributing to Health Care Disparitie." *The Journal of Equity in Health* 1, no. 1 [2008]: 22-40.

Nilsen, Sigurd R. "Poverty in America: Consequences for individuals and the economy." Government Accountability Office. January 24, 2007. http://www.gao.gov/new.items/d07343t.pdf. [accssed May 26].

Norman, R. J. "Autonomy in Applied Ethics." In *The Oxford Companion to Philosophy* edited by Honderich, T. Oxford: Oxford University Press, 2005.

Norris, Louise. "My Eligibility for Medicaid Depends on How My Income Compares to the Federal Poverty Level. Can You Spell Out What That Means in dollars?" Healthinsurance.org contributor, February 19, 2016. https://www.healthinsurance.org/faqs/my-eligibility-for-medicaid-depends-on-whether-im-133-percent-of-the-federal-poverty-level-can-you-spell-out-what-that-means-in-dollars/. [accessed 2/29/2016].

Nuffield Council on Bioethics. "Public Health: Ethical Issues." London, 2007, Foreword p. v. http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf. [accessed on 10/31/2016].

Oates, G., Tadros, A., and Davis, S. M. "A Comparison of National Emergency Department Use by Homeless versus Non-homeless People in the United States." *Journal of Health Care for the Poor and Underserved* 20, no. 3 [2009]: 840-845.

O'Brien, Nancy Frazier. "HHS Delays, but Does Not Change, Rule on Contractive Coverage." Catholic News Service, January 23, 2012. http://www.catholicnews.com/services/englishnews/2012/hhs-delays-but-does-not-change-rule-on-contraceptive-coverage-cns-1200287.cfm. [accessed on 1/30/2017].

The Offices of the Congregation for the Doctrine of the Faith. "Instruction Dignitas Personae on Certain Bioethical Questions." Rome, September 8, 2008. http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html. [accessed on 2/27/2017].

Olchanski, Natalia, Cohen, Joshua T., and Neumann, Peter. "A Role for Research: An Observation on Preventive Services for Women." *American Journal of Preventive Medicine* 44, no 1S1 [2013]: S12-S15.

Oliva, A., Pinnow, E., Levin, R., et al. "Improving Women's Health Through Modernization of Our Bioinformatics Infrastructure." *Clin Pharmacol Ther* 83 [2008]: 192-195.

Olson, Carl R. "The Church's Essential and Ultimate Mission: Is the Paramount Duty of the Church and Its Faithful to Aid Those in Need." The Catholic World Report, August 22, 2014. http://www.catholicworldreport.com/Item/3327/the_churchs_essential_and_ultimate_mission.aspx. [accessed on 2/17/2017].

O'Meara, A. T. "Present Standards for Cervical Screening." *Curr Opin Oncol* 14 [2002]: 505-511.

O'Neil, Onora. "Universal Laws and Ends-in-Themselves." *Monist* 72 [1989]: 341-361.

Ogden C.L., Carroll, L.R., Curtin, M.A., et al. "Prevalence of Overweight and Obesity in the United States, 1999-2004." *JAMA* 295, no 13 [2006]: 1549-55.

Office of the General Counsel. "Interim Final Rules on Preventive Services." United States Conference of Catholic Bishops. http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08.pdf. [accessed July 7, 2015].

Ozer, Elizabeth M., Urquhart, John T., and Brindis, Claire D. "Young Adult Preventive Health Care Guidelines: There but Can't be Found." *Arch Pediatr Adolesc Med* 166, no. 3 [2012]: 240-247.

Paine, Thomas. "Being an Answer to Mr. Burke's Attack on the French Revolution." In *The Rights of Man (1791-1792)*. http://www.let.rug.nl/usa/documents/1786-1800/thomas-paine-the-rights-of-man/text.php. [accessed on 6/16/2016].

Participants in the 2001 Conference on Ethical Aspects of Research in Developing Countries. *Moral Standards for Research in Developing Countries: From "Reasonable Availability" to "Fair Benefits." Hastings Center Report* 34, no. 3 [2004]: 17-27.

Partnership for Prevention. "Health Policy Priorities." Summer 2005. https://www.prevent.org/data/files/topics/health_policy_priorities.pdf. [accessed 1/23/2016].

Paul VI. "Dignitatis Humanae." December 7, 1965. http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decl_19651207_dignitatis-humanae_en.html. [accessed July 6, 2015].

Pearson, D. A., Bruggman, A. R., and Haukoos, J. S. "Out-of-hospital and Emergency Department Utilization by Adult Homeless Patients." *Annals of Emergency Medicine* 50, no. 6 [2007]: 646-652.

Pearson, Steven D., Sabin, James E., and Emanuel, Ezekiel J. *No Margin, No Mission: Health-Care Organizations and the Quest for Ethical Excellence.* New York, NY: Oxford University Press, Inc., 2003.

PBS-Healthcare Crisis. "The Uninsured." http://www.pbs.org/healthcarecrisis/uninsured.html. [accessed on 6/22/2016].

PBS.Org. "American Experience: The Pill." http://www.pbs.org/wgbh/amex/pill/peopleevents/e_church.html. [accessed on 2/14/2017].

Pharr, Jennifer R., Moonie, Sheniz, and Bungum, Timothy J. "The Impact of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors." International Scholarly Research Network Public Health [2012]. doi: 0.5402/2012/483432.

