Sending Mixed Messages to Congress: Mennonite Involvement in Proposed National Health Care Reform, 1992-1994

JONNY GERIG MEYER*

Abstract: In the early 1990s, comprehensive health care reform dominated the national political agenda in the United States. When Mennonites became actively involved in this endeavor, however, they struggled to present a unified and clear message to Congress. Specifically, Mennonite Mutual Aid and the Washington Office of Mennonite Central Committee found themselves advocating for strikingly dissimilar legislative solutions, despite the fact that they agreed in principle on the primary goals of universal coverage and cost containment, among others. After recounting the details of national health care reform and the divergent positions of MMA and the Washington Office, this paper suggests that the conflicting approaches of these two organizations can be best understood by exploring the natural tension between representing the self-interests of Mennonites as a group, and representing aspects of Mennonite theology by advocating on behalf of the poor and uninsured.

In late February of 1994, LeAnne Zook, an intern from Mennonite Central Committee's Washington Office, traveled to the capital office of Rep. James Greenwood, Republican of Pennsylvania. Congressman Greenwood represented Bucks County, home to many Mennonites. Two representatives from other religious lobbying groups accompanied Zook, all participants in the Interreligious Health Care Access Campaign. While analyzing various proposals for health care reform the previous year, the campaign had given its support to the American Health Security Act, also known as the "single-payer" proposal, which pledged to provide universal health care coverage as well as substantial cost savings to the American public. The group was visiting Greenwood's office to voice their support for that proposal.

Near the end of the brief half-hour meeting Susan Cobb, an aide to Greenwood, informed the visitors that Greenwood's office had already heard from the Mennonites' representative, a lobbyist hired by Mennonite Mutual Aid, or MMA. Cobb reported, "They [Mennonites] are not interested in universal coverage; they simply want to be exempt

*Jonny Gerig Meyer is currently pursuing an M.Div. in Theological Studies at Associated Mennonite Biblical Seminary, Elkhart, Ind.

from health care reform."[1] At this point, Zook tried to explain to Cobb that there was continuing dialogue within the Mennonite Church over health care reform, and that the Washington Office was "very concerned about the plight of those currently without adequate health care."[2] She also clarified that MMA did not represent all Mennonites, and that both MMA and the Washington Office were in agreement on the principle of universal coverage.[3] According to one source, Zook stated plainly, "We want you to realize that MMA does not speak for the Mennonite Church. They're just an insurance agency with their own agenda."[4] Cobb replied that they had been informed by MMA (ostensibly speaking for the Mennonite Church) that "the Mennonites are opposed to comprehensive reform like the American Health Security Act," and that more generally, "the Mennonites are against single-payer."[5] Frustrated by these inconsistent reports and unclear about MMA's role as a representative of Mennonites, Greenwood contacted MMA and asked for greater clarity about what Mennonites wanted. He wondered why Mennonites—as a relatively small group with limited representation on Capitol Hill—were seemingly unable to present a unified opinion on health care reform.[6] According to the notes of Karl Shelly, a Washington Office legislative associate, Greenwood clarified his own position as "philosophically opposed to comprehensive reform."[7] He also stated that he did not view universal coverage as the ultimate goal of MMA's lobbying effort. Until he received "an official [Mennonite] statement from someone in a real position to make it," Greenwood refused to consider supporting MMA's position on health care reform.[8]

---

1. Susan Cobb, quoted in Karl Shelly, "Health Care Reform: MMA & MCC U.S.," in file "HC and Mennos, 1990s," in the personal files of Karl Shelly, Goshen, Ind. [hereafter cited as Shelly Files].

2. LeAnne Zook, quoted in ibid.

3. LeAnne Zook, quoted in Karl Shelly, facsimile to Lynette Meck and Harold Nussbaum, Mar. 10, 1994, "MMA & Health Care Reform," in file "HC and Mennos, 1990s," Shelly Files.

4. Karl Sommers, "The MCC Problem," in the personal files of Karl Sommers, Goshen, Ind., quoted in an interview with Karl Sommers, Feb. 29, 2008, Goshen, Ind., digital recording in the author's personal files, Goshen, Ind. Until he retired in late 2008, Sommers was MMA's vice president of corporate planning.

5. Susan Cobb, quoted in Shelly, "MMA & Health Care Reform."

6. Karl Shelly, interview by author, Feb. 11, 2008, Goshen, Ind., digital recording in author's personal files, Goshen, Ind.

7. Rep. James Greenwood, quoted in Shelly, "MMA & Health Care Reform."

8. Sommers, "The MCC Problem," quoted in an interview with Sommers, Feb. 29, 2008. See also Karl Shelly, facsimile to Harold Nussbaum, Mar. 3, 1994, "Health Care Reform & MMA," in file "HC and Mennos, 1990s," Shelly Files. Numerous versions of this story have appeared in various publications since the event, and no single description can be accepted as entirely accurate word-for-word. At the time, there was considerable confusion and disagreement between MMA and the Washington Office over what exactly was said

Greenwood's confusion was understandable. While MMA had indeed promoted universal coverage as one of four "Guiding Principles for Responding to the Health Care Crisis," its involvement on Capitol Hill had focused primarily on seeking an amendment to the proposed Health Security Act (H.S.A.) that would allow it to continue operating as a fraternal organization serving only Anabaptist-related groups.[9] In its communication with legislators, MMA emphasized its determination for a provision allowing it to participate in the H.S.A. as an "Anabaptist-only" institution, which often overshadowed its desire for universal access to health care.[10] While in agreement with the Washington Office about the need for universal coverage in some form, MMA ultimately disagreed about the value of a single-payer proposal.[11]

