



The Heart in Health Care Reform

Reflections to help people of faith understand how health care reform moves us toward a more compassionate health care future that affords health, wholeness, and human dignity for all

A Moral Vision for Our Health Care Future

Reflections on “A Faith-Inspired Vision of Health Care” and Health Care Reform

We are witnesses to an unprecedented opportunity to make substantial progress in moving toward a health care future that includes everyone and works well for all of us. When that vision becomes reality, one in six children and non-elderly adults in our country will no longer live sicker and risk dying younger because they cannot get needed care. Medical costs will cease to be a cause of financial ruin for families, individuals, institutions, businesses, and governments. All of us will have needed quality health care regardless of our differences.

The United States took a major step toward such a future with the passage of the Patient Protection and Affordable Care Act (H.R. 3590), and the Health Care and Education Affordability Reconciliation Act (H.R. 4872), which amended some of the bill’s budgetary provisions.

One thing became clear in our public discourse about health care reform: As a nation, we had never made a national legislative or moral commitment to guarantee health care for all.

Is it any wonder, then, that we fought bitterly over 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, decrease the deficit, 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. While we have legislated health care for most of us, we are not yet united around a moral commitment to health care for all.

People of faith sought to change that by offering “A Faith-Inspired Vision of Health Care” as a statement of shared moral values to help measure legislative proposals. By identifying where provisions do/do not reflect values of community, human dignity, shared responsibility, compassion, stewardship of resources, and concern for those who are vulnerable, we are at the heart of the

transformation that will be needed to help shape a sustainable and more compassionate health care future.

In continuing to move forward, we will be called upon to take the age-old moral test of a society – the test which measures how we treat:

- 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*.

Essential to this framework are the most basic questions about justice in health care which will guide our reflection:

- ? Who is included? Who is excluded?
- ? Who pays? Who profits? Who profits at the expense of those who cannot pay?
- ? Who is accountable? And to whom?
- ? Whose voices are heard as legislation is written? Whose voices are not heard?

What follows is a consideration of reform through the lens of health care justice. Coupled with shared moral values, these questions do not lead to an exhaustive analysis of the legislation, but guide our reflection about how the bills advance our vision for our health care future.

We begin by affirming our vision of a society where each person is afforded health, wholeness, and human dignity. We continue by seeking a system of health care that is inclusive, affordable, accessible and accountable.

We acknowledge that the new law is not the final word, but just the beginning – the seeds that have been planted that must be cultivated, weeded, and fertilized until they yield the fruit we need to sustain this endeavor. This reflection is intended to guide us as we define our ongoing role in that growth – the role of changing hearts and minds and of transforming the public conscience around the moral commitment to health care for all.

Vision: Inclusive Health Care

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 in reform that contribute to this Vision

- Over 30 million uninsured persons will gain access to health insurance. When reform is fully implemented, most U.S. citizens and legal residents will be enrolled in insurance through employer coverage, Medicare, Medicaid, other government programs, or individual private policies.
- Beginning with plan years that start after Sept 23, 2010, qualifying young adults may remain on their parents' policies until age 26 if those policies provide dependent coverage. (Some insurers have announced that they will offer this coverage at an earlier date!) Foster children who age out of the foster care system will be covered in Medicaid through age 26.
- By 2014, Medicaid eligibility will be expanded to 133% of the federal poverty level (FPL) to cover an estimated 16 million more low-income uninsured persons. In the meantime, in most cases, states are required to maintain current eligibility standards for adults.
- Insurance industry reforms will:
 - Prohibit the denial of insurance because of pre-existing conditions for children up to age 19.
 - Result in "guaranteed issue" by 2014, eliminating the practice of denying coverage because of pre-existing conditions, health status, gender, or age. (Until then a national high-risk pool will be offered for persons who have been uninsured for 6 months because of pre-existing conditions.)
 - Limit waiting periods for coverage to 90 days
 - Eliminate life-time (2010) and annual (2014) caps on essential benefits claims.
- Prohibit insurers from rescinding (dropping) coverage when people get sick – except for clear evidence of fraud.
- Federal funding for the Children's Health Insurance Program (CHIP) is extended from 2013 to 2015. The program is now authorized through 2019.
- Through the health insurance exchanges, families will have insurance security with guaranteed choices of quality, affordable insurance – regardless of changes in life circumstances.

Seeking justice for an inclusive health care future: Who remains excluded or uninsured?