Pitts, Stephen R., Niska, Richard W., Xu, Jianmin, et al. "National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary." National Health Statistics Reports, no 7, August 6, 2008.

Pogge, T. "A Global Resources Dividend." In *Ethics of Consumption: The Good Life, Justice and Global Stewardship* edited by D. A. Crocker and T. Linden. Lanham, MD: Rowman and Littlefield, 1998.

The Pontifical Council for the Family. "The Truth and Meaning of Human Sexuality." Vatican City, December 8, 1995. http://www.vatican.va/roman_curia/pontifical_councils/family/documents/rc_pc_family_doc_08121995_human-sexuality_en.html. [accessed 2/16/2017].

Pope Benedict XVI. "Encyclical Letter *Caritas in Veritate* on Integral Human Development in Charity and Truth." Given in Rome at Saint Peter's on June 29, 2009. http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate.html. [accessed on 2/20/2017].

Pope Benedict XVI. "Encyclical Letter *Deus Caritas Est* on Christian Love." Given in Rome on December 25, 2005.

Pope Benedict XVI. "Post-Synodal Apostolic Exhortation Sacramentum Caritatis on the Church's Life and Mission." Given in Rome on February 22, 2007.

Pope Francis. "Encyclical Letter: Laudato Si on Care for Our Common Home." Given in Rome at Saint Peter's on May 24, 2015. http://w2.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si.html. [accessed on 2/27/2017].

Pope Francis. "Apostolic Exhortation Evangeli Gaudium on the Proclamation of the Gospel in Today's World." Given in Rome on November 24, 2013. https://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html. [accessed on 2/20/2017].

Pope John XXIII. "Pacem in Terris: Encyclical of Pope John XXIII on Establishing Universal Peace in Truth, Justice, Charity, and Liberty." Given in Rome at St. Peter's on April 11, 1963. http://w2.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii_enc_11041963_pacem.html. [accessed on 6/18/2016].

Pope John Paul II. "Sollicitudo Rei Socialis." Given in Rome, at St. Peter's on December 30, 1987. http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_30121987_sollicitudo-rei-socialis.html. [accessed on 2/28/2017].

Pope John Paul II. "Redemptoris Missio: On the Permanent Validity of the Church's Missionary Mandate." Given in Rome, at St. Peter's, on December 7, 1990. http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_07121990_redemptoris-missio.html. [accessed 2/19/2017].

Pope John Paul II. "Centesimus Annus: Encyclical Letter to His Venerable Brother Bishops in the Episcopate The Priests and Deacons Families of Men and Women Religious all the Christian Faithful and to All Men and Women of Good Will on the Hundreth Anniversary of Rerum Novarum." Given in Rome at St. Peter's on May 1, 1991. http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_01051991_centesimus-annus.html. [accessed on 6/18/2016].

Pope Leo XIII. "Rerum Novarum: Encyclical of Pope Leo XIII on Capital and Labor." Given at St. Peter's in Rome on May 15, 1891. http://w2.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html. [accessed on 6/18/2016].

Pope Paul VI. "Pastoral Constitution on the Church in the Modern World *Gaudium et Spes*." Promulgated on December 7, 1965. http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html. [accessed on 2/20/2017].

Pope Paul VI. "Populorum Progressio: Encyclical of Pope Paul VI on the Development of Peoples." Given in Rome at St. Peter's on March 26, 1967. http://w2.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_26031967_populorum.html. [accessed on 6/18/2016].

Pope Pius XI. "Quadraesimo Anno." Given at Rome, at Saint Peter's on May 15, 1931. http://w2.vatican.va/content/pius-xi/en/encyclicals/documents/hf_p-xi_enc_19310515_quadragesimo-anno.html. [accessed on 6/18/2016].

Popple, Philip R. and Leighninger, Leslie. *Social Work, Social Welfare, and American Society.* Boston, MA: Allyn and Bacon Inc., 1996.

Powers, Madison and Faden, Ruth. *Social Justice: The Moral Foundations of Public Health and Health Policy.* Oxford, NY: Oxford University Press, 2006.

PRNewswire. "FRC opposes hhs mandated coverage of abortifacients under obamacare." http://www.prnewswire.com/news-releases/frc-opposes-hhs-mandated-coverage-of-abortifacients-under-obamacare-126523823.html. [accessed July 5, 2015].

Public Broadcasting System. "The Kevorkian Verdict." http://www.pbs.org/wgbh/pages/frontline/kevorkian. [accessed on November 14, 2013].

Rawls, John. *A Theory of Justice.* Cambridge, Mass: Harvard University Press, 1971.

Rawls, John. The basic liberties and their priorities. In *The Tanner Lectures on Human Values,* vol. III. Salt Lake City: University of Utah Press, 1982.

Rawls, John. "Justice as Fairness: Political not Metaphysical." *Philosophy and Public Affairs* 14, no. 3 [Summer, 1985]: 223-251.

Rawls, John. *Political Liberalism.* New York: Columbia University Press, 1993.

Reformed Church of North America. "Nicene Creed." https://www.crcna.org/welcome/beliefs/creeds/nicene-creed. [accessed 7/30/2016].

