Creating a Socially Just Benefits Package

A Wisconsin System Examines Various Options in Light of Catholic Social Teaching

In fiscal year 2006, the trustees of Columbia St. Mary's Health System, Milwaukee, asked the system's executives to create a socially just benefits package for their employees. Surveys had revealed that staff members were struggling with their ability to afford the medical plan then in place, which included biweekly payroll premium contributions, a deductible, and coinsurance out-of-pocket expenses.

The authors of this article were members of the committee assigned to create the new benefits package. The committee began by trying to ascertain how many of the system's 4,633 eligible employees might be unable to afford the current plan, given the fact that 1,164 (48 percent of whom were full-time employees and 52 percent were part-time) did not participate in it. We found that roughly 10 percent of the nonparticipants had no health insurance coverage at all. Having made that discovery, we appointed a work team to examine various models of medical plan funding, the goal being to establish a plan for employees that would be aligned with our vision of health care for the community as a whole—health care that "leaves no one behind."

What, precisely, constitutes a socially just medical insurance plan? In this article, we will examine the concept of justice in light of Catholic social teaching (CST), hoping to describe a socially just medical plan appropriate for a Catholic health ministry. Using CST as a lens, we will flesh out the three components of the Catholic conception of social justice: distributive justice, commutative justice, and contributive justice (see **Box,** p. 34). We will then examine certain models that the human resources (HR) literature proposes as "socially just" medical plans, asking whether and to what extent each model is in fact socially just as the term is defined in a specifically Catholic context.

Having done that, we will argue that one of these models is indeed consistent with the mission, vision, and values of a Catholic health ministry.

The Principle of Justice

The principle of justice in CST cannot be understood apart from three foundational norms.

The Inviolable Dignity of the Human Person The inviolable dignity of the human person comes from the person's relationship to God, since people are "created in [God's] image and likeness" (Gn 1:27). In this way, the person's *inviolable* dignity is understood in terms of both the person's beginning and ultimate end, which is God.[1]

The Essentially Social Nature of Human Beings The tradition's second foundational norm recognizes a person's need to enter into social orders as an essential component of the human reality.[2] Participation in the social orders (e.g., family, associations, and political community) is necessary for the person's proper development.

The Belief That All of Creation Is Given for the Benefit of All People The third foundational norm relates the inherent and inviolable dignity of the human person to the person's essentially social nature as those two realities engage creation. All creation is given as gift and, because it is, each person has the right to a set of goods proportionate to his or her human dignity.[3] This notion of proportionality is defined by the principle of participation—securing those goods necessary to *participate* fully in society in accord with one's human dignity.[4]

In CST, the three forms of justice (commutative, distributive, and contributive) that traditionally stand in isolation are brought together as *social* justice. More specifically, the foundational norms of human dignity, the essentially social nature of human beings, and the principle of participation conceive of the relationship between persons and the goods of society relative to the common good. From this relationship arises CST's understanding that all human beings have a right to a basic set of goods that allow him or

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her to flourish in community. An insight of Karen Lebacqz, PhD, is helpful in this respect. The common good, she argues, is shaped by three questions: What do moral policies concerning economic life do *for* people? What do they do *to* people? And how do people *participate* in them.[5]

In the CST tradition, which has the preferential option for the poor embedded in its construction of human dignity, social justice is concerned primarily with the ways that moral policies in economic life affect the poor and vulnerable. As a result, commutative, distributive, and contributive justice are interpreted uniquely.