Despite the fact that Greenwood's aide misrepresented the official position of MMA, to those involved the incident illustrated the importance of carefully considering how Mennonites choose to represent themselves on Capitol Hill. MMA and the Washington Office both claimed to represent and support Mennonite constituents, but disagreed in the early 1990s about how best to approach the various proposals for national health care reform. This discord between Mennonite institutions raised important questions for Mennonites: While lobbying in Washington, were both institutions legitimately representing the Mennonite Church on the issue of health care reform? How should the Mennonite Church deal with competing national lobbies within the body of believers? Most basically—and perhaps most importantly—why were

---

between Zook and Cobb. The quotes from Karl Shelly were conveyed to him by Zook and Patrick Conover (co-chair of the I.H.C.A.C.), both of whom were in the meeting with Susan Cobb. The quotes from Karl Sommers were either passed from Cobb directly to Sommers, or were related to him via Walter Vinyard, MMA's counsel in Washington, D.C.

9. See Mennonite Mutual Aid, "Guiding Principles for Responding to the Health Care Crisis," May 1992, in file "HC and Mennos, 1990s," Shelly Files.

10. For an example of MMA's communication with legislators, see Mennonite Mutual Aid, "Statement by Mennonite Mutual Aid on Health Care Reform," 1993, in file "HC and Mennos, 1990s," Shelly Files. This statement was included in a letter sent from Walter Vinyard, MMA's lobbying counsel in Washington, to Sen. Harris Wofford (D-Pa.). The statement was revised before being presented to the Subcommittee on Health of the U.S. House Committee on Ways and Means. The revised version stated more clearly MMA's position on universal coverage: "MMA supports the health care reform principles the President is calling for and we think universal access is of highest priority. We want to support government in bringing about reform." For this revised version, see Mennonite Mutual Aid, "Statement by Mennonite Mutual Aid on Health Care Reform," Feb. 4, 1994, in file "HC and Mennos, 1990s," Shelly Files. For another example of MMA's communication with legislators, see a letter from Sen. Paul Simon, (D-Ill.), to Sen. Daniel Patrick Moynihan, (D-N.Y.), June 22, 1994, in file "HC and Mennos, 1990s," Shelly Files. In it, Simon encouraged Moynihan, chairman of the Senate Finance Committee, to support MMA's proposal to be grandfathered into the Health Security Act.

11. Interview with Sommers, Feb. 29, 2008.

Mennonite institutions advocating different forms of health care reform in the first place?[12]

An understanding of the roles that the Washington Office and MMA occupied in relation to the Mennonite Church is crucial for an adequate analysis of Mennonite involvement in national health care reform. Over the course of their histories, MMA and the Washington Office both strayed from their original (distinctly Mennonite) mandates, and became increasingly similar to other institutions in their fields of operation.[13] As they did so, they developed different understandings of their responsibilities as Mennonite Church institutions. Despite a relatively unified message from Mennonite leaders in support of universal coverage, MMA and the Washington Office of Mennonite Central Committee advocated for different goals in the 1992-1994 debate over national health care reform: MMA understood its primary role as representing and serving members of the Mennonite Church; the Washington Office, by contrast, undertook a more general mission of advocacy on behalf of the poor and marginalized, regardless of religious affiliation.

Origins and History of Mennonite Mutual Aid, Inc.

The Mennonite Church incorporated Mennonite Mutual Aid in 1945 for the purpose of providing loans to Mennonites who had been involved in Civilian Public Service (C.P.S.) during and after World War II. Civilian Public Service was established in 1941 to provide a form of alternative service for conscientious objectors during the war, and many Mennonites chose this form of service in lieu of joining the military. Because supportive churches were the primary groups responsible for

12. At the time, MMA was an official program board of the Mennonite Church (M.C.). This meant that while it was an inter-Mennonite institution in its board and membership, it was directly accountable to the M.C. In 1992, the MMA board of directors included eleven members appointed by the M.C., four members appointed by the General Conference Mennonite Church (G.C.), and two members appointed by the Mennonite Brethren Church. Both M.C. and G.C. were also active supporters of M.C.C., but the latter organization was not directly responsible to either group. While this article attempts to include information from both Mennonite denominations, the M.C. is the primary focus at times because of its official relationship with MMA.

13. This shift from distinctly Mennonite mandates should not imply movement away from the position of the Mennonite Church. Instead, these shifts within both MMA and the Washington Office were accompanied (and even prodded) by corresponding changes in the broader Mennonite Church. See especially Keith Graber Miller, *Wise as Serpents, Innocent as Doves: American Mennonites Engage Washington* (Knoxville: University of Tennessee Press, 1996); Willard M. Swartley and Donald B. Kraybill, eds., *Building Communities of Compassion: Mennonite Mutual Aid in Theory and Practice* (Scottdale, Pa.: Herald Press, 1998); and, more generally, Leo Driedger and Donald B. Kraybill, *Mennonite Peacemaking: From Quietism to Activism* (Scottdale, Pa.: Herald Press, 1994).

financing C.P.S. workers, many Mennonite volunteers finished their service without any form of economic security. The economic condition of these Mennonites presented the church with a situation that today seems unremarkable. At the time, the Mennonite leader and historian Guy F. Hershberger wrote:

> There are in the Mennonite Church persons whom God has blessed with material means above their own needs. There are in the Mennonite Church those who need financial and other assistance in order to establish homes and means of livelihood in the Mennonite Community and to meet emergencies which may not be otherwise provided for.[14]

In the mid-twentieth century—a time when Mennonites were investing in many new church-based institutions—these straightforward observations led the leaders of the Mennonite Church to create Mennonite Mutual Aid with the following mission: "To bring the existing resources and the existing needs together in a manner to strengthen the Church community and to promote loyalty on the part of its young people to the Church and the scriptural principles it upholds."[15] To achieve this lofty goal, MMA was to provide financial assistance through loans with low-interest rates—set "in no case [to] exceed 5 percent"—for C.P.S. men, young Mennonites and other persons with unexpected emergencies "not otherwise reasonably provided for."[16] In 1945 MMA opened a small office in Goshen, Indiana, and quickly began to develop aid programs for the church. The new organization carefully attempted to stay away from the sale of insurance—especially life insurance, which the Mennonite Church traditionally condemned as displaying "a lack of faith in God and God's church."[17]

Avoiding the sale of life insurance was not enough to reassure some Mennonite leaders, who were concerned that the church would be unable to maintain its integrity and fulfill its mission in the ethically ambiguous realm of business. In 1970, the Association of Mennonite Aid Societies (made up of thirty-one Mennonite-related mutual aid organizations in the United States and Canada) chronicled the ensuing discussion about the pros and cons of forming a Mennonite insurance

14. [Guy F. Hershberger], "Mennonite Mutual Aid: A Venture in Christian Stewardship and an Expression of the Principles of Christian Brotherhood," 1946, available in the Mennonite Historical Library, Goshen, Ind. [hereafter cited as MHL].

15. Ibid.

16. Ibid.

17. Steven M. Nolt, "Problems of Collectivity and Modernity: Midcentury Mennonite Conflicts Involving Life Insurance and Biblical Hermeneutics," *MQR* 72 (April 1998), 210.

agency. The resulting collection of essays—*The Compassionate Community*, compiled by H. Ralph Hernley—dealt with the Mennonite doctrine of mutual aid, and considered the ways Mennonite institutions were helping one another through mutual aid organizations. The book presented a positive view of Mennonites as religiously called to practice mutual aid, and of Mennonite institutions as highly successful in that effort. On the other hand, it also included many warnings from Mennonite leaders worried about the dangers of allowing the "need and concern to serve people" to "take second place to the strength of a financial institution."[18] These leaders worried that MMA would eventually allow the business model of secular institutions—with a driving emphasis on economic profit—to overpower the sacred Mennonite ethics of service and mutual aid.

In a 1962 presentation to the Association of Mennonite Aid Societies, Richard Yordy, a Mennonite pastor and conference leader, plainly stated his concerns about MMA: "It is possible that the administrators of an organization may become too much concerned about its financial strength and stability."[19] In order to maintain the ethical integrity of the institution, Yordy solemnly warned:

> We must constantly bend the purposes of our organization to serve people. This might involve, and this is where the acid test would come, the dissolution of an organization that has outlived its usefulness. We may need to consider giving up an economic resource that has outlived its validity. . . . Would we have the courage to do this?[20]

While in support of MMA as a valuable Mennonite institution, Yordy was clearly worried about the ability of the Mennonite Church to ensure MMA's continuing "margin of difference" from self-interested secular insurance institutions.[21]

During the latter half of the twentieth century, MMA's growing membership—and gradually shifting attitudes toward the sale of insurance—prompted MMA to initiate an increasing number of insurance programs. After developing forms of life insurance plans like

18. Richard J. Yordy, "Mutual Aid: An Expression of Basic Christian Experience" (paper presented at the Association of Mennonite Aid Societies, Chicago, 1962), in H. Ralph Hernley, ed., *The Compassionate Community: A Collection of Lectures Presented at Conferences of the Association of Mennonite Aid Societies* (Scottdale, Pa.: Association of Mennonite Aid Societies, 1970), 138.

19. Ibid.

20. Ibid., 151.

21. This language of maintaining a "margin of difference"—a term originally used by marketing professionals—became increasingly popular during the 1990s as a way to discuss the differences between MMA and other secular insurance institutions.

"burial aid" and "survivor's aid," in addition to more conventional health insurance, MMA continued to add various programs: long-term care insurance, disability income protection, auto collision coverage, retirement investment programs, mutual funds, financial services, estate planning and management of planned charitable giving, Sharing Fund grants, annuity scholarships, congregational grants, educational resources and advocacy programs.[22] By and large, these programs were highly successful. By 2007, MMA was an umbrella organization composed of thirteen corporate entities that managed nearly $1.9 billion in total assets.[23]

Throughout this period of considerable expansion, MMA strove to maintain its "margin of difference" from secular insurance agencies in a variety of ways. Beginning in 1965, MMA was organized as a fraternal benefit organization. Because it served only Mennonites and other Anabaptist-related denominations, MMA was exempt from most insurance industry taxes—although it was required to use the funds it would normally pay in taxes for charitable purposes.[24] MMA created a Fraternal Benefits Fund to distribute this money through grants to Mennonite congregations and individuals. The amount of money given back to the Mennonite Church through the Fraternal Benefits Fund increased steadily over time; in 2007, MMA provided $1.2 million in fraternal grants.[25]

