

Standing Commission on Health

Membership

The Rev. Canon Richard F. Brewer, <i>Chair</i>	Long Island, II	2012
The Rev. Trudie J. Smither, <i>Vice-Chair</i>	Dallas, VII	2012
The Rev. Sarah Knoll, <i>Secretary</i>	Kansas, VII	2012
The Rt. Rev. David Alvarez	Puerto Rico, IX	2015
Mr. Isaiah Brokenleg	Fond du Lac, V	2015
Mr. Victor Feliberty-Ruberte*	Puerto Rico, IX	2015
Ms. Dorothy J. Fuller	El Camino Real, VIII	2015
The Rt. Rev. Rayford B. High, Jr.	Texas, VII	2012
The Rt. Rev. Barry R. Howe	West Missouri, VI	2012
The Rev. Harriet Kollin	Pennsylvania, III	2015
Dr. Margo E. McMahon	Western Massachusetts, I	2012
Dr. Miguel E. Umana Erazo	Honduras, IX	2012
Ms. Deborah J. Stokes, <i>EC Liaison</i>	Southern Ohio, V	
Mr. DeWayne Davis, <i>Staff</i>		

Changes in Membership

There was one change in the membership of the Commission during the triennium, the resignation of Mr. Feliberty-Ruberte.

Summary of Work

After networking accomplishments in the previous triennium, the Standing Commission on Health worked to respond in more specific ways to its mandate. The Church and the wider world alike are in a crucial time to thoughtfully consider healthcare and to respond to rapid policy changes and paradigm shifts in the United States and abroad. Healthcare is not only a political issue, however; for the Church, it is also a theological issue.

With two face-to-face meetings, one summit of experts, and several online work sessions, the Commission studied, prayed, and responded to the wide-ranging issues of health that affect the world, within and outside of the Church.

The Commission is comprised of members who have long histories of commitment to the health of the Church and their local communities. As social workers, nurses, chaplains, hospital administrators, and public health employees, Commission members brought their stories, concerns, and experience to the table to address the resolutions received, and to respond to a mandate “to identify and study national and international healthcare issues, practices, and policies and the Church’s healthcare ministries.”

The Commission continued to mine the Archives of the Episcopal Church, so as not to repeat the work of the past, and also kept active connections to other Commissions, Committees, Agencies and Boards (CCABs), to minimize overlapping resources and energies. During this triennium, the Committee collaborated with the Executive Council Committee on HIV/AIDS, and the Executive Council Committee and Science, Technology and Faith. The Commission received regularly detailed reports from a liaison at the Church’s Office of Government Relations and the Episcopal Public Policy Network to stay well informed as healthcare bills went through congressional approval processes.

The Commission’s funding allowed for two face-to-face meetings, with the supplement of several online work sessions. With the generous assistance of the Church Pension Group, the Commission was able to hold a summit in Spring 2011 where a handful of experts worked with the Commission on specific topics of healthcare reform, genetically-modified organisms, and a working theology of health.

A Working Theology of Health

Despite the archival evidence of vehement commitment to improved health for the Church and the world, there has been little time spent in articulating the Church's motivation for this work. The Commission finds this to be an unfortunate oversight, and sought to lay a foundation for a future theology of health. Though not within the scope of the Commission's resources to generate a definitive document, the Commission researched and studied theological documents from other denominations and groups, and participated in Bible study as a subcommittee. During the summit in 2011, Steven Fowl of Loyola and Leonard Hummel of Gettysburg Seminary facilitated a theological brainstorm, and as a result of such study helped collect these springboard insights:

- A belief that we are created by God, that creation is a gift, and that our health is a gift from God. We believe we are called to be thankful for and excellent stewards of this gift.
- An acknowledgment that we are not all healthy and do not all have equal opportunities to be healthy, and that these disparities and suffering are marks of the need for reconciliation with God and God's plan for us in the world.
- A belief in the incarnated God, who lived as a person with a mind for the health of his people, who experienced bodily suffering, and who bore the wounds of his suffering in his resurrected body. The implication for health is the assurance that we have a God who suffers with, and cares deeply for, the human creation in body as well as spirit.
- A belief that engagement in personal and communal health issues is a sign of our hope in God's creation and redemption. Our commitment to justice is the living out of our faith in God's gift of health. Conversely, a lack of commitment shows a lack of faith.
- A belief that scripture provides a model for these efforts: including but not limited to Eden, the prophets including Amos, Jesus' efforts towards healing, Jesus' resurrected body, and the Christian community of Acts.
- A belief that our tradition is rich in communal attention to a spiritual life that honors the body. We also experience in our tradition a valued engagement with the secular world, critically valuing participation and contribution at personal, local, national and international efforts.

In the current political climate, and in the absence of any such document, the Commission strongly urges the General Convention to formulate a task force for the purpose of generating a more comprehensive theology of health.

Genetically Modified Organisms

At its meeting in Minneapolis on October 5–7, 2010, in response to a referral by Executive Council Resolution A&N-011, the Commission formed a subcommittee to focus on the health aspect of the Genetically Modified Organisms (GMOs). The Commission wishes to express its heartfelt gratitude to Mr. Jaydee Hanson from the Center for Food Safety, which advocates for non-GMO use, for his assistance during the Commission's summit in March 2011. During this meeting the Commission had the opportunity of meeting with the Rev. Phina Borgesson from the Executive Council Committee on Science, Technology and Faith via telephone conference; and Ms. Brenda Harrison from the Standing Commission on Anglican and International Peace with Justice via video conference.

The subject of GMOs is broad and complex. It involves many issues and concerns in the areas of science, faith, technology, economy, justice, and health. It is a controversial issue nationally and globally among scientists, governments, agribusiness and food industry, small farmers, and consumers. One main concern with respect to health is safety. Debates between GMO supporters and non-GMO activists regarding the safety of genetically modified food have been emotionally charged. While the Food and Drug Administration claims that there is no reason to believe that GMOs "differ from other foods in any meaningful or uniform way," non-GMO activists are demanding labeling of GMO foods claiming consumers have a right to be informed about the status of the foods they eat.

While the scope of this report will be limited to health concerns around GMOs, the Commission acknowledges that health is not an issue that is entirely separate and distinct from the other issues surrounding GMOs. Concerns about health are interconnected with concerns of science, faith, technology, ethics and justice. Health is a gift; it is part God's shalom for us and for the entire created order.

There is an abundance of literature regarding the GMOs. While the Commission only cites a small amount of the available literature, it encourages readers to continue to research the issue of GMOs. As with most things, the Internet is a good place to begin gathering information for those so inclined.

What GMOs Are

Genetically modified organisms are the products of a laboratory technique called genetic engineering or biotechnology. Genetic engineering is a technology that enables a single gene to be taken from one organism and inserted into another. In practice, foods produced involve the insertion of several “genes”, or fragments of DNA from several different organisms into a DNA arrangement different from that which occurs in nature. Scientists use two main methods to insert genes: 1) the genes are either transported into the gene by viruses or microbes that infect the plant of interest, or 2) microscopic gold or tungsten particles are coated with the gene and shot into the cell nucleus with what is called a “gene gun.”

The purpose of these laboratory techniques is to manipulate the genetic makeup of an organism to create or enhance desirable characteristics from the same or another species such as increased resistance to herbicide and increased nutritional content.

The enhancement of desired traits has traditionally been undertaken through breeding, but conventional plant breeding methods can be very time consuming and the outcomes are not as precise as with genetic engineering. Genetic engineering, on the other hand, can create plants with the desired trait very rapidly and with great accuracy. For example, plant geneticists can isolate a gene responsible for drought tolerance and insert that gene into a different plant. The new genetically-modified plant will thereby become drought tolerant as well. Not only can genes be transferred from one plant to another, but genes from non-plant organisms also can be used. The best known example of this is the use of B.t. genes in corn and other crops. B.t., or *Bacillus thuringiensis*, is a naturally occurring bacterium that produces crystal proteins that are lethal to insect larvae. B.t. crystal protein genes have been transferred into corn, enabling the corn to produce its own pesticides against insects such as the European corn borer. (Deborah B. Whitman, *Genetically Modified Foods: Harmful or Helpful?*, ProQuest, 2000)

Health Concerns

Genetic engineering is considered the largest food experiment in history. Most of the organisms involved have been plants that are the food sources for human and animal consumption. The most popular crops that are genetically engineered are soybeans, corn/maize, canola, sugar beets, and alfalfa. According to the Center for Food Safety, most of the food products purchased from supermarkets likely contain genetically modified ingredients that come from genetically modified crops like canola oil, corn oil, sugar, and corn chips.