Justice in the Catholic Tradition

Pope Leo XIII's *Rerum novarum* (1891) refers specifically to distributive justice, arguing that people in positions of power, especially rulers, should be mindful of those most vulnerable, making sure that all are "housed, clothed, and enabled to support life."[6] Pope Pius XI, in *Quadragesimo anno* (1931), stresses the importance of commutative justice, which calls us all to "faithfully respect the possessions of others, and not to invade the rights of another, by exceeding the bounds of one's own property."[7] Pope Pius XI also develops the notion of distributive justice while introducing the term "social justice." He links economic justice and human dignity, since both relate to the participation of all people in economic and political life.[8] Although debate still continues on precisely what the pope meant by social justice,[9] an apparent consensus now holds that social justice exists with "its own set of obligations . . ."[10] wherein "the distribution of created goods . . . must be effectively brought into conformity with the . . . common good, i.e., social justice."[11]

It is also clear that when the world synod of bishops takes up the task of articulating the church's sense of global justice, it intends *social justice* to be not simply a concept but a true call to action that creates obligations on society as a whole. For the Roman Catholic Church, the phrase means that the "right to development must be seen as a dynamic interpenetration of all those fundamental human rights upon which the aspirations of individuals and nations are based";[12] and in this way "action on behalf of justice and participation in the transformation of the world fully appear to us as a constitutive dimension of preaching of the Gospel, or, in other words, of the Church's mission for the redemption of the human race and its liberation from every oppressive situation."[13] Or as Ron Hamel, PhD, succinctly points out, "the church *must* be engaged in this world to bring about justice for all."[14]

But what obligations are derived from the CST-based conception of social justice as those obligations relate to health care benefits? We will now turn to specific implications of these convictions in light of proposed "just" benefits packages. Then, after detailing various models offered by the HR literature, we will argue that one particular model is most closely in line with Catholic teaching.

"Just" Models

The models can be divided roughly into *premium funding* models and *plan design* models. Among premium funding models, three further distinctions can be made: the *wage-based* model, the *annual base salary* model, and the *household total income* model. Three further distinctions can also be made among plan design models: the *funded health reimbursement* model, the *health care savings accounts* (HSA) model, and the *catastrophic plan design* model.

Premium Funding Models

The wage-based and the annual base salary models are similar but have different implications for

Three Components of Justice

Justice, as understood in Catholic social teaching,* has three components:

- *Commutative justice* concerns relationships between or among persons or corporate persons. It is largely a notion of justice that governs contracts or agreements.
- *Distributive justice* concerns relationships between society and the individual. It involves deciding how finite sets of resources are to be distributed equitably and fairly among society's members.
- *Contributive justice* concerns relationships between the individual and society—specifically, what the individual owes to society.

In Catholic social teaching, these three forms of justice establish the minimum levels of participation in the life of the human community for all persons, with highest priority given to the basic needs of the poor and marginalized.

*See K. Lebacqz, *Six Theories of Justice: Perspectives from Philosophical and Theological Ethics*, Augsburg Publishing House, Minneapolis, 1986, p. 73; C. E. Curran, *Catholic Social Teaching, 1891-Present: An Historical, Ethical and Theological Analysis*, Georgetown University Press, Washington, DC, 2002, pp. 190-191; N. J. Paulhus, "Uses and Misuses of the Term 'Social Justice' in the Roman Catholic Tradition," *Journal of Religious Ethics*, vol. 15, no. 2, 1987, pp. 274-276; and P. Land, "Justice," in J. A. Komochak, M. Collins, and D. A. Lane, eds., *New Dictionary of Theology*, Liturgical Press, Collegeville, MN, 1994, pp. 548-553.

hourly employees, as the term annual base salary implies. Since work in a health care facility typically involves frequent wage adjustments (resulting from the many, subtly variegated roles that can occur in even a single job description, and from the off-shift and overtime hours such roles often require), an employee may earn considerably more in a year than his or her base salary. Because this is so, many employees may qualify under an annual base salary plan rather than a wage-based plan.

Wage-Based Model A wage-based model turns on the principles of solidarity and proportionality. The model presumes that both employer and employees participate in plan funding in proportion to their own financial resources. Under this model, the employee portion of the plan funding is based on selected wage grades. Tier I and II employees, for example, would be eligible for a subsidized premium based on the total amount of dollars reallocated by increasing premiums for employees earning higher wages.

