

The Role of Faith-based Clinics in America's Healthcare System

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Abstract

The purpose of this research paper is to examine the potential impact of religion on the delivery of healthcare in the environment created by the Affordable Care Act (ACA). The methodology employed includes a review of relevant literature and pertinent scholarly sources. Findings include faith-based clinics have the potential to hold larger roles in this post-ACA environment, facilitated by the Supreme Court decisions, due to their relationships with those in the coverage gap. Future research should be conducted on what financial and constituency impact, if any, the Affordable Care Act has on faith-based clinics nationwide.

Introduction

The current state of America's healthcare system is highly controversial. While this has long been the case, the passage of the Affordable Care Act has caused tensions to run seemingly higher than ever before. However, good cause exists for the current political tension. The United States spends more money than any other nation in the world (The Kaiser Family Foundation) in order to operate a healthcare system that left an estimated 44 million Americans uninsured as recently as 2013 (PBS). The recently passed Affordable Care Act has been championed as a potential solution to this problem. However, the landed effectiveness of the law may be limited. Legal challenges, primarily from religious institutions, have called various aspects of specific provisions into question.

Statement of the Problem

Healthcare spending comprises an enormous portion of America's gross domestic product. The United States spends more per capita on healthcare than any other nation (Smith). Furthermore, America spends more than two to three times the amount spent by other industrialized nations, such as Canada and the United Kingdom, who fund universal healthcare systems (Smith). Despite the spending advantage enjoyed by the United States, almost 44 million American citizens were uninsured as recently as 2013 (PBS). The proposed solution for this problem, the Affordable Care Act, was essentially rendered inert by the Supreme Court, which struck down the portion of the law that required states to expand Medicaid coverage. Other challenges have come from the religious community.

In states that do not opt for Medicaid expansion, a coverage gap exists (Henry J. Kaiser Family Foundation). Demographically, those in the coverage gap are most likely to be members

of a minority group (specifically Hispanic or African American) (Henry J. Kaiser Family Foundation). Furthermore, members of those particular minority groups are statistically likely to be affiliated with organized religion (Stoddard). The purpose of this research paper is to examine the potential impact of religion on the delivery of healthcare in the environment created by the Affordable Care Act.

Theoretical Framework

The healthcare system as we know it is inherently dualistic. While the modern notion of healthcare is a relatively recent development, the concept of dualism has pervaded philosophical discourse for much of recorded human history. Ancient philosophers discussed the interrelatedness of the human mind, body, and spirit in attempts to rationalize their own experiences. In fact, a large swath of philosophy is devoted to examining this dualism of the human experience. Etymologically, the word “dualism” comes from the Latin word “duo,” and denotes two states that exist in binary opposition (good versus evil, light against dark, etc.). While countless philosophers have pondered the existence of segmented physical and spiritual entities, the most well known of these thinkers is Plato.

Plato, perhaps the most famous philosopher of all time, understood the soul to exist separately from the body as a pre-existing and eternal essence. One of Plato’s most prominent ideas was his Theory of Forms (Philosophy Online). In short, Plato pondered that every object has a corresponding perfect “form,” and that the idea of this form links all real objects together through their shared characteristics (Philosophy Online). The soul, essentially, is a conglomeration of these perfect forms, and serves as an ethereal foil to the body. Plato’s musings on this dualistic relationship came to be known as Platonic Dualism (Robinson).

While most would acknowledge that philosophy and healthcare are starkly different disciplines, the two areas share similarities. Dualistic relationships pervade the American healthcare system (for-profit vs. not-for-profit, insured vs. uninsured, rich vs. poor, etc.). The inherently dualistic aspect of the religious influence vs. secularization of the modern healthcare system drives the questions posed in this study.

Research Questions

Through this research, two fundamental questions will be answered:

- I. What, if any, historical connection is shared between organized religion and healthcare in the United States?
- II. Which, if any, current Affordable Care Act developments have faith-based dimensions?

Key Programs Defined

- I. Medicare is defined by Oxford Dictionary as follows:

A federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

- II. Medicaid is defined by Oxford Dictionary as follows:

A federal system of health insurance for those requiring financial assistance.

- III. The Affordable Care Act is defined by medicaid.gov as follows:

The Affordable Care Act provides Americans with better health security by putting in place comprehensive health insurance reforms that will:

- Expand coverage
- Hold insurance companies accountable
- Lower healthcare costs

- Guarantee more choice
- Enhance the quality of care for all Americans.

The Affordable Care Act actually refers to two separate pieces of legislation — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Healthcare and Education Reconciliation Act of 2010 (P.L. 111-152) — that, together expand Medicaid coverage to millions of low-income Americans and makes numerous improvements to both Medicaid and the Children's Health Insurance Program (CHIP).