Reid, T. R. *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care.* New York, NY: Penguin Books, 2010, eBook.

Religious Freedom Restoration Act of 1993, Public Law 103-141, 103d Cong. [November 16, 1993], codified at *U.S.Code* 42[2000bb].

Relman, A. S. and Reinhardt, U. "An exchange on for-profit healthcare." In *For-Profit Enterprise in Health Care,* edited by B.H. Gray. Washington: National Academy Press, 1986.

Rescher, Nicholas. *Distributive Justice.* Indianapolis, IN: Bobbs-Merill, 1966.

Riley, M. W. and Riley, J. W. "Structural Lag: Past and Future." In *Age and Structural Lag* edited by Riley, M. W., Kahn,, R. I., and Foner, A. New York, New York: Wiley, 1994.

Rodwin, Marc A. *Medicine, Money, & Morals: Physicians' conflicts of Interest.* Oxford, NY: Oxford University Press, 1993.

Rodwin, M. A. "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and the Obligations in a Changing Health Care System." *American Journal of Law and Medicine* 21 [1995]: 241-257.

Rockwood, K. "Hospitalization and Effects on Cognition." *Neurology* 78, no. 13 [2012]: 86-87.

Rosamond, W., Flegal, K., Furie, K., et al. "Heart Disease and Stroke Statistics: 2008 Update: A Report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee." *Circulation* 117 [2008]: e25-e146.

Ross, Catherine E. and Wu, C. "The Links between Education and Health." *American Sociological Review* 60 [1995]: 719-745.

Rosen, George. *A History of Public Health.* Baltimore, MD: The Johns Hopkins University Press, 1993.

Ross, Joseph S. "The Committee on the Costs of Medical Care and the History of Health Insurance in the United States." *The Einstein Quarterly Journal of Biology and Medicine* 19 [2002]: 130.

Ross, W. D. *The right and the Good.* Oxford: Clarendon, 1930.

Rowe, J. W. and Kahn, R. L. *Successful Aging.* New York, NY: Random House, 1998.

Rowland, Diane and Lyons, Barbara. "Medicare, Medicaid, and the Elderly Poor." *Health Care Finances Review* 18 no. 2 [1996 Winter]: 61-85.

Roy, Avik. *How Medicaid Fails The Poor.* New York, NY: Encounter Books, 2013, ebook version.

Royal College of Psychiatrists. "Mental Health in Pregnancy." Last updated November 2012. http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/mentalhealthinpregnancy.aspx. [accessed on 2/9/2017].

Royalty, Anne Beeson. "Estimating Workers' Marginal Valuation of Employer Health Benefits: Would Insured Workers Prefer More Health Insurance or Higher Wages?" *Journal of Health Economics* 27, Issue 1 [2008]: 89-105.

Ruger, Jennifer Prah. *Health and Social Justice.* New York: Oxford University Press, 2010.

Russell, Alex. "Ensuring Access to a Healthy Life." Center for Poverty Research. Spring 2014 Issue. http://poverty.ucdavis.edu/sites/main/files/file-attachments/poverty_research_now-poverty_and_health_2014.pdf. [accessed May 24, 2015].

Saloner, Brendan and Le Cook, Benjamin. "An ACA Provision Increased Treatment for Young Adults with Possible Mental Illnesses Relative to Comparison Group." *Health Aff* 33, no. 8 [2014]: 1425-1434.

Savulescu, J. and Mommeyer, R. W. "Should Informed Consent be based on Rational Beliefs?" In *Medical Ethics* edited by M. Boylan. Upper Saddle, NJ: Prentice Hall, 2000.

Scanlon, T. M. *What We Owe to Each Other.* Cambridge, Mass: Harvard University Press,1999, Chapter 1 and 8.

Schimpff, Stephen, MD. *The Future of Health-Care Delivery.* Dulles, VA: Potomac Books, 2012.

Schmidt, Nelly. "Slavery and its Abolition, French Colonies, Research and Transmission of Knowledge." http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/CLT/pdf/Nelly_Schmidt_Eng_01.pdf. [accessed on 6/18/2016].

Schneider, Carl E. *The Practice of Autonomy: Patients, Doctors, and Medical Decisions.* New York: Oxford University Press, 1998.

Schultz, Amy J., Williams, D. R., and Isreal, B. A., et al. "Racial and Spatial Relations as Fundamental Determinants of Health in Detroit." *The Milbank Quarterly* 80, no. 4 [2002]: 677-707.

The Scottish Government. "Healthy Food at Corner Shops." 7/2/2015. http://www.gov.scot/News/Releases/2005/02/07095154. [accessed 1/23/2016].

Scribd. "Summary of Final Rule for CHA Members." Overview of Final Rules on Contraceptive Coverage for Religious Employers and Other Religious Organizations Issued June 28, 2013. https://www.scribd.com/document/152673086/Summary-of-Final-Rule-for-CHA-members. [accessed on 2/26/2017].

Seedhouse, David. *Health Promotion: Philosophy, Prejudice, and Practice.* Chichester West Sussex, England: John Wiley and Sons, 2004.

Sen, Amartya. *Inequalities Re-examined.* Oxford, NY: Oxford University Press, 1992.

Sen, Amartya. *The Idea of Justice.* Cambridge, MA: The Balknap Press of Harvard University Press, 2009.