- Some children will remain uninsured because of the different ways in which states offer coverage for the Children's Health Insurance Program (CHIP).
- Some persons will simply not be able to afford insurance, even with subsidies, and will receive hardship exemptions.
- The current requirement that low-income legal immigrants reside in the country 5 years before becoming eligible for Medicaid remains intact – even though they work, pay taxes, and contribute to society.
- Undocumented immigrant adults and children remain ineligible for non-emergency Medicaid. In addition, they are explicitly prohibited from buying insurance in the exchanges, even at full cost with their own money.
- Some persons will qualify for Medicaid, but will not enroll.
- Some persons will simply choose to be uninsured and pay the penalty.
- Some persons will be exempt from the requirement to have insurance:
 - those with religious objections to insurance
 - those without coverage for less than 3 months
 - American Indians
 - undocumented immigrants
 - those for whom the lowest cost plan available exceeds 8% of individual income
 - those who earn too much to qualify for Medicaid but earn too little to file income tax

Vision: Affordable Health Care

Provisions in reform that contribute to this Vision

- In 2010, 4 million small businesses (including small non-profits) will be eligible for tax credits to help them provide insurance for their employees.
- In 2010, a new national high-risk insurance pool will be established to make affordable insurance available to persons with pre-existing or chronic illnesses who cannot get coverage and have been uninsured for six months.
- In 2010, persons in the Medicare prescription drug coverage gap (“doughnut hole”) will receive a \$250 rebate; discounts will follow in subsequent years until the gap will be phased out by 2020.
- Beginning in 2014, exchanges (insurance marketplaces) will be established through which small businesses and individuals can purchase insurance. Multi-state non-profit insurance plans administered by the federal Office of Personnel Management will be offered in the exchanges.
- Federal subsidies will be provided for insurance sold through the exchange for persons below 400% of the poverty level (~\$88,000 for a family of 4). Premium costs will be set on a sliding scale based on income.
- Private plans and Medicare will be required to provide a wide range of preventive services with no deductibles or co-pays.
- Annual individual out-of-pocket costs for premiums will be capped; annual and life-time caps on essential benefits will be eliminate.
- Beginning in 2014, persons cannot be denied coverage because of pre-existing conditions, health status, gender, age, previous treatment, domestic violence, or genetic information.
- The ratio of premium costs for gender, health status, age and geographic ratings will be regulated.
- The federal government will pay to states the full cost of persons newly eligible for Medicaid for the first three years, after which states begin to cover approximately 10% of the cost.
- These reforms will reduce the federal budget deficit by \$130 billion in the next decade and by \$1.2 trillion in 20 years.

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.

Seeking justice for an affordable health care future: Who pays? Who profits?

All of us will share responsibility in making health care affordable. But who will assume the greatest responsibility, and where does that responsibility fall in proportion to the ability to pay? While the emphasis has focused on bending the curve in federal spending, the justice perspective asks questions within 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 health care available for all?

Who pays?

- Most individuals will be required to have insurance, but sliding-scale premium subsidies will be available for many persons who are not covered by other programs and cannot afford the premiums. The measure of true affordability will need to be monitored.
- Businesses with more low-wage workers could find an inequitable burden of premium costs compared to those with fewer but higher-wage workers.
- Undocumented immigrants are prohibited from buying insurance in the exchange, even at full cost with their

own money. It is feared that predatory markets will emerge targeting undocumented persons.

- All of us will continue to pay for uncompensated care for the uninsured – and for those who purchase insurance just to cover anticipated surgery/treatment.
- Connecting wellness incentives to premium discounts could inadvertently lead to discrimination in premium costs based on health status.

Who profits at the expense of those who cannot pay?

- Insurers’ concessions were contingent upon including an individual mandate, which will force millions of new enrollees into for-profit insurance plans. Without premium caps and a public option, questions remain about premium costs and true affordability.
- Pharmaceutical industry support was contingent upon protecting patents and exclusivity rights, and prohibiting the purchase of prescription drugs from other countries.

Vision: Accessible Health Care

Vision: 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 in reform that contribute to this Vision

- Increased funding for community health centers will nearly double the number of persons who receive health care in under-served areas.
- 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 and 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. Initiatives will be expanded to increase the racial and ethnic diversity of medical professionals and to expand cultural competency among providers.
- Incentives in medical education are designed to increase the number of primary care physicians and nurses in order to expand access to high quality health care in under-served geographic areas.
- The Indian Health Care Improvement Act, now included within the overall reform, is designed to improve quality and access for Native Americans.
- A new national insurance program for long-term care is created – the Community Living Assistance Services and Supports Program (CLASS). Funded with voluntary payroll deductions, it will provide cash assistance for seniors and persons with disabilities who are able to remain in their homes.
- A temporary reinsurance program will be established in 2010 to assist participating employer health plans provide coverage for early retirees who are age 55+.
- Standard benefit packages from insurers in the exchange will include general categories of essential benefits: ambulatory services; emergency care; hospitalization; maternity and newborn care; mental health and substance use disorder services; behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive/wellness services; chronic disease management; pediatric services, including oral and vision care.