IV. The Coverage Gap is defined by The Kaiser Family Foundation as follows:

[Americans who] have incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits. Nationwide, nearly five million poor uninsured adults are in this situation.

Current State of Healthcare in the United States

The current incarnation of the American healthcare system is less than optimal, to say the least. The United States spends more money, both overall and per capita, on healthcare than any nation in the world. Rich Smith from DailyFinance states, “According to figures from the Organization for Economic Cooperation and Development, the United States spends more money on healthcare per capita than any other nation on Earth -- nearly \$7,300 per citizen in 2007 (the latest for which firm figures are available), of which nearly half was financed by tax dollars through programs such as Medicare and Medicaid (Smith).” These figures certainly are not cause for encouragement. Smith goes on to place those figures in perspective. He states, “[We spent] 87 percent more than Canada paid to give its citizens universal healthcare that year, and [spent] more than three times the expenditures in the United Kingdom.”

DailyFinance also quotes some startling gross expenditure estimates (\$2.8 trillion projected this year, \$4.5 trillion in 2019). Given that the World Bank quoted the American GDP as being \$15.68 trillion in 2012, it is evident that healthcare spending comprises a significant portion of the total economy. This is especially startling when one considers that as many as 44 million Americans were estimated to not have health insurance prior to the enactment of the Affordable Care Act (PBS).

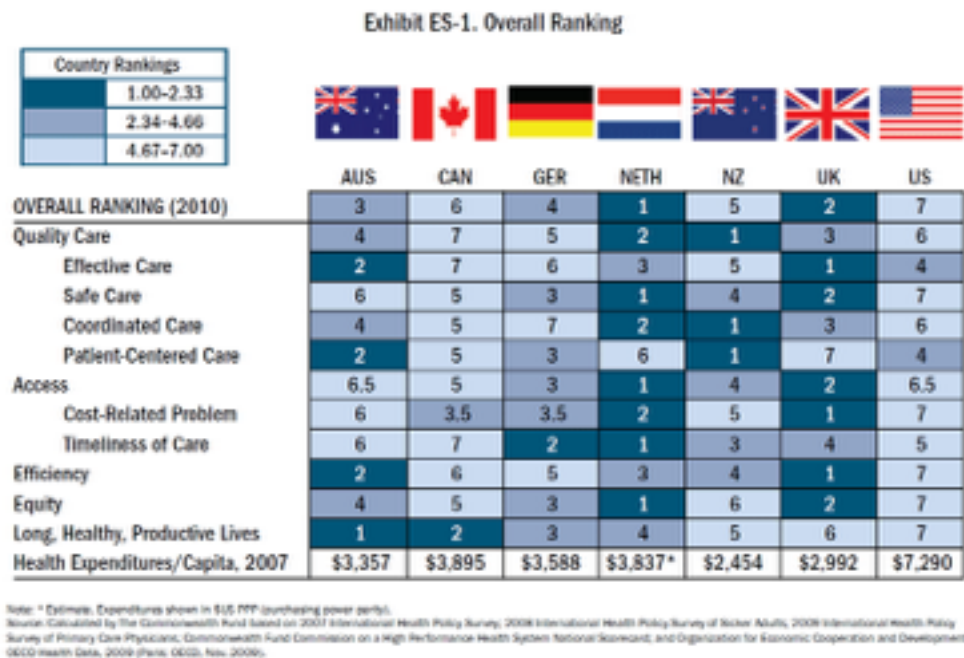
Despite being the world's sole superpower, the United States lags well behind most other Western states in many health-related metrics, such as care quality, access to care, and health expenditure per capita. A landmark study by the Commonwealth Fund illuminates this deficiency (illustrated in detail in Figure 1), with the United States falling significantly behind six other developed states in the aforementioned areas. The authors took particular issue with the spending inefficiencies, unequal access to care, and poor nutrition which characterize the American healthcare system today.

Strikingly, the World Health Organization (WHO) echoes the Commonwealth Fund's findings. In *Health Systems: Improving Performance*, the WHO found that the United States' health outcomes are decidedly mediocre: in spite of spending a substantially larger share of its GDP on healthcare than other Western states (17.9% vs 9.6 percent in the United Kingdom according to Burn-Murdoch of The Guardian), the US ranks 36th in the world in life expectancy, 39th in infant mortality, and 37th overall. This dismal showing helped galvanize the American medical community, leading many to openly call for reforms. One such call came from Drs. Murray, Phil and Frenk in one of the country's preeminent medical journals, *The New England Journal of Medicine*. In their article “Ranking 37th—Measuring the Performance of the U.S.

Healthcare System”, the physicians state “given the vast number of preventable deaths associated with smoking (465,000 per year), hypertension (395,000), obesity (216,000), physical inactivity (191,000), high blood glucose levels (190,000), high levels of low-density lipoprotein cholesterol (113,000), and other dietary risk factors, there are huge opportunities to enact policies that could make a substantial difference in health system performance—and in the population's health (Murray, et al).”