Senate and House of Representatives of the United States of America in Congress Assembly. *Consolidated Appropriations Act of 2010.* Public Law111-117. Division D, sec. 507(a). H.R.3288. 111th Cong. [December 16, 2009].

Sen-Gupta, Paul, Rita, de Wit, Margaret L., and McKeown, David. "The Impact of Poverty on the Current and Future Health Status of Children." *Paediatr Child Health* 12, no. 8, [2007]: 667-672.

Sheridan, M. J., Bulls, R. K., Adcock, C. R., et al. "Practitioners' Personal and Professional Attitudes and Behaviors Towards Religion and Spirituality: Issues for Education and Practice." *Journal of Social Work Education* 28, no. 2 [1992]: 190-203.

Silow-Carroll, S, Edwards, J., and Lashbrook, A. "Reducing Hospital Readmissions: Lessons from Top-performing Hospitals." Commonwealth Fund, 2011. http://www.commonwealthfund.org/publications/case-studies/2011/apr/reducing-hospital-readmissions. [accessed 2/10/2016].

Sirico, Louis J. "Benjamin Franklin, Prayer, and the Constitutional Convention: History as Narrative." *Legal Communication & Rhetoric: JALWD* 10 [2013]: 89-124.

Sloan, F. and Bentkover, J. D. *Access to Ambulatory Care and the US Economy.* Lexington, MA: Lexington Books.

Smith, Charles C. "The Committee on the Costs of Medical Care." Presented to the Innominate Society for the Study of Medical History." April 10, 1984. http://innominatesociety.com/Articles/The%20Committee%20%20On%20The%20Costs%20Of%20Medical%20Care.htm.

Smith, J. P. "Healthy Bodies and Thick Wallets: The Dual Relationship between Health and Socioeconomic Status." *Journal of Economic Perspectives* 13, no. 2 [1999]: 145- 66.

Smith, R. A., Cokkinides, V., and Eyre, H. J. "American Cancer Society Guidelines for the Early Detection of Cancer, 2004." *Cancer J Clin* 54 [2004]: 41-52.

Sobel, Laurie and Saiganicoff, Alina. "Round 2 on the Legal Challenges to Contraceptive Coverage: Are Nonprofits "Substantially Burdened" by the "Accommodation"?" The Kaiser Family Foundation, November 9, 2015. http://kff.org/womens-health-policy/issue-brief/round-2-on-the-legal-challenges-to-contraceptive-coverage-are-nonprofits-substantially-burdened-by-the-accommodation/. [accessed 2/2/2017].

Society of Hospital Medicine. "Overview Project BOOST Implementation Toolkit." http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality__Innovation/Implementation_Toolkit/Boost/Overview.aspx. [accessed 4/3/2016].

Social Security Administration. "Fast Facts & Figures About Social Security, 2015." SSA Publication no. 13-11785, released in September 2015. https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2015/fast_facts15.pdf. [accessed in 11/26/2106].

Sokol, Daniel. "A Guide to the Hippocratic Oath." BBC News, page last updated on October 26, 2008. http://news.bbc.co.uk/2/hi/health/7654432.stm. [accessed on 2/11/2017].

Somanader, Tanya. "4 Ways the Affordable Care Act is Improving the Quality of Health Care in America." Home/Blog, March 25, 2015. https://www.whitehouse.gov/blog/2015/03/25/4-ways-affordable-care-act-improving-quality-health-care-america. [accessed April 9, 2016].

Sommers, B. D., Baicher, K., and Epstein, A. M. "Mortality and Access to Care Among Adults After State Medicaid Expansion." *New England Journal of Medicine* 367, no. 11 [2012]: 1025-1034.

Sommers, Benjamin D., Buchmueller, Thomas, Decker, Sandra L, et al. "The Affordable Care Act has Led to Significant Gains in Health Insurance and Access to Care for Young Adults." *Health Aff* 32, no 1 [January 2013]: 165-174.

Sonfield, Adam. "Contraception: An Integral Component of Preventive Care for Women." Guttmacher Policy Review Volume 13, Issue 2, June 1, 2010. https://www.guttmacher.org/gpr/2010/06/contraception-integral-component-preventive-care-women. [accessed 1/27/2017].

Sonfield, Adam. "The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost Sharing." Guttmacher Policy Review, Volume 14, Issue 1. https://www.guttmacher.org/gpr/2011/03/case-insurance-coverage-contraceptive-services-and-supplies-without-cost-sharing. [accessed on 2/25/2017].

The Staff of the Washington Post. *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All.* New York. NY: Public Affairs Books, 2010.

Stanford, Peter. "Introduction and the Church in Britain: The Roman Catholic Church." BBC, last updated on June 29, 2011. http://www.bbc.co.uk/religion/religions/christianity/catholic/catholic_1.shtml. [accessed on 2/20/2017].

Stansfeld, S. and Marmot, M. "Deriving a Survey Measure of Social Support: The Reliability and Validity of the Close Persons Questionnaire." *Social Science and Medicine* 35 [1992]: 1027-35.

Stanford Encyclopedia of Philosophy. "Mill's Moral and Political Philosophy." Revised on August 22, 2014. http://plato.stanford.edu/entries/mill-moral-political/. [accessed on 11/5/2016].

