



Moral Vision in the Health Care Reform Bills

The Patient Protection and Affordable Care Act (SENATE BILL H.R. 3590)
and the Affordable Health Care for America Act (HOUSE BILL H.R. 3962)

Working toward our health care future

We are living through an unprecedented opportunity to move further than ever toward a health care future that includes everyone and works well for all of us. Those of us in faith communities believe that such a future must be grounded in the sacred bonds of our common humanity and reflect faithful stewardship and equitable distribution of our abundant health care resources.

When that future moves from vision to reality, one in six children and non-elderly adults in our country will no longer have to live sicker and risk dying younger because they cannot get needed health care. Medical expenses will no longer be a cause of financial ruin for families, individuals, institutions, businesses, and governments. All of us will have the quality health care we need regardless of our age, income, race, gender, pre-existing conditions, sexual orientation or place of residence.

Perhaps the greatest stumbling block in moving toward that reality is that up until now as a nation we have never made a national legislative commitment to guarantee needed health care for everyone who lives here. The Senate and House bills get us closer to that commitment but, because we aren't yet there, we argue about whether we should increase access, reduce costs, add or reduce benefits in public programs, increase income eligibility for public assistance, institute cost controls, improve delivery, and more. The ongoing debate over such details demonstrates that it is not a lack of policy creativity or resources to move us forward, but the absence of a moral vision accompanied with political will to use our abundant resources in service to the common good.

People of faith have sought to change that by offering "A Faith-Inspired Vision of Health Care" as a statement of the shared values which inform our health care reform efforts – and as a measure by which legislative proposals for reform can be considered. By identifying where the legislative proposals do/do not reflect values of community, human dignity, shared responsibility, compassion, faithful stewardship, and special concern for those who are vulnerable, we will be at the heart of the transformation that will be needed to help shape our health care future.

This analysis is not about picking apart the bills. It is about keeping a shared vision in front of us so that we may discover together how we will make health care for all a reality. It is about recognizing that the current bills are not the final design for our health care future, but rather the seeds to be planted, cultivated, weeded, and fertilized until they yield the fruit we need to sustain this endeavor. And it is about defining our on-going role in transforming the public conscience.

It is NOT about “may the best plan win”

There is no *perfect* way to provide health care for the 300+ million people living in the United States. But we all know there has to be a better way. Our 150-year old jumble of law, policy, tradition, technology, bureaucracy and practice has resulted in an oversized and inefficient machine that consumes resources disproportionately to what it produces. It’s increasingly clear that if we were to start from scratch, we would design a U.S. health system that looks very different than what we have today. While we can’t start from scratch, we know we do need to move forward on a complete system overhaul.

Legislative considerations for health care reform over the last century have mostly been “pure form” models which focused on financing – models in which the author proposed the elimination of either public or private insurance. While there are still strong proponents of the exclusively public or private models, the current proposals have moved in the direction of hybrid models that attempt to maintain and improve both public and private roles, and knit them together more effectively to eliminate gaps. This, in part, is due to the broad recognition that health care reform must be more than just financing health care or reforming insurance. It must also address quality, delivery, costs, and disparities to make quality affordable health care for all a reality.

It IS about a moral vision for our health care future

The pages which follow present an overview of current proposals, beginning with what is currently understood about the bills passed in the House of Representatives (H.R. 3962 – the “Affordable Health Care for America Act”) and the Senate (H.R. 3590 – “The Patient Protection and Affordable Care Act”).

It is often said that the moral test of a society is how that society treats those who are in the dawn of life – *the children*; those who are in the twilight of life – *the elderly*; and those who are in the shadow of life – *the sick, the needy, and the differently-abled*. Out of this framework the most basic questions about justice in health care arise and must be answered as legislative efforts move forward:

Who is included in the proposals? Who is still out?

Who pays? Who profits? Who profits at the expense of those who cannot pay?

Whose voices were heard as the legislation was written? Whose voices were not heard?

Who is accountable? And to whom?