As a consequence of the prevalence of processed food on the supermarket shelves, most consumers are exposed to genetically modified organism the nature of which have fundamentally been changed and have never been part of human food supply. This poses the concern for safety, the safety of these products are to human health. One way to test for unintended effects to health is to perform long-term studies. While a few tests described below have shown toxic and allergic reactions to genetically modified food, other studies could not be done effectively due to the lack of cooperation from the industrial scientists not to mention the FDA’s claim that there is no difference between food derived from genetically modified source and food that is traditionally grown.

The Commission mentions three major cases that came to light that demonstrated the unintended consequence of GMO use. In the late 1980s, the outbreak of the disease called eosiphilia-myalgia syndrome reached epidemic proportion. The cause of this disease was traced to L-tryptophan that was manufactured by Showa Denko K.K., Japan’s fourth largest chemical manufacturer and largest supplier of L-tryptophan to the United States. L-tryptophan is one of the essential amino acids, a protein needed by the body as a building block. It is taken as a food supplement by those unable to manufacture it. It is also aids in the production of serotonin which promotes sleep. In manufacturing this food supplement Showa Denko used genetically modified bacteria. The CDC reported monitoring 5,000–10,000 cases, of which forty persons died. The manufacture of L-tryptophan was discontinued as a consequence of the epidemic. (Jeffrey M. Smith, *Seeds of Deception*, Chapter 4)

The New England Journal (March 1996, Vol. 334, No. 11) describes Nordlee et al’s study which demonstrated that “food allergens can indeed be transferred from one plant to another by transgenic manipulation -- in this case, from Brazil nuts to soybeans. They identify 2S albumin as the principal allergen of the Brazil nut and demonstrate that people who react to Brazil-nut extracts on standard skin-prick tests have similar reactions in response to extracts of transgenic soybeans that contain 2S albumin. The authors also collected serum from people known to be allergic to Brazil nuts and

analyzed the ability of proteins in transgenic soybeans to bind to IgE in the serum samples, using radioallergosorbent tests and sodium dodecyl sulfate-polyacrylamide-gel electrophoresis.”

The third case is that of the StarLink corn controversy. Starlink corn is a variety of sweet corn patented by Aventis Crop Sciences that produced its own pesticide through genetic engineering by inserting the gene of a bacterium called *Bacillus thuringiensis* (B.t.) into the corn gene. B.t. was suspected to have an allergenic substance. In the 2000 episode involving Taco Bell tacos 28 people reported allergic reaction related to eating corn products that may have contained Starlink protein prompted a test that was reviewed by the Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Panel points out that while “the negative results decrease the probability that the Cry9C protein is the cause of allergic symptoms in the individuals examined ... in the absence of a positive control and questions regarding the sensitivity and specificity of the assay, it is not possible to assign a negative predictive value to this.” (Transgenic Maize, Wikipedia)

Genetic engineering also involves the use of antibiotic-resistant genes to mark genetically engineered cells that pose the possibility of conferring resistance to antibiotics which may lead to human resistance to bacteria that antibiotics are intended to fight.

The Commission believes there are sufficient grounds for concern to support those who seek to have GMO products to be labeled. Labeling would enable consumers to make more informed decisions about the food they are using for themselves and their families. In addition, labeling may create a groundswell of additional support for opposition to GMOs and calls for more and better testing. The Commission expresses its hope that the Church will explore developing educational materials about products derived from GMOs that will assist in efforts to make consumers more aware of the potential risks and side effects of GMO products.