Seeking justice for an accessible health care: What barriers remain?

- 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. In spite of increased levels of reimbursement to Medicaid providers, the reimbursement rates could still result in medical professionals refusing to accept Medicaid patients. (This is also true of Medicare.)
- Oral health and vision services are considered essential benefits for children, but not for persons over age 21.
- 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 addition, they are explicitly prohibited from purchasing insurance in the exchange, even at full cost with their own money.
- Excessive citizenship documentation, intended to keep undocumented persons from receiving health care through government-sponsored programs, creates barriers for eligibility for numerous categories of citizens, 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.
- Uninsured persons will have even fewer options for services as the case load of insured patients grows.

Vision: Accountable Health Care

Provisions in reform that contribute to this Vision

Individual accountability:

- Most individuals will share responsibility for health care by contributing a fair share for affordable coverage and services.
- Those who can afford to purchase insurance will be expected to do so, freeing all of us from the burden of paying for uncompensated care.
- Greater emphasis is placed on wellness, prevention and personal self-care.

Government accountability:

- After 100 years of debate, the federal government acknowledged its role in guaranteeing health care for all.
- Members of Congress and their staff members will purchase their insurance in the same exchanges as millions of Americans and small businesses.
- Standard benefits and actuarial values will be defined by federal regulation for plans in the exchanges.
- The solvency of the Medicare Health Insurance Trust Fund will be extended.

Employer accountability:

- Waiting periods for coverage cannot exceed 90 days.
- Employers with more than 200 employees will be expected to provide insurance for all workers; those with more than 50 employees will pay a penalty if their contributions are not affordable for full-time workers who then seek and qualify for coverage and subsidies in the exchange.

Insurance industry accountability:

- New standards are set for the percentage of premiums that insurers must spend on medical costs rather than excess profit, paperwork and advertising.
- Insurance policies offered in the exchanges will provide clear information on benefits and costs.
- A process will be established to review premium increases, and require insurers to justify the increases.
- Demonstration projects will help develop, implement and evaluate models for malpractice reform.
- Insurers may rescind coverage only upon “clear and convincing evidence of fraud,” with action subject to notification and independent third-party review.
- This year, consumers in new plans will have access to an independent appeals process.

Medical provider accountability:

- Payment mechanisms and policies will be implemented to improve health outcomes; incentives will focus on quality of care rather than quantity of services.
- New tools and practices will address waste, fraud, and abuse within the delivery of health care.
- Research will identify best practices in preventing, diagnosing, treating and managing diseases, disorders and other health conditions.
- Whistleblower protections will be implemented.
- Investments in effort to coordinate care, including health information technology, will improve the provision of treatments and reduce errors.
- Public reporting on health care-associated infections in hospitals and ambulatory surgical centers will be required and coordinated within new protocols.
- Payments will be reduced for hospital re-admissions that can be attributed to errors or gaps in quality.

Seeking justice for an accountable health care future: Who is accountable to whom?

- Rewarding providers that demonstrate improved outcomes could create adverse incentives to limit services to lower-risk populations, and penalize doctors and hospitals that serve at-risk or underserved persons.
- Industry and provider lobbies still have undue access to and power over legislators and regulators.
- The monitoring of industry and provider groups seems to remain internal to those groups.
- Selling policies across state lines opens the door to insurers moving to states that they deem to be more “insurance-friendly,” raising questions about whether we’ll see real competition or a “race to the bottom.”

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.

Sources for information, policy analysis, and messaging:

Center on Budget and Policy Priorities: <http://www.cbbp.org>
Community Catalyst: <http://www.communitycatalyst.org>
Congressional Budget Office: <http://www.cbo.gov>
Faithful Reform in Health Care: <http://www.faithfulreform.org>
Families USA: <http://www.familiesusa.org>
Herndon Alliance: <http://www.herndonalliance.org>
Kaiser Family Foundation: <http://www.kff.org>
Library of Congress: <http://thomas.loc.gov>
Medicare Rights Center: <http://www.medicarerights.org>
National Immigration Law Center: <http://www.nilc.org>
National Women's Law Center: <http://www.nwlc.org>
Small Business Majority: <http://www.smallbusinessmajority.org>
The Commonwealth Fund: <http://www.commonwealthfund.org>
United States Department of Health and Human Services: <http://www.hhs.gov>
United States House of Representatives: <http://www.house.gov>; <http://www.speaker.gov>
United States Senate: <http://www.senate.gov>
White House: <http://www.whitehouse.gov>

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