Starr, Paul. *The Social Transformation of American Medicine.* New York, NY: Basic Books, Inc., 1982.

Stedman, Thomas. *Stedman's Medical Dictionary.* New York, NY: Lippincott, Williams, and Wilkins, 2000.

Steinberg, L. "A Behavioral Scientist Looks at the Science of Adolescent Brain Development." *Brain Cogn* 72, no. 1 [2010]: 160-164.

Steinman, Michael A., Sands, Laura P., and Covinsky, Kenneth E. "Self-restriction of Medications Due to Cost in Seniors without Prescription Coverage." *J Gen Intern Med* 16, no. 12 [2001]: 793-799.

Stephen Hawking. "Brief Biography." http://www.hawking.org.uk/about-stephen.html. [accessed on 1/15/2017].

Stroupe, Kevin T., Kinney, Eleanor D., and Kniesner, Thomas J. J. "Chronic Illness and Health Insurance-Related Job Lock." *Journal of Policy Analysis and Management* 20, no. 3 [Summer 2001]: 525-544.

Swartz, K. *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do.* New York, NY: Russell Sage Foundation, 2006.

Swartz, Katherine. "Health Are for the Poor: For Who, What Are, and Whose Responsibility?" *Focus* 26, no. 2 [fall 2009]: 69-74.

Swift, A. *Political Philosophy: A Beginners' Guide for Students and Politicians.* Cambridge, MA: Polity, 2001.

Swift, Art. "Americans See Healthcare, Low Wages as Top Financial Problems." Economy, January 21, 2015. http://www.gallup.com/poll/181217/americans-healthcare-low-wages-top-financial-problems.aspx. [accessed 2/27/2016].

Tarantal, A.F., Hendrickx, A.G., Matlin, S.A., et al. "Effects of Two Antiprogestins on Early Pregnancy in the Long-tailed Macaque (Macaca Fascicularis)." *Contraception* 54, no. 2 [1996]: 107-15.

Tate, Nick J. *ObamaCare Survival Guide: The Affordable Care Act and What it Means for You and Your Healthcare.* West Palm Beach, FL: Humanix Books, 2012. Kindle Edition.

Taylor, Erin, Dale, Stacy, Peikes, Deborah, et al. "Evaluation of the Comprehensive Primary Care Initiative: First Annual Report." Mathematica Policy Research, January 2015. https://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf. [accessed 4/11/2016].

Taylor, Rod S., Brown, Allan, Ebrahim, Shah, et al. "Exercise-based Rehabilitation for Patients with Coronary Heart Disease: Systematic Review and Meta-analysis of Randomized Controlled Trials." *AM J Med* 116, no. 10 [2004]: 682-92.

Taylor, Telford. "Opening Statement of the Prosecution, December 9, 1946." In *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation,* edited by G. J. Annas and M. A. Grodin, 67-93. New York, NY: Oxford University Press, 1992.

Thurow, L.C. "Learning to say 'No'." *The New England Journal of Medicine,* 311, [1985]: 611-14.

Torpy, Janet M. "Women's Health." *JAMA* 295, no. 12 [March 2006]: 1474.

Transitional Care Model. "About TCM." http://www.transitionalcare.info/about-tcm. [accessed 4/1/2016].

Trawinski, Lori A. "Nightmare on Main Street: Older Americans and the Mortgage Market Crisis." AARP, July 2012.

http://www.aarp.org/content/dam/aarp/research/public_policy_institute/cons_prot/2012/nightmare-on-main-street-AARP-ppi-cons-prot.pdf. [assessed 12/3/2016].

Trivedi, A. N., Moloo, H., and Mor, V. "Increased Ambulatory Care Copayment and Hospitalizations among the Elderly." *New England Journal of Medicine* 362, no. 4 [2010]: 320-328.

Trivedi, A. N., Rakowski, W., and Ayanian, J. Z. "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans." *New England Journal of Medicine* 358, no. 4 [2008]: 375-83.

Tuohey, John. "Partnering for More Than the Survival of a Catholic Presence in Healthcare." *New Theology Review* 12, no. 1 [1999]: 52-59.

Unger, Irwin. *The Best of Intentions: The Triumphs and Failures of the Great Society Under Kennedy, Johnson, and Nixon.* New York, NY: Doubleday, 1996.

United Nations Treaty Collection. Treaty Series: Treaties and international agreements registered or filed and recorded with the Secretariat of the United Nations. New York: United Nations vol. 993, 1983.

United States Census Bureau. "2010 Census Shows Nation's Population is Aging." https://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn147.html. [accessed June 19, 2015].

United States Conference of Catholic Bishops. "Cardinal Dolan and Archbishop Lori to Congress: Support the Conscience Protection Act of 2017." February 10, 2017. http://www.usccb.org/news/2017/17-038.cfm. [accessed on 2/11/2017].

United States Catholic Conference. *Catechism of the Catholic Church.* New York, New York: Doubleday, 1994, no.1.

United States Conference of Catholic Bishops. "Catholic Social Teaching." http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/. [accessed on 2/26/2017].

United States Conference of Catholic Bishops. *Ethical and Religious Directives for Catholic Health Care Services.* Washington, D. C.: USCCB, 1994.