In addition to fraternal giving, MMA also remained distinctive for a time by charging flat rates for health insurance premiums, and by extremely limited use of medical underwriting. In the field of health insurance, medical underwriting refers to the use of patients' medical histories and knowledge of preexisting medical conditions to deny coverage or charge higher premium rates for higher-risk individuals. Resisting these common practices, MMA began by charging equal premium rates for all members, regardless of age, health or geographical location. Despite an occasional and brief waiting period for some preexisting medical conditions, all applicants were eventually given full insurance benefits.[26] MMA was proud of these distinctive practices, and

22. Keith Graber Miller, "Mennonite Mutual Aid: A Margin of Difference?" in *Building Communities of Compassion: Mennonite Mutual Aid in Theory and Practice*, ed. Willard M. Swartley and Donald B. Kraybill (Scottdale, Pa.: Herald Press, 1998), 265. See also Steven M. Nolt, "Fifty Year Partners: Mennonite Mutual Aid and the Church," in Swartley and Kraybill, *Building Communities of Compassion*, 213-243.

23. Mennonite Mutual Aid, "Going Your Way: MMA 2007 Annual Report and 2008 Outlook," 2008, 12, available from MMA, Goshen, Ind.

24. Nolt, "Fifty Year Partners," 221.

25. Mennonite Mutual Aid, "Going Your Way," 3.

26. Graber Miller, "Mennonite Mutual Aid," 271.

maintained that increased age rating and medical underwriting would be "counter to principles of love, caring and mutual aid."[27]

By the late 1970s and early 1980s, however, MMA's unconventional "mutual aid" form of health insurance was being threatened, as younger and healthier members opted for cheaper health insurance elsewhere. Because of MMA's policy of charging flat rate premiums, the elderly were paying substantially lower rates than market value, while younger and healthier members were paying more so as to subsidize the health care for the elderly. Reflecting increased competition in the health insurance market, younger members began leaving MMA in favor of health insurance organizations that used age rating to provide cheaper rates for themselves and other statistically lower-risk people. In order to retain these younger members, MMA abandoned its flat rate policy and instituted limited age rating in 1979. This change proved to be insufficient, however, and MMA's financial woes were aggravated in the 1980s as health care costs in the United States rose exponentially. A majority of MMA's business depended on income generated by health insurance, and MMA quickly found itself unable to compete in an increasingly competitive and expensive field. By 1988 MMA faced a financial crisis that threatened its existence as a sustainable business and generated concerns about the feasibility of MMA's refusal to implement medical underwriting. As younger members continued leaving MMA, the average age of MMA members rose. Older members required more medical care and MMA's costs increased significantly. Rising health care costs nationwide accentuated the problem. In 1988 MMA lost as much as $3.9 million and raised its premiums by 30 to 40 percent to compensate, but continued to lose as many as 400 to 500 healthy members each month.[28]

In order to survive as a business, MMA made a series of decisions in the late 1980s that shifted the institution from an unconventional model of mutual aid toward a secular model of health insurance. The first of these changes expanded the qualifications necessary for membership in MMA health insurance plans from "Mennonites and related groups" to

27. Karl Sommers, Jerry Troyer and Laban Peachey, memo to Division Management, Apr. 15, 1987, in MMA Board of Directors Meeting Minutes and Reports, May 8, 1987 (Box XII-9, 4/6), Mennonite Church USA Archives, Goshen, Ind. [hereafter cited as AMC], quoted in Graber Miller, "Mennonite Mutual Aid," 272.

28. "Mennonite Mutual Aid Association—Total," MMA Board of Directors Meeting Minutes and Reports, Aug. 10-11, 1989 (Box XII-9, 4/12), AMC, quoted in Graber Miller, "Mennonite Mutual Aid," 271. In 1988, MMA reported losses totaling $3,923,558. In an interview with Keith Graber Miller on May 23, 1996, Steve Garboden, who was at that time MMA's chief financial officer, stated that for three consecutive years—1988, 1989, and 1990—MMA reported 15 percent declines in its health plan memberships. See Graber Miller, "*Mennonite Mutual Aid*," 286, fn. 38.

include all members of denominations "historically associated with the Anabaptist tradition."[29] In practical terms, this broadened MMA's constituency to encompass twenty-six religious groups—including the Missionary Church, the Society of Friends (Quakers) and the Apostolic Christian Church—some of which shared very few theological or ethical values with modern Mennonites.[30] Some people viewed this as a positive reflection of changing understandings of the role of the church in serving non-Mennonites as well as Mennonites. Others worried that MMA's motives were increasingly being driven by business incentives, that a broadened constituency weakened MMA's ability to provide true mutual aid for its members, and that this expansion stretched the limits of MMA's fraternal benefit status.

MMA's other controversial business decision at this time had to do with medical underwriting. Beginning in 1988, MMA began refusing to insure people with certain preexisting medical conditions, and to charge scaled rates to members based on their medical histories. MMA's leaders felt strongly that this was the only way the institution could continue to serve some of its unhealthy members who would find it difficult or impossible to purchase health insurance elsewhere. This decision allowed MMA to save money by refusing to insure higher-risk individuals. But it caused some to question whether MMA could continue to justify its claim of offering a form of mutual aid since its practices increasingly mirrored those of secular health insurance organizations. Given that its underwriting practices were generally in conflict with the principle of mutual aid, Ted Koontz, a Mennonite ethicist and MMA board member, wondered if there was any reason for the church to continue to support MMA, or whether the organization had crossed the theoretical threshold between "church" and "business."[31]

Koontz's critique suggested a gradual shift in Mennonite perceptions of MMA as a uniquely Anabaptist organization, and represented an

29. "1996 MMA Corporate Plan," 1996 MMA Board Policy Manual, 104, available in the files of Mennonite Mutual Aid, Goshen, Ind., quoted in Graber Miller, "Mennonite Mutual Aid," 268, 284n.