Wage-Based Model Example

Tier I Wage grades $8-$12.99/hour (assuming that a living wage has been established as a wage floor for the ministry)

Tier II Wage grades of $13–$17.99/hour

Tier III Wage earners beyond Tier I and Tier II (not including members of the leadership team and employed physicians)

Tier IV Leadership team members and employed physicians

Tier I and II employees would be identified both in terms of percentage of premium contribution as a percentage of preadjusted rates and in terms of the earnings that would qualify. Using the example above, Tier I and Tier II employees would qualify for the wage-based model for health care premium funding. Tier I employees might be required to pay only from 1 to 5 percent of the traditional employee premium models (depending on the proportion of redistributed burden to other employees and physicians), in which the employee pays roughly 20 percent of the premium payment. In other words, if a "family"-designated premium is currently 20 percent of the total premium payment (e.g., $100 out of a total premium payment of $500), then Tier I employees would be required to pay only $10 or $25, respectively). Tier II employees might be required to pay 10 percent (which is still substantially lower than the 20 percent standard) of the total premium payment, which would equate to $50. A portion of the aggregate loss to the plan's funding might then be recouped through increased contributions from Tier IV employees, with the rest made up by a line-item allocation as part of the total budget of the facility.

This plan would allow flexibility in tier design, eligible wage bracketing, percentage of total premium funding reduction for eligible tiers, and amount of redistribution to leadership and employed physicians. However, such a plan might limit interest in career advancement, since promotion could mean that the employee promoted loses his or her premium subsidy. And the wage-based model does not involve the total household income of the participant. Because it does not, a participant might qualify for a subsidy under the wage-based model even though he or she has a spouse who contributes a significant salary to the total household income.

Annual Base Salary Model The annual base salary model is also based on the principles of solidarity and proportionality. It also assumes that the employer and the employees participate in health care plan funding in proportion to their own financial resources. However, in this model, employee contribution to the total health care plan funding is based on selected annual *base* salary grades. For example, employees in Tier I and II annual base salary grades would be eligible for a subsidized premium based on the total amount of dollars reallocated by increased premiums for higher-salaried employees.

Annual Base Salary Model Example

Tier I ≤ $25,000

Tier II ≤ $35,000

Tier III = Annual base salaries beyond Tier I and Tier II, excluding leadership team members and employed physicians

Tier IV = Leadership team members and employed physicians

The annual base salary model operates much like the wage-based model, with only a few exceptions. The annual base salary model would not be able to account for shift differentials, premium pay, and other modifications to the employee's base salary. These modifications may actually account for substantive variances in the actual salary of the employee. Where such variances are substantial, some employees may qualify for Tier I when they should actually be in Tier II, or not qualify at all. Additionally, an annual base salary

model might bring to the fore base wage rate disparities (involving, say, recruitment, years of service, or gender disparities) among employees who work at the same job or on the same shift.

Household Total Income Model The household total income premium funding model operates differently than the two models described above. This model seeks to establish household total income levels consistent with those of the facility's charity care policies that are based on total household income. To establish tiers under this model, the facility could calculate household total incomes equivalent to a given percentage of the federal poverty level (FPL) guidelines (i.e., 100 percent, 150 percent, or 200 percent) (see **Box**).

This model allows the facility to choose the percentage of total premium-funding for health care benefits. The premium paid by the employee—as a percentage of the total health care premium—is established in proportion to the level of total household income, family size, and percentage of that income as it relates to the FPL guidelines.

Household Total Income Model Example

(As in the previous model, we assume that the current employee contribution is 20 percent of the total premium for health care benefits.)

Tier I = Household Income ≤ 100% FPL, complete reduction in premium to $0

Tier II = 100% Household Income ≤ 150% FPL, 5% of total premium for health care benefits

Tier III = 150% Household Income ≤ 200% FPL, 10% of total premium for health care benefits

Under this model, an employee with a family of four and a total household income of $40,000 would qualify for Tier III and be eligible for a premium reduction to 10 percent of total premium for health care benefits. Similarly, an employee with a family of four and a total household income of $20,000 would qualify for a greater reduction in premiums than would the family with the $40,000 household income (i.e., 0 percent of total premium vs. 10 percent of total premium). In this way, the household total income model can account for variances in total household income and family size. This model can also account for total household income (i.e., federal tax filing records voluntarily submitted by the employee and stored by the employer in a manner that preserves confidentiality), thereby alleviating concerns about spousal income.