All three of the above studies take issue with the poor nutritional quality of the average American's diet. Likewise, given that many health issues can be traced directly back to poor diet and sedentary lifestyles, it stands to reason that a significant driver of America's poor overall health is simply nutritional deficiency. While the solution to poor nutrition is often simply eating better, offering the American public equal access to affordable, healthy food (and incentivizing its consumption over more popular, unhealthy alternatives) is a much more difficult proposition. Improving the health of millions of America's most vulnerable citizens is further complicated by the cyclical nature of poor health. Perhaps unsurprisingly, poor health is directly correlated with low levels of income. According to the Institute for Research on Poverty, “Health in the United States is very strongly correlated with income. Poor people are less healthy than those who are better off, whether the benchmark is mortality, the prevalence of acute or chronic diseases, or mental health.”

Figure 1 (taken from The Commonwealth Fund)



In summary, the United States is spending more than any other nation on healthcare. Beyond the sheer spending figures (both gross and per capita), the United States is achieving very little return on its investment in the healthcare sector. Several independent agencies have analyzed the state of the American healthcare system, and most concluded that the healthcare provided is suboptimal, especially when expenditure is factored in. Beyond that, access to healthcare is severely limited across the nation. The combination of these factors led to calls for reform, and is partially responsible for the enactment of the Affordable Care Act in 2010, the stated goal of which was to address these concerns.

History of Healthcare in the United States

Historically, healthcare has been treated as a privilege. This practice likely arose as a result of limited resources, substandard medical knowledge and access, and rampant inequality.

However, these trends began to reverse as the post-World War II economy expanded (The Post War Economy), government reforms were passed (Cassanego), and as technological and social norms progressed throughout the entirety of the twentieth century (Jayson).

This time period saw the rise of the modern healthcare system, which brought with it a dualistic system of care. This system is divided between enormous, for-profit hospitals and local, free clinics (Medicare Faqs). Faith-based clinics are a distinct subset of free clinics, and possess a unique heritage in the medical community. While churches and hospitals once were partners in healthcare, faith-based clinics are some of the last vestiges of this union between religion and health (Morris). Even though the secularization of modern hospitals is nearly complete (Eckman), faith-based clinics are seeing their role shift and even expand in the undulating tides of healthcare reform.

The system of healthcare in the United States has undergone a drastic evolution over the relatively short course of American history. It has evolved from a decentralized system of home remedies and sparsely trained physicians to the enormous conglomerate of corporations that is now known as the “medical industrial complex.” Fillmore Randolph, member of the National Association of Science writers, attributes this evolution to several factors. Specifically, Randolph lists “...the acceptance of germ as the cause of disease, professionalization of doctors, technological advancements in treating disease, the rise of great institutions of medical training and healing, and the advent of medical insurance...” as major factors in the transformation of medical care.

Perhaps unsurprisingly, Colonial America was not graced with state-of-the-art-medical

care. In fact, medical care was typically viewed as a family affair. Women, who at this point in history were generally restricted to a domestic purview, were often tasked with maintaining the health of their family (Harvard University Library). This practice of “domestic medicine” refers to “...nursing, medicine, and other healing practices associated with the home environment. Almost all healing work in Europe and the United States took place at home until the late 19th and early 20th centuries, and self-care guides and domestic medical manuals were found in nearly every literate household (Harvard University Library).”

Colonial America possessed shockingly little medical knowledge; medicine was still largely based on methods of the ancient Greeks (Four Humors). Modern physicians are connected to ancient Greeks through the Hippocratic oath (Tyson); colonial physicians actually practiced medicine through the Hippocratic corpus (Gill), a body of medical knowledge that attributed disease to an imbalance of the four bodily humors. These humors, or fluids, are yellow bile, black bile, phlegm, and blood (Four Humors). It is not surprising that medical outcomes were often suboptimal during this time period.

Randolph attributes the wide acceptance of germ theory as one of the factors that catapulted colonial medicine into modern healthcare. Germ theory was a major departure from humoral theory, and was legitimately a revolution of medical understanding. Germ theory posits that microorganisms, or germs, are the typically the root cause of illnesses and infections. Harvard University Library defines germ theory as, “...[encouraging] the reduction of diseases to simple interactions between microorganism and host, without the need for the elaborate attention to environmental influences, diet, climate, ventilation, and so on that were essential to earlier understandings of health and disease.” The revolution of germ theory shifted the focus of

medicine from a belief-based system to a more clinical, laboratory-based setting. The importance of this shift is succinctly described in the Harvard University Library *Contagion*, which states, “The dramatic successes of germ theory, together with a new association of medicine with the laboratory, brought about an elevation in the social status of physicians and of medical research and practice during a period of public skepticism about the value of traditional medical practice.”