Health Care Reform in the United States

Though The Episcopal Church includes members from several countries outside the United States, legislative reform efforts in the United States are certainly in the spotlight and of great concern to many Episcopalians. The Commission was particularly focused on understanding legislation as it was proposed, changed, accepted, and voted on, and on articulating the implications of health care reform to the wider Church. In addition to the valuable interpreting and reporting of DeWayne Davis of the Church’s Office of Government Relations, the Commission received a visit from Mara Vanderslice, the Deputy Director and Senior Policy Advisor to the White House Office of Faith-Based and Neighborhood Partnerships. Ms. Vanderslice’s team attended the Commission’s Spring 2011 summit both seeking to inform The Episcopal Church about current legislation and to seek feedback on the efforts of the current administration.

In March 2010, a health care reform bill was signed into law and became known as the Patient Protection and Affordable Care Act, commonly referred to as the ACA.

Members of the Church as Consumers of Health Care

The benefits of the ACA are being phased in over a period of years, with the majority being introduced by 2014. Current benefits include:

- Adults with pre-conditions who have been uninsured for 6 months can receive insurance coverage under the new Pre-Existing Condition Insurance Plan.
- Children can no longer be denied health care coverage because of pre-existing conditions; such protection will be added for adults in 2014.
- Children can remain on their parent’s health care plan up until age 26.
- Medicare recipients are eligible for an increased number of preventative services, and receive a 50% discount on covered brand-name prescription drugs when they reach the gap (“donut hole”) of prescription coverage, though the gap will be completely closed by 2020.
- New appeal processes are in place for insured persons who are denied care or payment for services.
- Protection from insurance coverage being discontinued due to unintended mistakes on application.
- No lifetime cap on the amount insurers will pay for an individual’s health care.
- Best insurance option for individuals and families can be found online at HealthCare.gov.
- Greater access to primary care health services through an expanded network of community health centers, increased payments for rural health care providers, and increased numbers of scholarships and forgiveness of educational loans for physicians and others health care professionals who agree to work in underserved areas.

By 2014, uninsured persons will be able to compare affordable insurance through state-based Health Insurance Exchanges on easy to use websites. An increased percentage of low-income individuals and families will qualify for Medicaid. Those with low and moderate income will be able to receive tax credits in advance (affordability subsidies) to help pay for coverage. It is estimated that over 30 million currently uninsured American citizens and legal immigrants will obtain health insurance through the exchanges. For a complete implementation timeline of the ACA, details are available at HealthCare.gov.

The Episcopal Church as Employer

The ACA will have both short-term and long-term effects on the Church. In the near term, there will be some health insurance plan design changes and some additional costs for plans offered by most dioceses. Small employer tax credits for health coverage and federal reinsurance of early retiree coverage may help abate the costs of continuing to cover clergy and lay employees through health plans.

In the long term, the insurance exchanges will offer employees of the Church the same array of coverage and affordability options described in the consumer section. A survey done by another church benefit board found that 80% of its participants may be eligible for the individual affordability subsidies.

How the employer is defined will impact whether or not the employer is eligible for the tax credits, subject to potential employer penalties in the future or have access to the state Health Insurance Exchanges when they are implemented. Whether the local church, the diocese, or the denomination is considered the “employer” (i.e., the health plan provider) under the ACA depends on how the affiliated employer rules are applied to churches. Regulatory guidance may clarify how church employers and church plans are treated.

In response to the ACA, the Episcopal Church Medical Trust expanded the list of covered in-network preventive care services. All Medical Trust plans now provide expanded in-network coverage for specified preventive care services with no member contribution (\$0 co-pay). Cost-sharing requirements for preventive care services rendered out of network will continue to apply. The Medical Trust removed the annual and lifetime limits on its plans, and expanded coverage for adult children up to age 30, regardless of their student or dependent status.

Both the removal of annual and lifetime maximums and the expansion of covered in-network zero copay preventive care services reduce out-of-pocket costs for Medical Trust members. In addition, the Medical Trust was approved to participate in the Early Retiree Reinsurance Program, a government subsidy program created under the ACA. The federal subsidies of approximately \$400,000 for 2010 and \$550,000 for 2011 that the Medical Trust anticipates receiving as a result will be used to reduce future premium increases.