What follows is a consideration of the current bills as viewed through the lens of the values articulated in “A Faith-Inspired Vision of Health Care.” (*printed at the end of this document*) Coupled with the questions about health care justice, the Vision Statement guides our reflections and analysis in considering how legislative proposals do/do not advance our vision for health care. It is not an exhaustive description of the bills, but a reflection on the issues of justice which concern people of faith.

The discussion about the public health insurance option

Over the years, we have accepted moral responsibility for our most vulnerable populations. We have recognized that those with the lowest incomes, our elderly, our veterans, and our Native American populations need the support of our collective resources for health care. And we have responded appropriately. The crisis facing us now is the millions of persons who do not have employer-sponsored health care, do not qualify for any of these programs, and cannot afford to buy insurance or pay out-of-pocket for their medical expenses. The public option is proposed to address that reality.

Reflection on this issue through the lens of faith values can help us move from debate that focuses solely on government-run vs. market-driven health care toward dialogue that evaluates the public option as a potential tool to serve the common good. The public option is highlighted in this document because it demonstrates the core values in “A Faith-Inspired Vision of Health Care.”

► Vision ~ Inclusive

Health care is a shared responsibility that is grounded in our common humanity. In the bonds of our human family, we are created to be equal. We are guided by a divine will to treat each person with dignity and to live together as an inclusive community. Affirming our commitment to the common good, we acknowledge our enduring responsibility to care for one another. As we recognize that society is whole only when we care for the most vulnerable among us, we are led to discern the human right to health care and wholeness. Therefore, we are called to act with compassion by sharing our abundant health care resources with everyone.

Provisions common to both the Senate and House bills that contribute to this Vision:

- Most U.S. citizens and legal residents will be required to have health insurance, with penalties for failure to comply.
Senate bill exemptions: financial hardship, religious objections, those without coverage for less than 3 months, American Indians, undocumented immigrants, incarcerated persons, those for whom the lowest cost plan exceeds 8% of individual income, or those who earn less than 100% of the FPL.
House bill exemptions: religious objections, financial hardships, or incomes below \$9,350 for singles or \$18,700 for couples.
- The expansion of Medicaid to a higher percentage of the federal poverty level (FPL) will cover more persons who are currently uninsured.
House bill – 150% FPL, beginning in 2013, covering about 15 million new enrollees
Senate bill – 133 % FPL, beginning in 2014, covering about 14 million new enrollees
[Note: Currently, in 43 states childless adults are not eligible for Medicaid, regardless of income. Nationally, the median eligibility for parents is only 67% of the FPL. (Source: Families USA calculations)]
- Dependent coverage will be extended to age 27 in the House bill or age 26 in the Senate bill for all individual and group policies.
- Insurance industry reforms:
 - Annual and life-time caps on insurance claims will be eliminated.
 - “Guaranteed issue” will eliminate the insurance industry practice of denying coverage because of pre-existing conditions, health status, gender or age.
 - Insurers will be prohibited from rescinding coverage except for clear evidence of fraud.

Additional provisions that contribute to this Vision:

- The **House bill** requires businesses with \$500,000+ payroll to either provide insurance or pay fee equal to 2-8% of payroll (graduated by size of payroll). The **Senate bill** requires employers with more than 50 workers to pay fees if any of their workers receive premium tax credits (employers with less than 50 workers exempt from requirements and penalties).
- The **House bill** establishes a public health insurance option for those who have the most difficulty in purchasing insurance in the private market, and who do not qualify for other public programs – those who are uninsured, self-employed and owners of small-businesses. The **Senate bill** creates private national health plans, at least one of which must be non-profit.
- The **House bill** eliminates the Children’s Health Insurance Program, but would include children and their families in Medicaid. The **Senate bill** extends the program and increases the federal reimbursement to states for beneficiaries.

Seeking justice in health care

Where do these bills fall short of a moral vision for inclusive health care?

Who remains excluded from health care in both bills?