30. Nolt, "Fifty Year Partners," 231. While these various denominations are included in MMA membership, for the sake of simplicity this paper consistently refers to "Mennonites" as MMA's primary constituents.

31. Ted Koontz, "Initial Reflections on MMA Orientation and Board Meetings and Materials," Dec. 1991, 5, in the personal files of Ted Koontz, Goshen, Ind. See also Ted Koontz, "A Dream for an Alternative MMA Congressional Testimony (Witness) on Health Care Reform," May 6, 1994, in file "HC and Mennos, 1990s," Shelly Files. These sentiments were also conveyed in an interview with Ted Koontz, Mar. 6, 2008, Goshen, Ind., digital recording in author's personal files, Goshen, Ind. Koontz also openly questioned MMA's decision to begin operating in mutual funds, but this critique is less relevant to the specific discussion of health insurance.

ongoing discussion about the ethics and goals of MMA as it continued to grow. In 1998, nearly thirty years after the publication of *The Compassionate Community*, editors Willard M. Swartley and Donald B. Kraybill published another collection of essays on the topic of Mennonites and mutual aid. This book, *Building Communities of Compassion: Mennonite Mutual Aid in Theory and Practice*, grew out of a 1996 conference sponsored by MMA to explore the history of MMA and mutual aid.[32] It emphasized more strongly and explicitly the importance of maintaining a "margin of difference" from secular insurance institutions, recognizing the critical response to MMA's controversial decisions in the late 1980s and early 1990s. In it, for example, Mennonite ethicist Keith Graber Miller asked if MMA truly maintained a practical margin of difference or whether it had become too similar to secular insurance agencies in its methods and ultimate goals. Graber Miller also noted MMA's consistent mission to "go along with its members and help them wherever in good conscience they need to go," and questioned MMA's ability to represent both its customers and the Mennonite Church as MMA grew to include more denominations.[33] In a similarly critical vein, bioethicist and MMA employee Scot D. Yoder wrote an article questioning MMA's priorities in allowing market demands to eclipse ethical principles.[34] In a more recent master's thesis, Heather Klassen concluded that MMA's increasingly secular organizational model and its blend of church and business "is skewed sharply in favor of business, with the need to be financially viable and to stay in business as the ultimate concerns."[35]

As questions of its distinctiveness continued to surface, MMA was understandably defensive about its "margin of difference" as a not-for-profit Mennonite institution. MMA President Howard Brenneman generally responded to these critiques by maintaining that "MMA is not just another insurance or financial services company as some people would suggest."[36] MMA leaders highlighted what they considered to be the unique aspects of the organization: namely, its status as a not-for-profit fraternal organization that returned all of its profits to members through various programs and grants. Additionally, leaders emphasized that "MMA's underwriting policies and practices are different,"

32. Swartley and Kraybill, eds., *Building Communities of Compassion.*

33. Orie O. Miller, quoted in Graber Miller, "Mennonite Mutual Aid," 265.

34. Scot D. Yoder, "Transplants, Justice, and Health Care Reform," *Second Opinion* 18, no. 1 (1992), 49-67.

35. Heather L. Klassen, "Faith at Work: Christian Spirituality and Ethics in Mennonite Church-Related Organizations" (master's thesis, Associated Mennonite Biblical Seminary, 2001), 80, available in Associated Mennonite Biblical Seminary Library, Elkhart, Ind.

36. Howard L. Brenneman, quoted in Graber Miller, "Mennonite Mutual Aid," 280.

specifically citing monetary assistance given to those whose medical histories called for high premiums.[37] Supporting these claims, sociologist Donald B. Kraybill drew attention to "MMA's continuing partnership with the church, its fraternal benefits program, its ecumenical constituency, its promotion of the core values of mutual aid and stewardship, and its sponsorship of a variety of educational and advocacy programs."[38] Meanwhile, despite some criticism from individuals within the church, MMA received broad support for its continuing "margin of difference."

Origins and History of Mennonite Central Committee's Washington Office

More than twenty years after the formation of MMA, Mennonite Central Committee (M.C.C.)—a service and relief organization of the Mennonite and Brethren in Christ churches—opened an office in Washington, D.C. The creation of the Washington Office of Mennonite Central Committee was primarily a response to the increasing impact of the American government on the people and programs with whom M.C.C. regularly worked. As M.C.C. repeatedly "bumped up against" the U.S. government in its relief and service work abroad, Mennonites recognized a growing need to "deal both with the positive welfare functions of the state and with the more problematic areas."[39] Mennonite leader and historian Guy F. Hershberger—who in 1951 had written that for the Mennonite Church to "become or maintain a lobbyist organization . . . would be a perversion of its purpose and function"—wrote in 1968 that Mennonites ought to open an office in the nation's capital because M.C.C.'s service and relief programs were "daily affected, for good or ill, by a host of government agencies."[40] The purpose of the new office was to "keep in closer touch with the working of the federal government than is possible under present circumstances."[41]

---

37. Ibid.

38. Donald B. Kraybill, quoted in Graber Miller, "Mennonite Mutual Aid," 264.

39. Graber Miller, *Wise as Serpents*, 2; John Richard Burkholder, "Talking Back to Caesar: The Christian Witness to the State," Mar. 26, 1985, 6, available in MHL, quoted in Graber Miller, *Wise as Serpents*, 3.