The nineteenth century built upon these medical discoveries. As medical knowledge and technology began to spread, healthcare gravitated toward a more centralized model. City governments funded the construction of hospitals, which were primarily designated for those who could not afford private medical care. The American Medical Association (AMA) was also founded during this time period in a bid to centralize the educational and professional standards of American physicians (Randolph). The healthcare industry made many of the same leaps through the nineteenth century as many other American industries did. Unionization increased the compensation and authority of physicians, and provided the various protections that are associated with unionized trades.

The twentieth century saw the most radical changes yet in the American healthcare system. One of the largest changes came in the form of modern health insurance policies. While various forms of insurance existed prior to the twentieth century (accident, sickness, and life insurance), the first form of modern health insurance was created for Dallas schoolteachers in 1929. This insurance agreement came to be known as the Baylor Plan; it cost a mere \$0.50 per month, and guaranteed school teachers up to 21 days of medical care each year (Yale University). This form of prepaid insurance soon became the most common method of insurance

around the country. In a bid to avoid price competition, community hospitals began working together to create health coverage plans. The American Hospital Association designated the acceptable plans created by the non-profit hospitals “Blue Cross.” Private companies soon began to compete with the non-profit plans; these companies varied coverage rates based on how risky they deemed the applicant to be. These private plans were so successful that the Blue Cross plans eventually were altered to emulate the private plans, creating what we now would recognize as the modern health insurance market (Yale University).

In this same time period, employers began to offer their employees health insurance. In the 1940s, the federal government altered the tax laws to allow employer-sponsored health insurance to be exempted from income taxation. Interestingly, the tax-exempt status was a political maneuver made by the federal government during the Second World War. The war effort placed a cap on wage limits and price controls, so “...to grant a concession to labor without violating wage and price controls, Congress exempted employer-sponsored health insurance from wage controls and income taxation—in effect allowing off-the-books raises for employees in the form of non-taxable health benefits. (Lindquist).”

Healthcare continued in much the same manner for decades, with several modifications made along the way. Most notably, Medicare and Medicaid were enacted by President Johnson as “The Social Security Amendments of 1965, Pub.L. 89-97 Stat. 286 ([cms.gov](https://www.cms.gov)).” The two programs were designed to provide healthcare services for those who were unable to access them ([cms.gov](https://www.cms.gov)). Apart from Medicare and Medicaid, notable changes to the American healthcare system were not made until 2010, when President Obama signed the Affordable Care Act into law.

Until the passage of the Affordable Care Act, the American health insurance market was governed by rules and laws that were almost entirely set up in this time period. While most do not associate religion with hospitals, the church has played a large role in maintaining the health of American citizens for the better part of the country's existence. However, despite that tradition, churches have played an increasingly smaller role in caring for people's health, keeping with the trend of American secularization.

Religion and Healthcare

One of the most obvious dualistic relationships in the United States today is the relationship between science and faith. While many would argue that science and religion do not necessarily oppose one another, I anticipate that the typical American would side with a scientific conclusion rather than take a leap of faith. While correlation certainly does not prove causation, technology is increasing in everyday importance and significance at the same time that religion continues its decline in America. This correlation is reflected in the relationship between the rise of the large, powerful, for-profit hospitals and their small, relatively independent faith-based counterparts.

It is well documented that in today's America, the general population is becoming more secular. While much has been made of Christianity's declining presence ("War on Christmas"), American citizens at large are simply becoming less religious. Dan Harris states that, "...the percentage of Americans who define themselves as Christian has dropped from 86 percent in 1990 to 76 percent in 2008...[and] 15 percent of Americans now say they have no religion -- a figure that's almost doubled in 18 years." In addition to the number of Americans who claim religion decreasing, the number of Americans who regularly attend church is in decline as well.

In fact, some studies place the percentage of the American population who regularly attend church to be as low as 17.7% (Barnes et al.).

The spread of secularization has swept through most of America, and it certainly has not missed the healthcare community. As previously detailed, many modern hospitals were either founded or funded by religious denominations, but shed their religious affiliations in favor of administrative control and higher profits. While the for-profit hospitals legitimately dominate their smaller counterparts, the wave of change brought about by the Affordable Care Act will significantly alter the landscape of the clinical world.

While it is simple to gather opinions about the Affordable Care Act, it is significantly more difficult to obtain facts about the new set of healthcare laws. As of now, two facts are clear about healthcare reform. First, the Affordable Care Act was signed into law by President Obama in March of 2010. Second, the law has and will bring radical change to healthcare in the United States. Beyond those two statements, most other claims are simply conjecture. Even a statistic as simple as a total enrollment figure is convoluted. Depending on what source is cited, the Affordable Care Act either exceeded its enrollment goal of 6 million (Mason et al.) or missed it completely (Fox News).