- Some children still will not have health insurance because of the different ways in which states offer/administer coverage for children.
- Both bills maintain the current 5-year waiting period for low-income, legal immigrant adults to access Medicaid – even though they work, pay taxes, and contribute to society.
- Undocumented immigrants, including children, remain ineligible for non-emergency Medicaid.
- Both bills explicitly prohibit undocumented immigrants from receiving subsidies in the exchange.
- It appears that the subsidies will be insufficient to make the system completely inclusive. The answer to “who is still out” will depend upon how these issues are resolved.
- It is anticipated that even with expanded eligibility for Medicaid, increased employer responsibility, and new subsidies to purchase insurance in the exchange, low-moderate income workers still will find insurance to be unaffordable, resulting in several million people excluded from the system.



Additional provisions that exclude persons from needed health care

- The **Senate bill** explicitly blocks undocumented immigrants from purchasing insurance in the exchange – even with their own money and no premium subsidies. Some undocumented persons who already purchase private insurance may find it no longer possible to do so.
- The provision in the **House bill** to move children from the CHIP program to Medicaid could result in a cumbersome transfer of enrollees, resulting in some children losing coverage.

What the public option means for inclusive health care

A public health insurance option (or an alternative that achieves the same goal of getting everyone covered) can be seen as the moral center of health care justice. Do we want to guarantee that everyone is included in our health system – or not? The public option is proposed to address the reality that in spite of other program expansions and greater employer responsibility, some persons still will be excluded from the system.

Consideration of the public option, or an alternative, begins not with the public option itself, but with the proposed individual mandate. There is broad understanding that such a mandate is necessary to achieve truly universal coverage. It is supported by the private insurance industry because they see millions more persons buying their products. From a faith and justice perspective, however, health care reform advocates generally have opposed individual mandates because, at the state level, they have proven to be unworkable, inequitable, and too costly for government entities to subsidize.

The advocacy community has not opposed the proposed federal individual mandates because of the companion provisions – the Medicaid expansion, increased employer responsibility, public premium subsidies, and most notably the public option. If the public option does not survive legislative deliberation, there is grave concern about the morality of forcing persons to buy private insurance.

► Vision ~ Affordable

Health care must contribute to the common good by being affordable for individuals, families and society as a whole. We believe that in the sacred act of creation we are endowed with the talents, wisdom and abundant resources necessary to meet the needs of one another, including the health care needs of all. Therefore, in our calling to be faithful stewards, we understand our responsibility to use our health care resources effectively, to administer them efficiently, and to distribute them with equity.

Provisions common to both the Senate and House bills that contribute to this Vision:

- Annual caps on individual out-of-pocket expenses will be set.
- Annual and life-time caps on insurance payouts will be eliminated.
- Federal regulations will impose greater responsibility upon the insurance and pharmaceutical industries to control costs.
- Federal subsidies will be provided for insurance sold through the exchange for individuals who earn too much for Medicaid eligibility, are too young for Medicare, and cannot afford to purchase insurance in the private market.

The **House bill** provides better affordability standards for low-moderate income families; the **Senate bill** provides better affordability standards for middle-income families.

- Tax credits are projected for more small businesses to help make premium costs for workers' insurance more affordable.
- The ratio of costs for premium based on pre-existing conditions, gender, health status or age will be regulated.

Additional provisions that contribute to this Vision:

- **The House bill** establishes a public health insurance option in the insurance exchange to provide a guaranteed cost-effective alternative to private for-profit insurance for three categories of persons (small business owners, self-employed persons, and uninsured individuals), and to contribute to more affordable insurance by restraining the growth of premium costs through competition among all plans in the exchange.

The Senate bill establishes multi-state non-profit insurance plans administered by the federal Office of Personnel Management that will be offered in each state exchange. In addition, it allows for a Basic Health Plan to be created by states for uninsured persons with incomes 133-150% of the FPL who would be eligible for premium subsidies in the exchange.

- **The House bill** establishes a national exchange through designed to facilitate competition for lower premiums between a public option and private insurers; the **Senate bill** establishes state exchanges with no public option to facilitate competition for lower premiums among private insurers.
- **The House bill** closes the gap/donut hole in Medicare prescription drug coverage by 2019; the **Senate bill** negotiated a PhRMA discount and implements a \$500 reduction in the donut hole for 2010 only.
- **The House bill** requires that employers meet a financial contribution level for both individuals and families; the **Senate bill** requires that employers pay a penalty if employer contributions do not make insurance affordable for full-time workers who then seek coverage and subsidies in the exchange.