2007 Federal Poverty Level

Family Size	100% FPL	150% FPL	200% FPL
1	$10,210	$15,315	$20,420
2	$13,690	$20,535	$27,380
3	$17,170	$25,755	$34,340
4	$20,650	$30,975	$41,300
5	$24,130	$36,195	$48,260

Federal Register, vol. 72, no.15, January 24, 2007, pp. 3,147-3,148 (http://aspe.hhs.gov/poverty/07poverty.shtml).

Plan Design Models

Plan design models, in contrast to premium funding models, attempt to target out-of-pocket expenses or deductibles in order to reduce the cost of the *use* of health care for the employee. In other words, a plan design model emphasizes reduced financial burden to the employee as he or she utilizes the health care plan, while potentially reducing financial burden to the employee for the cost of the plan itself. These models can be broken down into health fund reimbursement mechanisms, HSAs, and catastrophic plan design.

Health Fund Reimbursement One kind of health fund reimbursement plan offers a group of employees (selected according to some predetermined criteria) a prefunded card to pay a portion of a deductible or coinsurance out-of-pocket expense. Since the prefunded card could be based on a sliding scale, not all employees qualifying for it would obtain the same reimbursement amount. Such a plan could account for proportionality between employee's income (i.e., household or individual) and the amount of reimbursement.

HSAs Another plan design model builds choice into the number of plans offered to employees. These plans can vary, depending on the factors involved, but most try to balance cost with risk. In other words, the employee may incur a substantially reduced health care premium in lieu of higher deductible medical plans.

Deductibles:
Employee $1,000; Family $2,000

Out-of-pocket expenses (maximum):
Employee $5,000; Family $10,000

These plans usually allow for some pre-tax contribution to a fund that would allow for the accumulated dollars to account for the higher deductible or out-of-pocket expense with restrictions on the use of such an account. However, these plans assume that the employee will (or even can) utilize such pretax contribution plans in order to fund these substantially higher deductibles and out-of-pocket expenses. Furthermore, a tax benefit from such a plan would be nonexistent for an employee whose wages were already below a taxable threshold.*

Catastrophic Plan Design Catastrophic care plans are offered to employees to allow the employees to evaluate the balance between cost and risk. Such plans often have low premium contributions, but do not begin to cover medical expenses until high thresholds are achieved (i.e., length of stay or total dollars).

Both the HSA and the catastrophic plans assume access to health care through traditional premium funding. The lower premiums in both models allow for greater access to health insurance coverage in the aggregate. However, given the greater financial burden shifted to the employee, he or she may be reluctant to utilize the access the plan makes possible. Such plans do "incentivize" participants to steward their health care dollars. However, they also assume that the participant has the information he or she needs to be a prudent steward, and this assumption may not always be realistic.[15]

Plan Models and Justice

Now that we've explored some basic pros and cons of both premium funding models and plan design models, we will analyze each plan in light of the principle of justice. Since we intend to determine which plan will best suit the concept of social justice as that principle is defined in the Catholic moral tradition, we will concentrate on the extent to which each plan does that. The Catholic bishops' 1985 pastoral letter on the U.S. economy offers a substantive basis upon which a critique of each health care benefit package may be evaluated as truly socially just.[16]

Both the premium funding models and the plan design models seem to provide greater access to health care, even though their various sub-categories approach this goal via different mechanisms. The premium funding models attempt to increase access to benefits either by redistributing disproportionate financial burdens or by subsidizing the benefits of low-paid employees. Plan design models, on the other hand, attempt to increase access to benefits by allowing the participant to choose from a variety of plan designs to balance cost and risk. In plans based on this model, employees may be able to afford a higher risk plan at a premium rate below that of the standard PPO or HMO model.