Whether or not President Obama's goals will ultimately come to fruition is anyone's guess. The stated goal of the law is simple: provide insurance to millions of uninsured Americans. Assuming the law is not repealed (the stated goal of many politicians), many changes will or already have taken place. One of the most notable changes brought about has been the creation of the health insurance marketplace. When operable, the marketplace serves as an alternative to the two traditional means of obtaining healthcare: employer and private

insurance. In addition to the marketplace, several other major provisions are outlined by Mike Patton in his Forbes article, “Obamacare: Seven Major Provisions And How They Affect You.”

While all seven of Patton’s provisions are worthy of discussion, three are especially significant and controversial. The first of these provisions is the “guaranteed issue” mandate. This mandate refers to the fact that insurance providers are no longer able to deny coverage for Americans with preexisting conditions (previously diagnosed medical conditions that increase their risk of hospitalization). Another important (and controversial) provision is known as the “individual mandate.” This provision (justified by the Supreme Court as a tax) means that unless you specifically qualify for an exemption, you are required to purchase some form of health insurance. Still another major reform is the expansion of Medicaid. However, when reviewing the constitutionality of the law, the Supreme Court ruled that the choice to expand Medicaid would be left to the states to decide. This “opt out” clause has essentially nullified segments of the law in states that have chosen not to expand Medicaid. Like much of the rest of the law, the effectiveness and implementation will depend on a myriad of factors.

While modern hospitals can be compared to secularized shrines to technology, hospitals in the early part of the twentieth century were almost exclusively funded by churches. This practice is what led many modern American hospitals to names that begin with “Baptist,” “Methodist,” and “Presbyterian.” Dr. Scott Morris, in his book Healthcare You Can Live With, details the end of the hospitals’ church-funded decades. He states that, “This arrangement lasted for several decades, but by the 1960s hospitals began to face significant challenges. Advances in technology don’t come cheap. If you’re going to be the best, somebody has to pay for it.”

While the churches were certainly capable of funding the hospitals, they weren’t as well-

equipped to manage them. Hospital administrators were introduced to increase operational efficiency and to increase profitability. When Medicare and Medicaid were introduced in 1965, billions of federal dollars were poured into hospitals (Morris). While the funds had been allocated to help those in need, an unintended consequence of the funding was the creation of what is now recognized as the for-profit medical system. At this point, churches neither funded hospitals nor made administrative decisions. The relationship officially ended when church denominations began to sell their hospitals to for-profit companies; for many, the names of the hospitals are all that the institutions have in common today (Morris).

In the United States and rest of the world, religious organizations have long played a critical role in the provision and administration of healthcare services. Mainline Christian denominations, most notably the Catholic Church, are driven by their religious convictions to serve the most vulnerable and needy among us. Examples of this commitment to service are manifold: to date, and throughout much of history, the Catholic Church remains the largest non-governmental provider of healthcare services worldwide. Prominent historians have noted how the early church's devotion to treating the sick helped spur conversion, as “in nursing the sick and dying, regardless of religion, the Christians won friends and sympathizers (Blainey).” During the Middle Ages, the Church took on an even more prominent role—in a period devoid of any meaningful form of strong, centralized politics, the Church became a proto-welfare state, according to historian Geoffrey Blainey. Monasteries became the focal point of medical life in the communities they served, as patients were treated and medical professionals were trained (to the best extent possible at the time).

Though the Church's dominant role in providing healthcare has diminished with time, it

remains a tremendously important source of care for the socioeconomically disadvantaged, especially in the developing world—some sixty-five percent of Catholic health institutions are located in developing countries (Calderisi). Furthermore, the Vatican estimates that the Church manages a quarter of the world's health facilities, most notably including 5,500 hospitals and 16,000 clinics (Agnew). In keeping with biblical traditions, many of these missions target those in greatest financial and medical distress, particularly sufferers of HIV/AIDS. Though somewhat smaller in scope and scale, mainline Protestant denominations mount similar faith-driven health initiatives, as well. Again, despite the fact that churches and the American government share similar overarching goals regarding healthcare, the two institutions disagree on how care should be administered. The two cases currently awaiting Supreme Court rulings are examples of this disconnect.

Summarily, a historical connection is shared between organized religion and healthcare in the United States. The two institutions became intertwined during the colonial era, and maintained a strong and constant relationship until the middle of the twentieth century, when many hospitals shed their religious affiliations in favor of professional administration and leadership. The commitment to treating the underprivileged and those in need remains a religious commitment.

The Affordable Care Act and Religion

The relationship between religious and the healthcare system seems to have worsened, as the Supreme Court recently heard cases involving the question whether affordable healthcare is a privilege or a right and if a right, whether the right to affordable healthcare supersedes or can inference upon the right to freedom of religion.