Seeking justice in health care

Where do these bills fall short of a moral vision for affordable health care for all?

Everyone will share greater responsibility in paying for health care. The questions of justice lie in determining who will assume the greatest responsibility for payment, and where that responsibility falls in proportion to the ability to pay. Many attempt to frame those questions around bending the curve in federal health care spending, with a focus on the federal budget. From a justice perspective, however, the questions must be placed in the context of the vision for our health care future. Is our goal to cover everyone? Or reduce federal government spending? Or reduce the overall costs of health care for *everyone* – while making quality health care available for all?



Who pays?

- Most individuals will be required to have insurance, but sliding-scale subsidies will be available to help purchase that insurance for persons who are not covered by employers, Medicare, Medicaid, the Veterans Administration, etc. Yet, it is estimated that the cost of premiums and out-of-pocket expenses still will create a financial burden for many low-moderate income families.
- Businesses with more low-wage workers could experience an inequitable burden of premium payments compared to businesses with the same size payroll with fewer but high-wage workers.
- The Senate bill prohibits undocumented immigrants from purchasing insurance in the exchange, even with their own money and without subsidies. Such a provision would likely lead to the creation of expensive predatory markets outside the exchange to target undocumented immigrants.

Who profits, especially at the expense of those who cannot pay?

- The insurance industry concessions, such as guaranteed issue and spending a higher percentage of premium dollars on patient care, are contingent upon the inclusion of an individual mandate which will place millions more people in for-profit insurance policies.
- If the public option does not survive legislative deliberation, if subsidies are not sufficient, and if out-of-pocket expenses are not sufficiently limited, insurance companies will still have millions of new enrollees (and new profits), but without premium caps there would be no assurances that comprehensive affordable coverage will be available for everyone.
- The pharmaceutical industry, while giving in on the gap/donut hole in Medicare prescription drug coverage, has made deals to protect their profits in patents and exclusivity rights, and to prohibit the purchase of prescription drugs at more affordable prices from other countries.

What the public option means for affordable health care

In addition to being a part of the formula to achieve universal coverage, the public option is also seen as an important step toward affordability. It would maximize the risk pool, meaning that it would spread the risk more broadly and, therefore, spread the costs more equitably.

The public option would also exist to help maintain competition among all plans in the health insurance exchange, which presumably would help keep the costs of premiums down.

If the public option does not survive legislative process, insurance will be available only through private plans for millions of uninsured persons. There are no assurances that premiums, co-pays, and out-of-pocket costs will be truly affordable. Low-to-moderate income workers, many of whom are persons of color, would likely be those least likely to be able to purchase insurance.

► Vision ~ Accessible

All persons should have access to health services that provide necessary care and contribute to wellness. We believe humanity is sacred and that all persons should benefit from those actions which contribute to our health and wholeness. Therefore, we are called to act with justice and love, to ensure that all of us have access to the health care we need in order to live out the fullness of our potential both as individuals and as contributing members of our society. We must work together to identify and overcome all barriers to and disparities in such care.

Provisions common to both the Senate and House bills that contribute to this Vision:

- Persons cannot be denied coverage or charged excessive premiums because of pre-existing conditions, health status, gender or age.
- A new insurance pool will be established in 2010 to make insurance available to persons with pre-existing conditions or chronic illnesses who cannot currently get coverage.
- A temporary reinsurance program will be established in 2010 to assist participating employer health plans provide coverage for early retirees who are age 55+.
- Annual and lifetime caps on insurance coverage will be eliminated.
- Payment mechanisms and policies will be implemented to improve health outcomes, reduce health disparities, provide efficient and affordable care, address geographic variation in the provision of health services, prevent/manage chronic illness, and promote quality care that is integrated, efficient, and patient-centered.
- Considerable attention is given to the reduction of disparities in both access to and outcomes in the provision of needed health care.
- The Indian Health Care Improvement Act, now included within the overall reform is intended to improve quality and access for Native Americans.
- Incentives in medical education are designed to increase both the number of primary care physicians and the geographic access to health care providers.
- Increased funding for community health centers will expand health care to those living in under-served areas.
- Standard benefit packages for insurance plans in the exchange will include these general categories of coverage:
 - hospitalization, emergency care, and ambulatory outpatient hospital and clinic services
 - services of physicians and other health professionals
 - laboratory services
 - prescription drugs
 - rehabilitative and habilitative services, including substance use disorder services
 - mental health care
 - preventive services
 - maternity care
 - well baby and well child care, including oral health, vision and hearing services, equipment and supplies for children under 21 years of age