Additional premium savings may be available for qualified small Episcopal employers. Through the efforts of the Church Benefits Association and the Church Alliance, organizations in which the Church Pension Fund is a participating member, certain small Episcopal employers providing employee healthcare benefits to their employees through certain Medical Trust-administered health plans may be eligible for a tax credit for 2010 through 2014. The employer must meet certain requirements as indicated by the IRS. For more information, please refer to the CPG tax credit guide at the Church Pension Group website. This section was written with extensive assistance from Tim Vanover of the Church Pension group.

The Episcopal Church’s Outreach Opportunities

Congregations can:

- Spread the word about the Affordable Care Act
- Encourage parishioners to become informed
- Host an adult forum on the ACC
- Partner with other congregations to host a community forum
- Partner with a community center to increase their ability to serve

Community health centers play an essential role in the implementation of the ACA. They emphasize coordinated primary and preventive services or a “medical home” for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations.

The Commission strongly recommends that Episcopalians become informed about and teach others in their communities about the Affordable Care Act. The most complete and up to date information is from United States Department of Health and Human Services at HealthCare.gov.

Another excellent resource is the Kaiser Family Foundation, a non-profit private operating foundation dedicated to producing and communicating the best possible analysis and information on health issues. Their “Summary of Coverage Provisions” document which describes the law as it affects individuals, families and employers can be found on their website.

Also attending the Commission’s Spring summit were the Rev. Linda Walling, of Faithful Reform in Healthcare, whose website may be a further resource at FaithfulReform.org. Amy Whitcomb Slemmer, the Executive Director of Healthcare for All, provided additional valuable insights for the Commission’s work.

The Episcopal Church as the Moral Voice of Health Care

With the passage of the ACA, the United States made a major legislative commitment to improve health care. However, the debate is far from over: the United States has not made a moral commitment to health care for all of citizens and legal residents, continuing to argue about increasing access, reducing costs, changing benefits in public programs, raising income eligibility for public programs, and decreasing deficits.

Many of the estimated 30 million additional insurance policies that become available through the Health Insurance Exchanges will be fully or partially paid by tax dollars. As budget decisions are made on the federal and state levels, the legislative commitment made by the passage of ACA is in danger of being eroded. The United States as a country has not yet made the moral commitment to insure that all its citizens have access to health care. The Department of Health and Human services is looking to faith communities to help the country make that moral commitment.

Christians do make a commitment to stand with the poor and the marginalized: Episcopalians pledge in the Baptismal Covenant “to strive for justice and peace among all people and respect the dignity of every human being.” General Convention Resolution 1994-A057 adopted multiple principals of health care including “universal access to quality cost effective health care services” and “the balanced distribution of resources” throughout the country. The Executive Council passed a resolution as recently as 2011 (A&N-027) that “urges all Episcopalians in the United States to engage in advocacy for a responsible federal budget that expresses the shared moral priorities of the nation.”

Clearly the Church has made the moral commitment to insure that all of citizens have access to health care, but how can The Episcopal Church assist the country in making the moral commitment needed to fund the legislative commitment made when the Affordable Care Act was enacted?

When the state and federal legislatures are debating cutting aspects of the ACA, the people of God need to be the moral voice for the most vulnerable by:

- **Speak out.** Lay or ordained Episcopalians can talk with congregations, friends and family; write to legislators and to local editorial pages. Bishop and clergy in particular need to take a public stand on health care as a justice issue not only in their own congregations and dioceses, but also in the press. The strength of a combined voice cannot be underestimated.
- **Join the Episcopal Public Policy Network (EPPN)**, a program of the Church’s Office of Public Relations. Members are connected via to email with federal legislators and updated on health care and other issues on which General Convention and Executive Council have taken a stand. EPPN focuses on federal legislation but does have a number of affiliates working on state legislation.

No matter what further changes may take place to the health care policy of the United States, the Commission will need to monitor and keep the Church and communities in the United States educated on the potential impact of the changes to the health and well-being of God’s people.