In the premium funding model, the goal is to provide access to the same benefits plan for all employees through varying levels of contribution based on certain criteria. The plan design models offer more flexibility in the choice of plans themselves in order to avail more opportunity for access to a benefits package. At first glance, then, it appears that, given the CST definition of justice, the premium funding model offers a more socially just benefits package than does the plan design model. But is this really so?

The Catholic social tradition's definition of justice includes the significant notion of a preferential option for the poor.

The CST definition of justice includes the significant notion of a preferential option for the poor.[17] This fact would suggest that any benefits package assessment must be evaluated in light of how it will affect, first, the organization's most vulnerable employee and, second, the organization as a whole.[18] That being so, in situations where financial vulnerability is a significant consideration, the just benefits package should initially provide a mechanism whereby access is increased based on reduced cost to the participant. In fact, costs are reduced in both premium funding models and plan design models, thereby presenting the opportunity for greater participation. However, if one looks at the modification of the benefit package to achieve this end, one sees stark differences.

Premium funding models achieve greater access to an affordable benefits package through a redistribution of the premium cost *without* adjustments to the benefits package itself. Plan design models, on the other hand, achieve greater access to an affordable package through lower cost options with greater levels of associated risk directly proportionate to cost. Here the primary

*The authors would like to thank Bill Solberg, director of community benefits at Columbia St. Mary's, for his insight concerning this point.

consideration seems to be the financial burden the employer might bear as a proportion of the plan's total cost.

Given the fact that all employees in premium funding models are offered the same benefits package and that the financial burden—which would be disproportionate if not adjusted (that is, the premium for the package would be a greater percentage of total income for a person earning $20,000 than for one earning $50,000)—is redistributed through a variety of mechanisms, these models seem more *socially just* than others, given the CST construction of the principle of justice.

Consider also that distributive justice—which is incorporated in the CST construction of the principle of justice—requires that benefit and burden be distributed equitably across the population being considered.[19] In plan design models, burden is not distributed equitably because the risk associated with less expensive plans is proportionate not to the population served but, rather, to the plan's risk. Again, it seems evident that the primary consideration in plan design models is the financial burden borne by the employer for the plan, not health care access in accord with human dignity and the common good. CST does not suggest that the financial burden should be ignored. It does suggest that it should not be the *primary* consideration.[20]

Distributive justice requires that benefit and burden be distributed equitably across the population being considered.

One should also note that, although plan design models make lower-cost benefit packages available to employees, this lower cost is often related to the significant cost for health care services borne by the employee, to the point where those services reach a significant financial threshold. Demands on the employee's budget (for food, clothing, shelter, and so forth) may leave him or her little for potential out-of-pocket health care expenses. Thus the just nature of the plan design model is contingent on a significant factor—the employee's ability to allocate pre-tax dollars for health care expenses. If the employee is unable to allocate such dollars, the plan's "justice" may be questioned.

A Truly Just Package

Generally speaking, plan design models seem less congruent than premium funding models with the principle of justice as defined by CST. And of the various premium funding models, the household total income model seems to us to be the most socially just. We have four reasons for our judgment.

- The primary question concerning employee benefits is: How broadly should household income be defined in order to justify a redistribution of the disproportionate financial burden placed on the employee for his or her benefit premium. As noted, under the household total income model, the employee's premium is adjusted proportionate to his or her *total* household income. As a result, the premium paid by the employee is adjusted to be commensurate with those of other contributors to the household's financial well-being. Premium adjustments can then take into account the spouse's financial contribution, if applicable, without applying the spousal surcharge typical of plans that attempt to compensate for an employee's spouse's ability to pay for his or her own benefits package.
- The wage-based and annual base salary models require arbitrary "cutoffs" to establish the tier structures necessary for calculating a redistribution of the premium incurred by all employees in a traditional premium model. In both models, an employee's desire to advance in responsibility, job description, or salary may be significantly thwarted if he or she happens to be at the upper limit of qualifying for some reduction in his or her benefit premium. Given that CST sees the dignity of work as integral to human dignity in general, a Catholic structure that imposes barriers on an employee who seeks to flourish in work responsibility, assignments, or salary would seem to be working against that dignity.
- The effort by the wage-based and annual base salary models to define an employee's true ability to pay for benefits is a significant drawback to those models. They cannot truly assess whether a particular employee's premium is disproportionate or not. Take the case of an employee earning $18,000 a year while his or her spouse earns $50,000; given the couple's *total* household income, use of the employee's annual base salary alone simply would not—according to the CST conception of justice—warrant a redistributed premium. Admittedly, the household total income model has limitations insofar as the tax returns needed to establish such income are always for the previous year.
- The household total income model allows congruity between efforts to equalize access to