Additional provisions that contribute to this Vision

- In the **House bill**, increased payments to primary care providers are intended to expand access to doctors for Medicaid enrollees.
- The **House bill** extends insurance market reforms in the exchange to all markets.

Seeking justice in health care

Where do these bills fall short of a moral vision for accessible health care?

What barriers to health care remain in both the Senate and House bills?

- Some children still will not have access to needed medical care because of their state's guidelines for providing health care for children.
- Raising Medicaid eligibility does not automatically guarantee that persons with low incomes will have access to health care providers. States set reimbursement rates for Medicaid providers; low reimbursement rates result in an increasing number of medical professionals refusing to accept Medicaid patients. In many areas, the doctors who actually accept Medicaid enrollees are not geographically accessible.
- Oral health, vision and hearing services are not specified in the list of minimum benefits for persons over 21 years of age.
- Legal immigrants who have been in the United States less than five years are not eligible for Medicaid (except pregnant women and children) – even though they work, pay taxes, and contribute to society.
- Undocumented immigrants are explicitly prohibited from eligibility for either Medicaid or premium subsidies in either bill. In addition, the Senate bill explicitly prohibits undocumented immigrants from purchasing insurance in the exchange, even with their own money and with no subsidy.
- Excessive citizenship documentation, intended to keep undocumented persons from accessing health care in government-sponsored programs, creates barriers for eligibility for numerous categories of citizens, as well, including: rural populations, Native Americans, impoverished persons who never received a birth certificate, persons born at home, victims displaced by natural disasters (such as Hurricane Katrina), members of mixed-status families, and members of small insular faith communities.



What the public option means for accessible health care

Data will be collected to “improve quality and to reduce racial, ethnic, and other disparities in health and health care.”

Payment mechanisms and policies will be designed and implemented in a manner that seeks to improve health outcomes, reduce health disparities, provide efficient and affordable care, address geographic variation in the provision of health services, prevent/manage chronic illness, and promotes quality care that is integrated, patient-centered, and efficient.

Negotiated rates with doctors and hospitals would help retain providers who might otherwise opt not to accept new patients enrolled in a new public program.

► Vision ~ Accountable

Our health care system must be accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community. We believe that as spiritual and sacred vessels, we are responsible for the care of our bodies to the best of our ability and for the care of one another regardless of individual circumstances. Therefore, individuals, families, governments, businesses, and the faith community are called to work in partnership for a system that ensures fully-informed, timely, quality and safe care that treats body, mind and spirit.

Provisions in the Senate and House bills that contribute to this Vision:

Government accountability:

- While the goal is not yet achieved, for the first time ever, the federal government has acknowledged its responsibility for health care for all.
- Reform will establish federal rules for health insurance, which is now regulated mainly by states.
- Health insurance exchanges (marketplaces) will be created through which insurance may be purchased. and purchasers will be able to fully understand the benefits and costs of their choices.
- Standard benefits and actuarial values will be defined by federal regulation for plans offered in the exchange, and purchasers will be able to fully understand the benefits and costs of their choices.

Insurance industry accountability:

- Insurance companies will be required to spend a minimum amount of their premium dollars on clinical services and quality (the medical loss ratio), rather than on profit, administration and advertising. (Senate: 85% for large group market, 80% for individual and small group markets; House: 85%) Rebates will be due to the policy holders for failure to meet these percentages. (Some insurers currently report a 60% MLR [Source: Families USA])
- Health insurers may rescind health insurance coverage only upon “clear and convincing evidence of fraud” with action subject to notification and independent third-party review.
- The **House bill** (but not the Senate bill) repeals the anti-trust exemption that shields insurers from liability for price-fixing, dividing up geographic areas, or creating monopolies.
- The **House bill** requires a review of premium increases prior to their implementation, effective upon enactment; the **Senate bill** creates a process to review increases and requires justification for them.
- The **House bill** provides financial incentives to states that enact alternative medical liability laws; the **Senate bill** awards demonstration grants to develop, implement and evaluate models for tort reform.