40. The earlier (1951) quote can be found in Guy F. Hershberger, *The Mennonite Church in the Second World War* (Scottdale, Pa.: Mennonite Publishing House, 1951), 248, quoted in Graber Miller, *Wise as Serpents*, 1. The later (1968) quote can be found in Guy F. Hershberger, "A Mennonite Office in Washington?" *Gospel Herald*, Feb. 27, 1968, 186, quoted in Graber Miller, *Wise as Serpents*, 41.

41. Hershberger, "Mennonite Office," 186, quoted in Graber Miller, *Wise as Serpents*, 1.

In the years leading up to 1968, the Peace Section of M.C.C. regularly sent representatives to Capitol Hill to work with legislators on conscription issues, and they maintained close relationships with other religious groups in Washington.[42] In January 1968—after Mennonites nearly "missed the boat" when Congress passed a bill renewing conscientious-objector status[43]—the M.C.C. Peace Section decided to open a permanent office to serve as a "listening post" in Washington.[44] Under the direction of the United States division of M.C.C. (M.C.C.-U.S.), the original functions of the Washington Office were designated as follows:

> 1) to serve as an observer in Washington, analyzing and interpreting trends that affect Mennonite concerns; 2) to equip the constituent groups where they desired to make representation to the government; 3) to serve as a source of knowledge and expertise on peace and social issues related to government; and 4) to provide facilitating services for constituent groups.[45]

Furthermore, the newly founded office was specifically to avoid "using the political pressure methods of lobbies."[46]

Paralleling trends in the broader Mennonite Church, this aversion to the use of political pressure was short-lived; over time the Washington Office took a more active role in advocating on behalf of the Mennonite Church. Along with this shift from monitoring to advocacy, the Washington Office focused increasingly on the interests of the "poor and oppressed"—a focus growing out of both Mennonite theology and M.C.C.'s experience working among the poor—and less on the specific self-interests of Mennonite constituents.[47] Far from claiming to represent "the Mennonite viewpoint," the 1982 guidelines of the Washington Office explicitly stated, "Without pretending to speak for all Mennonites, the office may convey to government officials the peace and justice

42. Graber Miller, *Wise as Serpents*, 42.

43. Hershberger, "Mennonite Office," 186, quoted in Graber Miller, *Wise as Serpents*, 45.

44. William C. Keeney, "The Establishment of the Washington, D.C., and Ottawa Offices" (first draft, 1977), 8, available in Mennonite Central Committee Washington Office files, Washington, D.C., quoted in Graber Miller, *Wise as Serpents*, 46.

45. William C. Keeney, "Report and Recommendation Concerning a Washington Office," Exhibit 1, to M.C.C. Peace Section Executive Committee Meeting, Chicago, Jan. 18, 1968, available in file entitled "Peace Section Minutes and Reports" (IX-7-8, Box 3), AMC, quoted in Graber Miller, *Wise as Serpents*, 81.

46. "Peace Section Opens Washington Office," *Gospel Herald*, Aug. 13, 1968, 733, quoted in Graber Miller, *Wise as Serpents*, 81.

47. Throughout this paper, the term "interests" is used narrowly to describe relatively short-term desires often related to matters of power and financial benefit. One could argue that pursuit of the common good and the interests of the poor and oppressed fit within a broader understanding of the self-interests of Mennonites.

concerns of the Mennonite constituencies as reflected in the consensus of representatives to the U.S. Peace Section and other MCC bodies."[48] Exploring this shift in the Washington Office's advocacy, Keith Graber Miller wrote:

> The MCC Washington office was founded both out of self-interest (protecting Mennonites from such evils as Selective Service) and for other-interest (speaking to the powers for and with those persons whom they encountered in their domestic and overseas service work). . . . But since those early years, the self-interest (the representation of Mennonites) has dropped almost completely out of the portfolio of MCC Washington. Now the office seeks almost exclusively to "represent" the "poor and oppressed" around the world, persons like those whom MCC workers encounter in the field.[49]

As the Washington Office broadened its vision to include those outside the Mennonite Church, the institution explicitly rejected the notion that it should try to represent the range of political views *within* the Mennonite Church. This involved not only a shift in the institution's mission but also a tactical shift to increasingly include lobbying efforts on Capitol Hill.

In 2001, political scientist Kenneth Eshleman analyzed Mennonite voting records to conclude that the Washington Office was indeed neither representative of Mennonite political viewpoints nor significantly different from other religious lobbyists in its methods or policy positions.[50] Eshleman's argument raised questions pertaining to the Washington Office that were similar to ones Graber Miller raised about MMA: are MMA and the Washington Office representative of the Mennonite Church? and, are they maintaining a "margin of difference" from other non-Mennonite institutions in their respective fields? A closer look at the involvement of both MMA and the Washington Office in health care reform during the early 1990s provides some initial answers to these crucial questions.

---

48. "Guidelines for the Washington Office of MCC U.S. Peace Section," Exhibit 9 at the M.C.C. U.S. Executive Committee Meeting, Dec. 15-16, 1982, Mennonite Central Committee Washington Office files, Washington, D.C., quoted in Graber Miller, *Wise as Serpents*, 114.

49. Keith Graber Miller, "American Mennonites in the Political Process: Wise as Serpents, Innocent as Doves," *Gospel Herald*, Jan. 18, 1994, 3.