health care for the community served by the facility, on one hand, and its employees, on the other. By virtue of their mission, vision, and values, many Catholic health care organizations provide to people in need charity care that is based on some method of assessing ability to pay. The most common method involves use of the FPL guidelines. A Catholic facility offering a premium funding model that utilizes the FPL guidelines to assess total household income for its employees creates congruity between the care received by its community and that received by its employees.

Using the FPL guidelines also eliminates the difficult task of creating arbitrary "cutoffs" for employees based on wage grades or annual base salary. If the facility's charity care committee conducted the evaluation of employees' applications, that would also contribute to congruity between the community and employees served.

In the end, we chose the total household income model as the basis for its health care benefits for the employees of Columbia St. Mary's. We did this because this model seemed to best satisfy all three CST criteria.

The Inviolable Dignity of the Human Person In the Catholic moral tradition, access to health care is a recognized right of *all* persons. The total household income model attempts to provide employees with greater access to health care benefits, thereby increasing the likelihood that they will in fact access the health care system. The model does this in a manner that alleviates the disproportionate financial burden that unadjusted premiums often impose on lower-wage workers. On the other hand, it does not completely release the employee from financial responsibility for his or her health care, and therefore recognizes the dignity of labor. The total household income model also considers the true financial burden imposed on the household by the premium because it takes into account *all* the household's sources of income, not just the employee's salary.

Because this is so, the larger community is not disproportionately burdened by subsidies the facility might offer its employees, subsidies that otherwise would have to be recouped through increased revenue generation or reallocation of all employees' contributions. And given the fact that the facility will subsidize its lowest-paid employees more heavily than others, the model serves the most vulnerable employees first.

The Essentially Social Nature of Human Beings CST holds that it is essential for human beings to enter into the social orders (e.g., family, friendships, political communities), which are necessary for the person's proper development. Because health is foundational to human flourishing and well-being, health care is vital if people are to engage in these social orders. Because it creates no barriers to health care access as a result of requiring financially disproportionately burdensome premiums, the total household income model most adequately allows for that level of human flourishing.

The Belief that All of Creation Is Given for All People Each person, in the Catholic tradition, has the right to a set of goods proportionate to his or her dignity as a human person. This proportion is defined by the principle of participation—that is, each person requires the goods enabling him or her to *participate* fully in society. The household total income model is consistent with the notions of both proportionality and participation. The model is consistent insofar as proportionality is preserved in the sliding-scale premium obligations for the employee and insofar as participation correlates with the relief of the disproportionate financial burden in an unadjusted premium model that necessarily creates financial barriers to participation in the health care environment.

In the Catholic moral tradition, access to health care is a recognized right of *all* persons.

The household total income model of premium funding recognizes the integral relationship involving human dignity, human flourishing, and health care access. Through mechanisms that alleviate financial barriers to access, the model allows people to participate in this integral relationship in accord with *all* persons' inherent human dignity and in a manner that is truly *socially just.* ■

NOTES

1. N. J. Paulhus, "Uses and Misuses of the Term 'Social Justice' in the Roman Catholic Tradition," *Journal of Religious Ethics,* vol. 15, no. 2, 1987, pp. 261-282.
2. "Gaudium et Spes," in Austin Flannery, ed., *Vatican Council II: The Conciliar and Post-Conciliar Documents,* Daughters of St. Paul, Boston, 1987, sections 24-25, pp. 925-926.
3. C. E. Curran, *Catholic Social Teaching, 1891-Present: An Historical, Ethical and Theological Analysis,* Georgetown University Press, Washington, DC, 2002, pp. 127-136.