Medical provider accountability:

- New tools will address waste, fraud, and abuse with the entire health system.
- Research will be conducted, supported, and synthesized to identify best practices in preventing, diagnosing, treating and managing diseases, disorders and other health conditions.
- Incentives for providing care will change. Instead of over-payment for services rendered, doctors and hospitals that demonstrate improved health outcomes will be rewarded.
- Investments in advancing health information technology and other efforts to coordinate care will improve the provision of complimentary treatments and significantly reduce errors.
- Public reporting on health care-associated infections in hospitals and ambulatory surgical centers will be required and coordinated within new protocols.
- Whistleblower protections will be implemented.

Seeking justice in health care

Where do these bills fall short of a moral vision for accountable health care?

Where are the gaps in accountability?

- Rewarding doctors and hospitals that demonstrate improved health outcomes could potentially:
 - Provide adverse incentives for providers to limit their services to lower-risk populations.
 - Penalize doctors and hospitals that serve sicker, at-risk or underserved populations.
- Oversight and monitoring of industry and provider groups seem to remain as functions internal to those groups.
- Insurance plans offered outside of the exchange, including self-insured plans, are initially exempt from the provisions of the basic benefits packages required of plans offered in the exchange.
- Industry and provider lobbyists still have disproportionate access to and power over those who legislate and regulate the provision of needed health care in the United States.



What the public option means for accountable health care

All insurance companies will be required to spend a minimum amount of their premium dollars on clinical services and quality (the medical loss ratio), rather than on profit, administration and advertising. Given the absence of profit, it is expected that the public option would spend an even higher percentage on patient care, thus posting a better medical loss ratio than private plans.

Apart from the \$2 billion in start-up funding, which must be repaid, premiums will have to cover the full cost of the plan.

Sources for information and policy analysis:

Community Catalyst: <http://www.communitycatalyst.org>

Families USA: <http://www.familiesusa.org>

Kaiser Family Foundation: <http://www.kff.org>

Library of Congress: <http://thomas.loc.gov>

National Immigration Law Center: <http://www.nilc.org>

The Commonwealth Fund: <http://www.commonwealthfund.org>

United States House of Representatives: <http://www.house.gov>; <http://www.speaker.gov>

United States Senate: <http://www.senate.gov>

“A Faith-Inspired Vision of Health Care”

As people of faith, we envision a society where each person is afforded health, wholeness, and human dignity.

That vision embraces a system of health care that is inclusive... accessible... affordable... and accountable.

Vision ~ Inclusive: Health care is a shared responsibility that is grounded in our common humanity. In the bonds of our human family, we are created to be equal. We are guided by a divine will to treat each person with dignity and to live together as an inclusive community. Affirming our commitment to the common good, we acknowledge our enduring responsibility to care for one another. As we recognize that society is whole only when we care for the most vulnerable among us, we are led to discern the human right to health care and wholeness. Therefore, we are called to act with compassion by sharing our abundant health care resources with everyone.

Vision ~ Affordable: Health care must contribute to the common good by being affordable for individuals, families and society as a whole. We believe that in the sacred act of creation we are endowed with the talents, wisdom and abundant resources necessary to meet the needs of one another, including the health care needs of all. Therefore, in our calling to be faithful stewards, we understand our responsibility to use our health care resources effectively, to administer them efficiently, and to distribute them with equity.

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Vision ~ Accountable: Our health care system must be accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community. We believe that as spiritual and sacred vessels, we are responsible for the care of our bodies to the best of our ability and for the care of one another regardless of individual circumstances. Therefore, individuals, families, governments, businesses, and the faith community are called to work in partnership for a system that ensures fully-informed, timely, quality and safe care that treats body, mind and spirit.