50. Kenneth Lee Eshleman, "Thirty Years of MCC-Washington Office: A Unique or Similar Way?" *MQR* 75 (July 2001), 293-313.

THE U.S. HEALTH CARE SYSTEM AND CLINTON HEALTH CARE REFORM

In the 1980s, health care costs in the United States were rising at 150 to 200 percent beyond the rate of general inflation.[51] As costs and the complexity of the health care system rose with no apparent end in sight, Americans became increasingly concerned and pressed for governmental reforms. The Reagan Administration responded by pushing for more health-maintenance organizations (H.M.O.'s) to manage care. Presumably, these organizations would reduce costs by requiring patients to use certain doctors and hospitals connected with the H.M.O., and by offering discounted (often called "negotiated") rates to members willing to accept those limited services. To avoid paying for services they regarded as nonessential, H.M.O.'s refused to cover costs outside each individual plan's network of providers. These centralized systems mediated by managed-care providers were substantially different from the "fee-for-service" (or "indemnity") system commonly used in the United States before the rise of managed-care. The unmanaged fee-for-service system partially reimbursed patients for using any medical professional, and thus did not control fees for medical services.

Managed-care plans grew rapidly in the latter half of the 1980s. However, less restrictive organizations also developed to give patients more choices of health care providers. Indeed, very soon the most common type of managed-care plan was something called Preferred Provider Organizations (P.P.O.'s), which offered members negotiated rates for using medical professionals within a plan's provider network (similar to H.M.O.'s), while also allowing members to receive services from outside the network at a higher price. Point-of-Service (P.O.S.) plans similarly combined aspects of H.M.O.'s and indemnity plans by providing a network of approved medical professionals at discounted rates, even as these allowed members to use external providers on a fee-for-service basis with deductibles and co-insurance payments similar to a traditional indemnity plan. Together, H.M.O.'s, P.P.O.'s and P.O.S. plans quickly dominated the health care market, and by 1998 conventional fee-for-service plans fell to 15 percent of the "under-65 health-insurance market."[52]

The rapid growth of H.M.O.'s in the late 1980s is often credited for slowing medical cost inflation. Supposedly, they did so by "reducing unnecessary hospitalizations, forcing providers to discount their rates, and causing the health-care industry to become more efficient and

51. Howard M. Leichter, ed., *Health Policy Reform in America: Innovations from the States*, 2nd ed. (Armonk, N.Y.: M. E. Sharpe, 1997), 5.

52. Stephen Blakely, "The Backlash against Managed Care," *Nation's Business*, July 1998.

competitive."[53] However, the rise in managed-care insurance did not stem the tide of public concern over rising health care costs. Employers—who traditionally were expected to provide, or at least to subsidize, health insurance for their employees—were finding it difficult to continue covering employees, especially as they competed with foreign competitors who were not required to provide health insurance. According to Howard M. Leichter, a clinical professor of public health, "Between 1988 and 1994, the percentage of nonelderly Americans receiving employer-based health insurance declined from 67 percent to 61 percent, while the number of uninsured rose from 32.7 million people to 39.3 million."[54] As employers declined, or were less able, to pay for health insurance, the number of uninsured Americans grew rapidly. Health care reform once again entered the national political agenda.

Analysts of health care reform in the United States often credit the special election of Senator Harris Wofford of Pennsylvania in 1991 for bringing their cause into the national political arena. Wofford was a little-known candidate who was able to close a 44-point gap in the polls by running on a reform platform: "if every American is guaranteed a lawyer, surely they should have access to a doctor, too."[55] Witnessing Wofford's success, Bill Clinton successfully ran his 1992 presidential campaign by making national health care reform a prominent goal. Only five days after his inauguration in January of 1993, President Clinton created the Presidential Task Force on National Health Care Reform in order to develop a comprehensive plan for universal health care for all Americans. Furthermore, Clinton named his wife—Hillary Rodham Clinton—as the chair of the task force, and gave her the responsibility of overseeing the development of a plan for health care reform.

Before creating the task force, President Clinton had already outlined the basic model of his proposal. During his presidential campaign, Clinton presented "a plan for universal coverage based on consumer choice among competing private health plans, operating under a cap on total spending"—what became known as "managed competition within a budget."[56] As such, Clinton prioritized economic aspects of reform and supported a move toward universal coverage, but tried to ensure that future costs would stay below current projections. As the task force—led by Ira Magaziner as director and Hillary Clinton as chair—began to work, it was clear that its responsibility was not to choose a policy for reform, but to develop the proposal that President Clinton had already

53. Ibid.

54. Leichter, ed., *Health Policy Reform in America*, 4-5.

55. Ezra Klein, "The Lessons of '94," *The American Prospect*, Jan. 22, 2008.

56. Paul Starr, "The Hillarycare Mythology," *The American Prospect*, Oct. 2007.

adopted. The president's continuing direct involvement in the policy-making process throughout 1993 reinforced the notion that he was personally invested in health care reform. The task force quickly became the subject of litigation stemming from the first lady's involvement in closed-door meetings related to the plan, and the president formally dissolved the group at the end of May. Throughout the rest of the summer, President Clinton personally led regular meetings with a small group of advisers and analysts (including both Magaziner and Hillary Clinton) to develop his proposal.[57]