4. An excellent summary of these foundations of CST can be found in K. Lebacqz, *Six Theories of Justice: Perspectives from Philosophical and Theological Ethics,* Augsburg Publishing House, Minneapolis, 1986, pp. 66-71.
5. Lebacqz, p. 72.
6. Pope Leo XIII, *Rerum novarum,* section 27.
7. Pope Pius XI, *Quadragesimo anno,* section, 47.
8. Pope Pius XI, section 34.
9. See, for example, J.-Y. Calvez and J. Perrin, *The Church and Social Justice: The Social Teaching of the Popes from Leo XIII to Pius XII (1878-1958),* E.J. Brill, Leiden, Netherlands, 1969; D. Dorr, *Option for the Poor: A Hundred Years of Vatican Social Teaching,* Orbis, Maryknoll, NY, 1983; D. Hollenback, *Claims in Conflict: Retrieving and Renewing the Catholic Human Rights Tradition,* Paulist Press, New York City, 1979; Daniel Maguire, *A New American Justice: Ending the White Male Monopolies,* Doubleday, New York City, 1980, p. 57; Curran, pp. 188-189; and Paulhus, pp. 268-271.
10. Pope Pius XI, *Divini redemptoris,* 1937, section 51.
11. Pope Pius XI, *Quadragesimo anno,* sections 57, 8.
12. World Synod of Bishops, *Justice in the World (Justitia in Mundo),* 1971, section 15.
13. World Synod of Bishops, section 6.
14. R. Hamel, "Justice in the World," in J. A. Dwyer, ed., *New Dictionary for Catholic Social Thought,* Liturgical Press, Collegeville, MN, 1994), pp. 495-501.
15. Much has been written on both the benefits and burdens of HSAs and catastrophic health care plan design models. See, for example, B. J. Orth, "Employee Contributions for Dependent Medical Coverage: Balancing Cost, Compensation and Society," *Benefits Quarterly,* vol. 14, 1998, pp. 30-33; S. E. Singer, "Ethical Considerations in Health Care Benefits Administration," *Benefits Quarterly,* vol. 14, 1998, pp. 24-29; and J. F. Higgins and E. M. Armenio, "A Review of Ethical Considerations in Benefits Planning," *Benefits Quarterly,* vol. 14, 1998, pp. 18-23.
16. National Conference of Catholic Bishops, *Pastoral Letter on Catholic Social Teaching and the U.S. Economy,* 2nd draft, U.S. Catholic Conference, Washington, DC, October 7, 1985, pp. 92-93.
17. See Dorr; N. F. Lohfink, *Option for the Poor: The Basic Principle of Liberation Theology in Light of the Bible,* Bibal, North Richland Hills, TX, 1995; S. J. Pope, "Christian Love for the Poor: Almsgiving and the 'Preferential Option,'" *Horizons,* vol. 21, 1994, pp. 303-308; and S. J. Pope, "Proper and Improper Partiality and the Preferential Option for the Poor," *Theological Studies,* vol. 54, 1993, pp. 242-71. For a discussion of the preferential option for the poor from the perspective of liberation theology, see G. Gutiérrez, "Option for the Poor," in I. Ellacuria and J. Sobrino, eds., *Mysterium Liberationis,* Orbis Books, Maryknoll, NY, 1993, pp. 235-250.
18. Paulhus, p. 274.
19. Curran, pp. 195-197; Paulhus, p. 275.
20. William E. Murnion, "The 'Preferential Option for the Poor' in *Economic Justice for All: Theology or Ideology,"* in B. P. Prusak, ed., *Raising the Torch of Good News: Catholic Authenticity and Dialogue with the World,* College Theological Society, Chestnut Hill, MA, 1986, pp. 203-237.

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