“This Vision Statement has proven to be the best faith statement on four key issues in health reform that we have found. It offers real insight into the fundamental values that shape our ability to speak differently on key issues. Does it work? Unquestionably. These moral values helped House members in three key California districts reverse their positions and move to support real reform. The moral voice of the faith community cannot be overestimated. We have shown that this singular voice for health care as part of the Common Good is most powerful.”

Elizabeth Sholes, Director of Public Policy
California Council of Churches/California Church IMPACT

“A Faith-Inspired Vision of Health Care” was developed by Faithful Reform in Health Care, the largest interfaith coalition of national, state and local organizations and individuals committed to working together to elevate shared faith values in shaping our health care future in the United States.

National and State/Regional Signers of “A Faith-Inspired Vision of Health Care”

National:

African Methodist Episcopal Church
 American Association of Pastoral Counselors
 American Baptist Churches, USA
 American Baptist Home Mission Society
 American Friends Service Committee
 American Muslim Health Professionals
 Association of Clinical Pastoral Education
 Association of Professional Chaplains
 Benedictine Coalition for Responsible Investment
 Bon Secours Health System, Inc.
 Buddhist Peace Fellowship
 Center for Healthcare Reform, St. Joseph Health System
 Center for Immigrant Healthcare Justice
 Church Women United
 Disciples Center for Public Witness
 Disciples Justice Action Network
 Evangelical Lutheran Church in America
 Friends Committee on National Legislation
 Health Vision International
 International Parish Nurse Resource Center
 Islamic Medical Association of North America
 Islamic Society of North America
 Jewish Reconstructionist Federation
 Jewish Women International
 Medical Whistleblower
 Mennonite Central Committee U.S. Washington Office

Mennonite Church USA
 National Advocacy Center of the Sisters of the Good Shepherd
 National Council of Jewish Women
 National Episcopal Health Ministries
 NETWORK: A National Catholic Social Justice Lobby
 Network of Spiritual Progressives and Tikkun Magazine
 Pediatric Chaplains Network
 Presbyterian Church (U.S.A.)
 Progressive National Baptist Convention, Inc.
 Reformed Anglican Catholic Church
 RESULTS Faith in Action Project
 Sisters of Charity Health System
 Sisters of St. Joseph
 Sisters of the Humility of Mary
 Sojourners
 The Episcopal Church
 The Hindu Temple Society of North America
 The Rabbinical Assembly
 Union for Reform Judaism
 Unitarian Universalist Association of Congregations
 United Church of Christ, Justice and Witness Ministries
 United Methodist Church, General Board of Church and Society
 United Methodist Church, General Board of Global Ministries

State/Regional:

Acts in Common (MI)
 Arkansas Interfaith Alliance
 Arizona Ecumenical Council
 Be Healthy Ministries (NC)
 California Council of Churches
 Catholic Healthcare West
 Colorado Council of Churches
 Commission on Catholic Community Action (OH)
 Delaware Ecumenical Council on Children and Families
 Delaware Region Health Ministries Network
 Ecumenical Ministries of Oregon
 FACE Hawaii
 Florida Church Women United
 Florida Council of Churches
 Florida-Bahamas Synod, Evangelical Lutheran Church in America
 Illinois Campaign for Better Health Care Faith Caucus
 Illinois Church Women United
 Interchurch Ministries of Nebraska
 Interfaith Health and Hope Coalition (MI)
 Islamic Shura Council of Southern California
 Kentucky Council of Churches
 Lutheran Family and Children’s Service of Missouri
 Lutheran Public Policy Office of Washington
 Maine Council of Churches
 Maryland Citizens Health Initiative
 Michigan Coalition for Human Rights
 Michigan Interfaith Health and Hope Coalition
 Michigan Unitarian Universalist Social Justice Network