United States Conference of Catholic Bishops (USCCB). "U.S. Bishops Vow to fight HHS Edict." http://www.usccb.org/news/2012/12-012.cfm. [accessed June 8, 2015].

United States Conference of Catholic Bishops (USCCB). "Forming Consciences for Faithful Citizenship. A Call to Political Responsibility from the Catholic Bishops of the United States." Washington, DC: USCCB, 2009, nos. 9 and 14.

United States Conference of Catholic Bishops, Natural Family Planning Program. "Human Sexuality." http://www.usccb.org/issues-and-action/marriage-and-family/natural-family-planning/catholic-teaching/upload/Human-sexuality.pdf. [accessed 2/16/2017].

United States Conference of Catholic Bishops. "Human Sexuality from God's Perspective: Humanae Vitae 25 Years Later." http://www.usccb.org/issues-and-action/marriage-and-family/natural-family-planning/catholic-teaching/upload/Human-Sexuality-from-God-s-Perspective-Humanae-Vitae-25-Years-Later.pdf. [accessed on 2/14/2017].

United States Conference of Catholic Bishops. "Seven Themes of Catholic Social Teaching." http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/seven-themes-of-catholic-social-teaching.cfm. [accessed on 2/26/2017].

United States Conference of Catholics Bishops. "U.S. Bishops Vow to fight HHS Edict." United States Conference of Catholic Bishops.

http://www.usccb.org/news/2012/12-012.cfm. [accessed August 18, 2013].

United States Conference of Catholic Bishops. "USCCB Urges Rescission of HHS Contraceptive Mandate, Criticizes 'Inexplicably Narrow' Definition of Religious Freedom." August 31, 2011. http://www.usccb.org/news/2011/11-168.cfm. [accessed on 1/30/2017].

United Sates Conference of Catholic Bishops, Office of the General Counsel. "Interim Final Rules on Preventive Services File code CMS-9992-IFC2." Submission Electronically on August 31, 2011. http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08.pdf. [accessed on 1/30/2017].

United States Conference of Catholic Bishops. "Living the Gospel of Life: A Challenge to American Catholics." A Statement by the Catholic Bishops of the United States, 1998. http://www.usccb.org/issues-and-action/human-life-and-dignity/abortion/living-the-gospel-of-life.cfm. [accessed on 2/21/2017].

U. S. Congress. House. National Institutes of Health Revitalization Act of 1993. Public Law 103-43. 103d Cong., June 10, 1993.

United States Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590.

United States Department of Agriculture. "Fact Sheet: USDA Support for Older Americans." Last modified 7/10/2015. http://www.usda.gov/wps/portal/usda/usdahome?contentid=2015/07/0202.xml. [accessed 12/3/2016].

United States Department of Health & Human Services. "Administration Takes Steps to Ensure Women's Continued Access to Contraception Coverage, While Respecting Religious-based Objections." News release August 22, 2014. http://www.hhs.gov/news/press/2014pres/08/20140822a.html. [accessed June 8, 2015].

United States Department of Health & Human Services. "Affordable Care Act Rules on Expanding Access to Preventive Services for Women." http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html. [access March 21, 2015]

United States Department of Health & Human Services. "At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could be Denied Affordable Coverage Without Health Reform." https://aspe.hhs.gov/sites/default/files/pdf/76376/index.pdf. [accessed 1/11/2016].

U. S. Department of Health and Human Services. "Healthy People 2010: Understanding and Improving Health." November 2000. http://www.healthypeople.gov/2010/document/pdf/uih/2010uih.pdf. [accessed on 1/27/2017].

United States Department of Health & Human Services. "Key Features of the Affordable Care Act by Year." http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html. [accessed April 11, 2015].

United States Department of Health and Human Services. "Multiple Chronic Conditions- A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions." Washington, DC, December 2010,

https://www.hhs.gov/sites/default/files/ash/initiatives/mcc/mcc_framework.pdf. [accessed 12/26/2016].

United States Department of Health & Human Services. "Preventive Services Covered Under the Affordable Care Act." September 23, 2010, http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/#CoveredPreventiveServicesforAdults. [accessed 1/1/2016].

United States Department of Health & Human Services. "The Affordable Care Act and Immunization." September 14, 2010. http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/aca-and-immunization/index.html. [accessed 1/2/2016].

United States Department of Health & Human Services. "The Affordable Care Act, Section by Section." http://www.hhs.gov/healthcare/rights/law/. [accessed on March 11, 2015].

United States Department of Labor. "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans." Federal Register, November 26, 2012. http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=26492&AgencyId=8&DocumentType=1. [accessed 3/5/2016].

United States Department of Treasury, Labor, and Health and Human Services. "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the patient Protection and Affordable Care Act." *Federal Register* 75, no. 137 [July 19, 2010]: 41726-41760.

United States District Court for the Southern District of Ohio, Western Division. "In re:

Cincinnati Radiation Litigation." 875 F. Supp. 796; [U. S. Dist. 1995]. http://www.fda.gov/ohrms/dockets/dockets/04p0349/04p-0349-ref0001-77-Tab-73-In-Re-Cincinnati-Radiation-Litigation-vol7.pdf. [accessed 4/30/2016].