Proposed Resolution

Resolution A039 Improve the Church’s Health Care Outreach

Resolved, the House of _____ concurring, That every congregation of The Episcopal Church educate its membership and the wider community spread

the word about the health care reform law by encouraging parishioners to become informed, hosting an adult forum, partnering with other congregations to host a community forum, and partnering with a community center to increase ability to provide health care locally.

Explanation

The benefits of the health care reform law officially entitled the Patient Protection and Affordable Care Act are being phased in over a period of years with the majority being introduced by 2014. Current benefits include:

- Adults with pre-conditions who have been uninsured for 6 months can receive insurance coverage under the new Pre-existing Condition Insurance Plan.
- Children can no longer be denied health care coverage because of pre-existing conditions. This protection will be added for adults in 2014
- Children can remain on their parent's health care plan up until age 26.
- Medicare recipients are eligible for an increased number of preventative services and receive a 50 percent discount on covered brand name prescription drugs when they reach the gap ("donut hole") of prescription coverage. The gap will be completely closed by 2020.
- New appeal processes are in place for insured persons who are denied care or payment for services.
- Protection from insurance coverage being discontinued due to unintended mistakes on application.
- No lifetime cap on the amount insurers will pay for an individual's health care.
- Best insurance option for individuals and families can be found online at: <http://finder.healthcare.gov/>
- Greater access to primary care health services through an expanded network of community health centers, increased payments for rural health care providers, and increased numbers of scholarships and forgiveness of educational loans for physicians and other health care professionals who agree to work in underserved areas.

By 2014 uninsured persons will be able to compare affordable insurance through state-based Health Insurance Exchanges on easy to use websites. An increased percentage of low-income individuals and families will qualify for Medicaid. Those with low and moderate income will be able to receive tax credits in advance to help pay for coverage. It is estimated that over 30 million currently uninsured American citizens and legal immigrants will obtain health insurance through the exchanges. For a complete implementation timeline of the law go to HealthCare.gov.

Resolution A040 Establish the Church as the Moral Voice of Health Care

Resolved, the House of _____ concurring, That every member of The Episcopal Church make a moral commitment to health care for all of citizens and legal residents by actively supporting the full implementation and funding of the health care reform law in the United States.

Explanation

Episcopalians who are resident in the United States should be aware of the legislative commitment made to improve health care through the passage of the Patient Protection and Affordable Care Act (ACA). Unless Episcopalians make the moral commitment to support the provisions of that law, the goal of the legislative commitment will be eroded away as budget decisions are made on federal and state levels.

Christians have made the commitment to stand with the poor and the marginalized, and Episcopalians pledge in the Baptismal Covenant "to strive for justice and peace among all people and respect the dignity of every human being." General Convention Resolution 1994-A057 adopted multiple principals of health care including "universal access to quality cost effective health care services" and "the balanced distribution of resources" throughout the country, and the Executive Council passed a resolution as recently as 2011 (A&N-027) that "urges all Episcopalians in the United States to engage in advocacy for a responsible federal budget that expresses the shared moral priorities of the nation." The Episcopal Church has made the moral commitment to insure that all citizens have access to health care, and can live into that moral commitment by speaking out in communities and to legislators for the full implementation and funding of health care reform in the United States.

Budget Report

In the 2010–2012 triennium, the Commission had a budget of \$24,000. For teleconference and face-to-face meetings, the Commission spent \$20,040 (including a generous grant of \$5,000 from the Church Pension Group), which enabled the Commission to hold a summit of noted professionals in the Commission's areas of study. Regrettably, even with this additional funding, the budget did not allow the Commission to meet a third time to finalize the preparation of a report to the General Convention.

While meeting through video-conferencing and teleconferencing are useful, the Commission has found that its work is most productive when its membership can gather with experts in the areas which it is tasked to study; this allows for discussions of longer duration than electronic methods typically allow.

The Commission hopes to meet three times during the next triennium, including at least one meeting with experts in areas of concern. This will require \$10,000 for 2013, \$20,000 for 2014, and \$10,000 for 2012 for a total of \$40,000 for the triennium.