Missouri Health Care for All
 Missouri Impact
 Montana Association of Churches
 New Hampshire Council of Churches
 New Mexico Conference of Churches
 New York State Council of Churches
 North Carolina Council of Churches
 North Carolina Fair Share
 Ohio Council of Churches
 Ohio-Meadville District of the Unitarian Universalist Association (*incl WV & Ohio*)
 Oklahoma Conference of Churches
 Pennsylvania Council of Churches
 Presbytery of Baltimore (MD)
 Religious Coalition for the Common Good (WA)
 Rhode Island State Council of Churches
 Southeast Michigan Synod, Evangelical Lutheran Church in America
 South Carolina Christian Action Council
 Texas Impact
 United Methodist Women, Tennessee
 Vesper Society
 Virginia Council of Churches, Inc.
 Virginia Interfaith Center for Public Policy
 Washington Association of Churches
 We Believe Ohio
 West Virginia Council of Churches
 West Virginia Health Kids and Families Coalition
 West Virginians for Affordable Health Care

Seeking justice in health care

Making change happen

To make change happen, a moral vision and a passion for justice ultimately need to be translated into support for particular provisions in public policy. Toward that end, leaders in our national faith communities have identified a health care reform policy agenda around which there is broad consensus. The principles they have articulated reflect the values found in “A Faith-Inspired Vision of Health Care” and address the need to move us toward a more just system of health care.

Outlined in a letter to the Senate (*below*)*, and later copied to the House of Representatives and the White House, these policy priorities have served as a broad basis for shared advocacy among people of faith who are working for comprehensive and compassionate health care reform. Individual groups will select their own specific legislative priorities as we move closer to the final form of the legislation.

Raising our voices in support of health care reform

Dear Senator,

Our organizations, as well as communities of faith at all levels of our society, have supported comprehensive health care reform for decades. As providers of services and care, our members, congregations and institutions are very familiar with the impact our current health care system has on individuals and their families, particularly vulnerable populations such as low-income individuals, women, children and the elderly.

We are pleased that the U.S. Congress has answered the call for health care reform and is working diligently to expand health care availability to all Americans. We look to the Senate at this important juncture to keep to a vision of comprehensive health care reform that is affordable, accessible, inclusive and accountable.

As people of faith, we envision a society where each person is afforded health, wholeness and human dignity. We are advocates of health care that is affordable, available to all, and in which access to quality health services is not limited by income, age, gender, race or ethnicity, geography, employment status or health status.

Too many Americans suffer because of our broken health care system. We urge you to support comprehensive health care reform legislation that:

- includes a strong public health insurance option that is available on day one and in all states;
- expands Medicaid to all individuals under age 65 with incomes up to 150% of the federal poverty level;
- prohibits pre-existing condition exclusions;
- provides adequate subsidies for all individuals and families up to 400% of the federal poverty level and reasonable limits on annual out-of-pocket expenses for all people;
- eliminates underwriting based on health status, age, gender or occupation;
- provides legal immigrants with equal access to subsidies to help them purchase health insurance and allows undocumented immigrants to purchase their own health insurance through any insurance exchange offered; (*over*)
- eliminates the five-year waiting period for all legal immigrants to receive Medicaid and CHIP

benefits;

- includes all immigrant children and pregnant women, regardless of immigration status, in eligibility for Medicaid.

We urge you to seize this opportunity to make important, positive changes to our health care system that will literally save lives and improve the quality of life for millions of Americans.

Original signers and additional supporters of this letter include:

African Methodist Episcopal Church

American Friends Service Committee

American Muslim Health Professionals

American Friends Service Committee

American Muslim Health Professionals

Buddhist Peace Fellowship

Disciples Justice Action Network (Disciples of Christ)

The Episcopal Church

Evangelical Lutheran Church in America

Faithful Reform in Health Care

Islamic Society of North America

Jewish Reconstructionist Federation

Mennonite Central Committee U.S. Washington Office

National Council of Churches of Christ in the U.S.A.

NETWORK: A National Catholic Social Justice Lobby

Presbyterian Church (U.S.A.) Washington Office

Progressive National Baptist Convention

The Rabbinical Assembly

The National Advocacy Center of the Sisters of the Good Shepherd

Union for Reform Judaism

United Church of Christ

United Methodist Church - General Board of Church and Society

Washington Office of Public Policy, Women's Division, United Methodist Church

** This letter was initiated by the Health Care Working Group of the Washington Interreligious Staff Community [WISC].*