United States Food and Drug Administration. "Menu and Vending Machines Labeling Requirements." Page last updated on 11/13/2015. http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm217762.htm. [accessed on 1/22/2016].

United States General Accounting Office. "Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain." 1995. http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed April 21, 2015]

United States House. *To Provide Affordable, Quality Health Care for All Americans and Reduce the Growth in Health Care Spending, and for Other Purposes.* 2009, H.R. 3200, section 1233.

U. S. Preventive Services Task Force. "Aspirin for the Prevention of Cardiovascular Disease: U. S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 150 no. 6 [March 2009]: 396-404.

U.S. Preventive Services Task Force. "Screening for Chlamydia Infection: Recommendations and Rationale." *Am J Prev Med* 20 [2001]: 90-94.

United States Preventive Services Task Force. "USPSTF A and B Recommendations." February 2016. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. [accessed 2/8/2016].

United States Small Business Administration. "Employers with Fewer Than 25 Employees."

https://www.sba.gov/content/employers-with-fewer-25-employees. [accessed on 3/16/2016].

U.S. Congress. U.S. Senate and U.S. House. *The Patient Protection and Affordable Care Act.* Cong. Assembly, 2d sess., 2010, H.R. 3590, sec. 2711.

U.S. General Accounting Office. "Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain, 1995." http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-95-135/pdf/GAOREPORTS-HEHS-95-135.pdf. [accessed April 21, 2015].

U.S. House. *To Provide Affordable, Quality Health Care for All Americans and Reduce the Growth in Health Care Spending, and for Other Purposes.* 2009, H.R. 3200, section 1233.

U.S. Senate and U.S. House. 2010. The Patient Protection and Affordable Care Act. HR 3590.

van de Water, Paul N. "Medicare Is Not "Bankrupt"." Centers on Budget and Policy Priorities, updated on July 30, 2015. http://www.cbpp.org/research/health/medicare-is-not-bankrupt. [accessed on 2/22/2016].

van Ryn, M. and Burke, J. "The Effect of Patient Race and Socio-economic Status on Physician's Perceptions of Patients." *Social Science and Medicine* 50, no. 6 [2000]: 813-828.

Vanderpool, H. Y. *The Ethics of Research Involving Human Subjects: Facing The 21st Century.* Frederick, MD: University Publishing Group, 1996.

Wadsworth, M. E. J. 'Serious Illness in Childhood and its Association with Later-Life

Achievement.' In *Class and Health* edited by R. G. Wilkinson. London: Tavistock Publications Ltd., 1986.

Wadsworth, M. E. J. and Kuh, D. J. L. "Childhood Influences on Adult Health: A Review of Recent Work from the British 1946 National Birth Cohort Study, the MRC National Survey of Health and Development." *Paediatric and Perinatal Epidemiology,* 11 no. 1 [1997]: 2-20.

Walker, Joseph. "Patients Struggle with High Drug Prices." Wall Street Journal, December 31, 2015. http://www.wsj.com/articles/patients-struggle-with-high-drug-prices-1451557981. [assessed 12/3/2016].

Wall, Barbra Mann. "Conflict and Compromise: Catholic and Public Hospital Partnership." *Nurs Hist Rev* 18 [2010]: 100-117.

Wall, P.D. *Pain: The Science of Suffering.* New York: Columbia University Press, 2000.

Walzer, Michael. *Spheres of Justice: A Defense of Pluralism and Equality.* New York, NY: Basic Books, 1983.

Ward, Brian W., Schiller, Jeannine S., Goodman, Richard A. *"Multiple chronic conditions among US adults: A 2012 update." Prev Chronic Dis* 11 [2014]: 130389. http://dx.doi.org/10.5888/pcd11.130389. [accessed May 23, 2015].

The Washington Library. "George Washington's Prayer for His Country and Remarks of the Regent at a Naturalization Ceremony at Mount Vernon." http://catalog.mountvernon.org/cdm/ref/collection/p16829coll4/id/96. [accessed on 2/12/2017].

Weijer, C. "Evolving Issues in the Selection of Subjects for Clinical Research." *Cambridge Quarterly of Healthcare Ethics* 5 [1996]: 4-5.

The White House. "Affordable Care Act: The New Health Care Law at Two Years." https://www.whitehouse.gov/sites/default/files/uploads/careact.pdf. [accessed 1/15/2016].

The White House, Office of the Press Secretary. "Fact Sheet: Women's Preventive Services and Religious Institutions." Briefing Room, February 10, 2012. https://obamawhitehouse.archives.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions. [accessed on 1/29/2017].

The White House President Barack Obama. "Health Care that Works for Americans." http://www.whitehouse.gov/healthreform/healthcare-overview [accessed March 7, 2015].

Wilkinson, Stephen. *Choosing Tomorrow's Children: The Ethics of Selective Reproduction.* Oxford, NY: Oxford University Press, 2010.

Wikler, Daniel. "Philosophical Perspectives on Access to Health Care: An Introduction." In *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services; Volume Two: Appendices, Sociocultural and Philosophical Studies*, edited by President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 108-51. Washington, DC: U.S. Government Printing Office, 1983.

Williams, David R., and Collins, C. "U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations." *Annual Review of Sociology* 21 [1995]: 349- 386.