Recently, the legality of the Affordable Care Act has been challenged in courts, and arguments have been heard before the Supreme Court with decisions due in Summer 2014. Specifically, two Supreme Court cases, *Sebelius v. Hobby Lobby Stores, Inc.* and *Little Sisters of the Poor v. Sebelius*, address the role of religion in a nation governed by the Affordable Care Act. Both plaintiffs (Hobby Lobby and Little Sisters of the Poor) are arguing that under the Religious Freedom Restoration Act of 1993 (42 U.S. Code Chapter 21B - RELIGIOUS FREEDOM RESTORATION), their respective organizations should not have to provide contraceptive care to their employees as would be mandated by the Affordable Care Act.

Of the two cases, *Sebelius v. Hobby Lobby Stores, Inc.* has likely received more media attention. While broad, sweeping implications about the respective roles of government and religion in the United States are implicit in the case, the arguments generally are centered around contraceptive care. To quote SCOTUSblog, the chief issue in this particular legal dispute is, “Whether the Religious Freedom Restoration Act of 1993 (RFRA), 42 U.S.C. §§ 2000bb et seq., which 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, allows a for-profit corporation to deny its employees the health coverage of contraceptives to which the employees are otherwise entitled by federal law, based on the religious objections of the corporation’s owners (SCOTUSblog).” David Green, owner of Hobby Lobby, claims that his company is run under biblical principles (Barnes). His legal stance is centered around the claim that providing contraception to his employees would be a violation of his religious beliefs. Argued before the Supreme Court on March 25, 2014, a decision on the case is expected by Summer 2014.

The second of the two cases, *Little Sisters of the Poor v. Sebelius*, is centered around the same debate. Like David Green and Hobby Lobby, Little Sisters of the Poor (a nonprofit to Hobby Lobby's for-profit) claim that providing contraceptive care to their employees would conflict with tenets of Catholicism. However, this case has progressed more quickly than *Sebelius v. Hobby Lobby Stores, Inc.* In January 2014, the Supreme Court issued a temporary order that proclaimed the group of nuns exempt from the contraceptives clause (Barnes). The Supreme Court, however, made it clear that the decision was temporary. The Washington Post states that, "The court's one-paragraph order came after three weeks of what was likely a vigorous behind-the-scenes debate among the justices. It essentially delays a consideration of the merits of the challenges and provides no legal reasoning for the compromise. It came without noted dissent (Barnes)." While final decisions have not yet been made on these two cases, they reflect perhaps a surprising ideological conflict. For much of history, religious institutions such as the Catholic Church have helped those in need in accordance to their religious doctrines and traditions. Governments across the world have shared similar goals. Again, despite the similarities, the two are clearly in conflict.

The implications of the Supreme Court rulings are potentially enormous. The simple fact that arguments are being heard before the Supreme Court imply that a strong relationship still exists between organized religion and healthcare. While nunneries are clearly religious institutions and will likely receive religious exemption from contraceptive coverage under the Affordable Care Act, corporate giants like Hobby Lobby are more vague in their positioning. If the Supreme Court decides that Hobby Lobby may be exempted from contraceptive coverage, it would further weaken an already emaciated Affordable Care Act, and would open the doors for

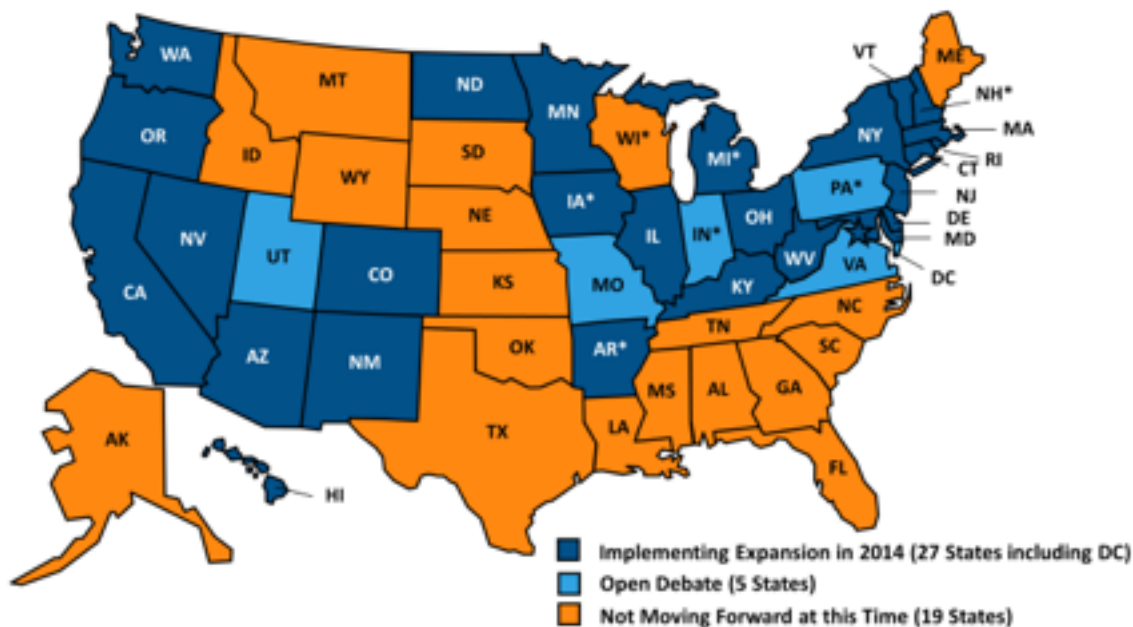
countless other corporations to claim similar exemptions. Many Americans who disagree with the Affordable Care Act (polling estimates for those who disapprove range from 58-43 percent, according to Real Clear Politics), believe that the government initially overstepped its bounds with this law, and evidence is beginning to compile for those in this camp (Supreme Court ruling on Medicaid expansion, initial nunnery ruling, etc.). However, despite what the Supreme Court rules on the Affordable Care Act, it is likely that the set of reforms will have an impact on faith-based clinics, regardless of contraceptive policies.