Williams, David R. "Patterns and Causes of Disparities in Health." In *Challenges in Modern Health Care* by Robert Wood Johnson Foundation. Rutgers University Press, 2004. http://www.rwjf.org/content/dam/farm/books/books/2004/rwjf11336. [accessed 1 2/27/2016].

Willis, Rosalind, Glaser, Karen, and Price, Debora. "Applying the Andersen Behavioural Model to Informal Support among Britain's Ethnic Minorities." Institute of Gerontology, King's College London. http://www.britishgerontology.org/DB/gr-editions-2/generations-review/applying-the-andersen-behavioural-model-to-informa.html. [accessed 12/22/2016].

Wilper, A.P., Woolhandler, S., Lasser, K.E. "Health Insurance and Mortality In U.S. Adults." *American Journal of Public Health.* 2009; 99:2289-2295.

Wilson, R. S., Hebert, L. E., and Scherr, P. A., et al. "Cognitive Decline After Hospitalization in a Community Population of Older Persons." *Neurology* 78, no. 13 [2012]: 950-956.

Winkler, J. "Reconsidering Employer-sponsored Health Care: Four Paths to Long-term Strategic Change." *Benefits Quarterly* 29, no. 2 [2013]: 8-15.

Wolf, Barbara, Evans, William, and Adler, Nancy. "The SES and Health Gradient- A Brief Review of the Literature." In *Biological Consequences of Socioeconomic Inequalities,* edited by Barbara Wolfe, William Evans, and Teresa Seeman. New York: Russell Sage Foundation, 2012.

Wolfe, Barbara. "Poverty and Poor Health: Can Health Care Reform Narrow the rich-poor Gap?" *Focus* 28, no.2[2011]: 25-30.

Wolf, Richard. "Supreme Court Agrees to Rule on Birth Control Insurance Mandate." USA Today, November 6, 2015. http://www.usatoday.com/story/news/2015/11/06/supreme-court-contraception-abortion-obamacare-religious-freedom/75287750/. [accessed on 1/30/2017].

Wolf, Richard. "Supreme Court Sends ‘contraceptive Mandate’ Cases Back to Lower Courts." USA Today, May 16, 2016. http://www.usatoday.com/story/news/2016/05/16/supreme-court-contraception-mandate-obama-religious-objectors/82358568/. [accessed on 1/30/2017].

Wood, S. F., Dor, A., Gee, R. E. et al. "Women's Health and Health Reform: The Economic Burden of Disease in Women." Washington, D. C.: The Jacob's Institute of Women's Health, The George Washington University School of Public Health and Health Services, 2010.

Wordsworth, William. "The Prelude of 1805, in Thirteen Books." http://triggs.djvu.org/djvu-editions.com/WORDSWORTH/PRELUDE1805/Download.pdf. [accessed on 6/16/2016].

World Health Organization. "Mental Health." http://www.who.int/mental_health/prevention/genderwomen/en/. [accessed on 2/8/2017].

World Health Organization. "Towards a Common Language for Functioning, Disability, and Health ICF." Geneva, 2002. http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf. [accessed 1/14/2017].

World Health Organization. "World Report on Disability." WHO Library Cataloguing-in-Publication Data, 2011. http://www.who.int/disabilities/world_report/2011/report.pdf. [accessed 1/14/2017].

World Medical Association. "Code of Ethics of the World Medical Association: Declaration of Helsinki. Helsinki." Finland: WMA; June 1964. *British Medical Journal* 2 [1964]:177.

World Medical Association. "WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects." http://www.wma.net/en/30publications/10policies/b3/. [accessed on 6/30/2016].

Wyn, R., and Solis, B. "Women's Health Issues Across the Lifespan." *Women's Health Issues* 11, no. 3 [2001]: 148-159.

Yale Law School, Lillian Goldman Law Library. "Declaration of the Rights of Man-1789." Art. 6. http://avalon.law.yale.edu/18th_century/rightsof.asp. [accessed 6/14/2016].

Yeh, G. Y., Davis, R. B., and Phillips, R. S. "Use of Complementary Therapies in Patients with Cardiovascular Disesae." *Am J Cardiol* 98, no. 5 [2006]: 673-80.

Yost, Pete. "Obamacare Contraception Loophole for Religious Groups is Not Too Restrictive, Court Rules." Associated Press, November 14, 2014. http://www.pbs.org/newshour/rundown/obamacare-contraception-loophole-religious-groups-restrictive-court-rules/. [accessed on 2/2/2017].

Zeleny, Jeff. "Michelle Obama: Health Care Overhaul is 'Next Step' for Women." *The New York Times,* September 18, 2009, under "Prescriptions." http://prescriptions.blogs.nytimes.com/2009/09/18/michelle-obama-health-care-overhaul-important-to-women/?_r=0. [accessed 3/6/2016].

Zimmermann, Carol. "U. S. Bishops Want to Give 'Careful Analysis' to HHS Final Rules." Catholic News Service. http://www.catholicnews.com/data/stories/cns/1302837.htm. [accessed June 8, 2015].

Zur, Julia, Mojtabai, Ramin, and Li, Suhui. 'The Cost Savings of Expanding Medicaid Eligibility to Include Currently Uninsured Homeless Adults with Substance Use Disorders." *J Behav Health Serv Res* 41, no. 2 [2014]: 110-124.