While the Affordable Care Act was designed to provide health insurance to a significant portion of these uninsured Americans, the recent Supreme Court ruling that struck down the mandatory expansion of Medicaid, meaning that states can choose to expand their Medicaid coverage or not (Kaiser Family Foundation). The landed effect of this ruling is that 24 states have opposed or delayed Medicaid expansion, while 26 have decided in favor of the expansion (Kaiser figure listed below).

(Figure 2, taken from The Kaiser Foundation)

Figure 1

Current Status of State Medicaid Expansion Decisions, 2014



NOTES: Data are as of March 26, 2014. *AR and IA have approved waivers for Medicaid expansion. MI has an approved waiver for expansion and plans to implement in Apr. 2014. IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the Medicaid expansion in Mar. 2014; the legislation calls for the expansion to begin July 2014.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS [here](#). States noted as "Open Debate" are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.



Mandatory Medicaid expansion was an essential part of the Affordable Care Act; without this expansion the core goal of the ACA (covering uninsured Americans) cannot be achieved. In other words, a lack of expansion results in the “coverage gap” remaining intact. This gap is explained succinctly by The Kaiser Family Foundation:

In states that do not expand Medicaid, nearly five million poor uninsured adults have incomes above Medicaid eligibility levels but below poverty and may fall into a “coverage gap” of earning too much to qualify for Medicaid but not enough to qualify for

Marketplace premium tax credits. Most of these people have very limited coverage options and are likely to remain uninsured...The ACA envisioned people below 138% of poverty receiving Medicaid and thus does not provide premium tax credits for the lowest income. As a result, individuals below poverty are not eligible for Marketplace tax credits, even if Medicaid coverage is not available to them. Individuals with incomes above 100% of poverty in states that do not expand may be eligible to purchase subsidized coverage through the Marketplaces; however, only about a third of uninsured adults (3 million people) who could have been eligible for Medicaid if their state expanded fall into this income range. Thus, there will be a large gap in coverage for adults in states that do not expand Medicaid.

To reiterate, the combination of aforementioned factors has led many Americans (who still need access to healthcare) to fall into a coverage gap. Many of these citizens will receive care from local, free clinics. Interestingly, and perhaps unintentionally, free clinics have been strongly connected to the Affordable Care Act. Registration difficulties, lack of accurate information, and lack of access to the online Marketplace have led many to use free clinics as vehicles to obtain healthcare coverage. A particular subset among these free clinics, faith-based clinics, may be set to thrive in this post-Affordable Care Act healthcare system. In addition to the increased traffic they will see from ACA registration, free clinics may hold an advanced role because of their unique status and relationship with members of low-income communities. Religion has long been connected to healthcare, and these clinics have the potential to carry that relationship into the future.

The first of these factors is the historical relationship between faith and medicine in the United States of America. Our dualistic healthcare system presents divided options for care, through large, for-profit hospitals and smaller, free clinics for the underprivileged. Hospitals once were nearly exclusively funded by churches, but now this relationship is often restricted to the smaller clinics. Organized religion still holds a major influence on many in America, and this influence can still be put to effective use by the clinics where faith is present.

Another factor that may result in faith-based clinics assuming a larger role is the sheer ineffectiveness and complexity of our current healthcare system. The Affordable Care Act was passed in 2010 in an attempt to rectify certain aspects of the healthcare system, but many would argue that it simply served to regulate and overcomplicate an already-broken system. Many underprivileged Americans are not likely to have a full, working understand of the ACA. In fact, many in Washington, D.C. seem to have trouble figuring it out. The complexity of the law means that many Americans may turn to their churches for guidance, or at least turn to areas where religion is present out of comfort.

More specifically, because the majority of uninsured Americans are minorities (The Henry J. Kaiser Family Foundation), and because a statistically significant proportion of the minority population subscribes to some denomination of religion (Newport, Stoddard), faith-based clinics may be especially attractive to this particular segment of the American population, and will gain prominence and relevance as they attract more patients and funding.

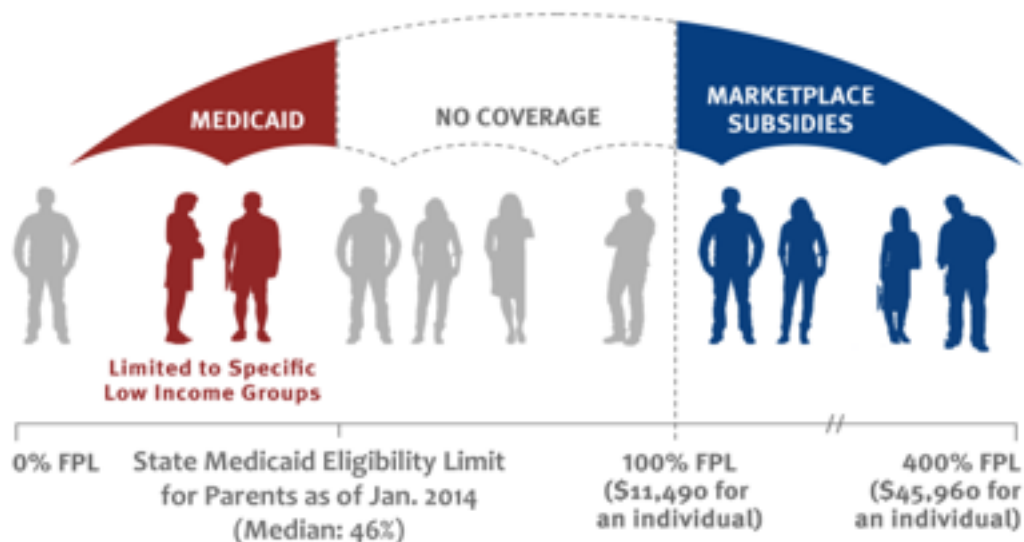
Many are concerned about the impact that the coverage gap will have on ACA effectiveness. To reiterate, this coverage gap is a result of the Supreme Court striking down the ACA's mandatory Medicaid expansion. Those who wrote the legislation did so under the

assumption that states would be required to expand Medicaid, and did not write legislation to compensate for the potential loss of that provision. As such, the ACA does not address the millions of Americans who fall into the coverage gap. Those in this gap earn too much to benefit from existing Medicaid coverage, but earn too little to get Marketplace subsidies from the Affordable Care Act. The number of Americans who fall into this gap is significant. It is estimated that 4.8 million non-elderly adults will fall into this gap (Kaiser). The Kaiser Family Foundation illustrates this gap excellently in the figure below.

Figure 3 (taken from The Kaiser Foundation)

Figure 3

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.



NOTE: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid.

Furthermore, The Kaiser Foundation analyzed the demographics of those projected to fall into the coverage gap. The fact that minorities were historically less likely to be insured has been previously discussed. Interestingly, the ACA (a law designed to provide equal access to healthcare) may further widen the healthcare demographic gap. The facts and implications of this widening gap are perfectly described by the Kaiser study:

However, in states that do not expand Medicaid, millions of poor adults will be left without a new coverage option, particularly poor uninsured Black adults residing in the South, where most states are not moving forward with the expansion. Four in ten uninsured Blacks with incomes low enough to qualify for the Medicaid expansion fall into the gap, compared to 24% of uninsured Hispanics and 29% of uninsured Whites. These continued coverage gaps will likely lead to widening racial and ethnic as well as geographic disparities in coverage and access.

While the Affordable Care Act was designed with good intentions, it may actually end up perpetuating the circumstances that it was written to address. As it stands, faith can be projected to play a large role in the post-Affordable Care Act healthcare environment. The demographics of those most negatively affected by the coverage gap align very closely with the demographics of communities who widely embrace organized religion.

Implications and Future Research

The conflict between religion and the Affordable Care Act will be largely resolved this summer. The decisions will clearly demonstrate what role religion can play in the current and

future healthcare systems. It can be inferred that faith-based clinics may hold an enhanced role in the post-Affordable Care Act healthcare system, both as liaisons between the government and low-income Americans and as primary venues for those in the coverage gap to obtain healthcare. A combination of factors has led some faith-based clinics, once essentially independent institutions of care, to become unofficial registration hubs for the federal government. While all free clinics will achieve and maintain this enhanced (and perhaps temporary) role, faith-based clinics could be especially prominent in the future because of their unique status and relationship with members of low-income communities. Future research should be conducted on what financial and constituency impact, if any, the Affordable Care Act has on faith-based clinics nationwide.

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