Although political momentum had gathered behind national health care reform, President Clinton did not publicly announce his proposal until September 23, 1993, and the bill itself—the "Health Security Act" (H.S.A.)—was not presented to Congress until November 20, ten months after the president's inauguration. Clinton had been counting on the fact that Americans would be more concerned about the continuing effects of the economic recession of 1990-1991 than the possible expenses of comprehensive health care reform. During the months between Clinton's inauguration and the announcement of his proposal, however, the economy stabilized significantly. Americans grew less worried about the economic future and public enthusiasm for health care reform declined.[58]

Despite this shift, interest in some form of comprehensive health care reform remained strong in Washington. Significantly, most congressional leaders from both parties supported a form of universal coverage through either an employer mandate (forcing employers to provide coverage for all employees) or a mandate on individuals to buy insurance. In addition to support from legislators, health care providers and interest groups were surprisingly vocal in their support of significant changes to an industry even though it was highly profitable for them in its current form. Looking back, Paul Starr, a White House senior health policy adviser, recalled, "Nearly every major health care interest group had endorsed substantial reforms—grandiose ones, in fact."[59] This included both the American Medical Association and the Health Insurance Association of America—groups that were historically opposed to compulsory insurance but who now supported an employer mandate to ensure universal coverage. The U.S. Chamber of Commerce and many other large corporations also added their endorsement. It

57. Ibid.

58. Ezra Klein, a journalist, summarized the turn of events: "As the recession eased and unexpected economic changes looked less likely, reform grew scarier, and thus the 'fierce urgency of now' that animated the 1991 discussion over health reform dissolved before a bill had even been presented."—Klein, "The Lessons of '94."

59. Paul Starr, "What Happened to Health Care Reform?" *The American Prospect*, Dec. 1995.

seemed to many policy-makers that some version of comprehensive health-care reform could hardly fail.[60]

As expected, the reform bill presented by Clinton in November of 1993 was based on his model of managed competition within a budget. It was composed of five primary features: "guaranteed private insurance for everyone, choice of physician and health plan, elimination of unfair insurance practices, preservation of Medicare [for Americans over age 65 or disabled], [and] health benefits guaranteed through the worksite."[61] Clinton outlined six principles that his proposal would ensure: security, savings, simplicity, choice, quality and responsibility.[62] In order to achieve these goals, the Health Security Act was built around the development of regional health care alliances, which would "collect all of the money used to support health services from all sources," and "contract with provider networks and groups in their region to provide a package of health services for all persons enrolled."[63] The alliances would serve specific geographic areas based on population, and would act as nonprofit organizations operated by state governments. According to MMA, the alliances "would be responsible for controlling the price of health insurance and the cost of medical care, and they would determine what insurance plans could be offered."[64] This centralized management of funds and services would simplify the flow of money as well as the required paperwork. And, it was hoped, it would lower the costs of the entire system.

The Health Security Act included a strong employer mandate to ensure universal access to health care, while also allowing individuals to choose their own insurance plans. Every person not covered by Medicare would be required to purchase insurance through an alliance; no person could be refused coverage, regardless of preexisting health conditions. Plans that enrolled relatively older or sicker populations (that is, higher-risk pools) would receive more money from an alliance, whereas plans enrolling younger and healthier populations would receive less. This "managed competition" would force insurers to focus on providing quality service at low costs instead of protecting their profits by

60. Ibid.

61. Steven Jonas, *An Introduction to the U.S. Health Care System*, 4th ed. (New York: Springer Pub. Co., 1998), 179.

62. U.S. Congress, House, *Health Security Act*, Nov. 20, 1993, 103d Cong., 1st sess., HR 3600.

63. Jonas, *An Introduction to the U.S. Health Care System*, 180.

64. Steve Bowers, "What Will U.S. Health Care Reform Mean for the Church?" *Gospel Herald*, Dec. 28, 1993, 2.

strategies of attracting only healthy subscribers and using strict medical underwriting.[65]

The alliances would be responsible to decide which health insurance plans to offer in a given area, and individuals would have to purchase an approved plan. Individuals would pay 20 percent of the premium; the employer would cover the remaining 80 percent. Employers would have no say in the plans available to employees, and each person could choose from three types of coverage: a low-cost option similar to an H.M.O. (with practically no choice of health care providers); a high-cost option similar to a conventional fee-for-service or indemnity plan (with the most freedom to choose any provider); or a cost-sharing option similar to a P.P.O. Additionally, all individuals would be guaranteed access to basic health services, including preventative dental care; prescription drugs; routine eye and ear examinations; limited psychotherapy and inpatient psychiatric care; office visits to physicians and laboratories; outpatient care; and certain preventative care procedures such as immunizations, prenatal care and mammograms.[66] It was perhaps a sign of the incredible complexity of the American health care system that the final version of the Health Security Act—intended to help simplify health care—ran to more than 1,000 pages.

Responses to Clinton's comprehensive reform proposal were understandably mixed, but from the beginning the bill never garnered the national political support that many expected. Democrats in the White House and Congress advocating for reform were not prepared for the strong partisan opposition that quickly developed. The bill had been developed entirely in the White House, and Republican congressional leaders had little or no investment in it. Ezra Klein, a journalist covering the story, wrote, "Reformers were operating under the assumption that the rules of bipartisanship were still in effect and a collection of public-minded Senators would eventually come together to successfully complete the process. They were wrong."[67] Instead, Republican leaders—led by the conservative political strategist William Kristol—came out in strong opposition to the bill, claiming that it was overly bureaucratic and restrictive of individual choice, and that it generally represented "too much government."[68] In what later became known as the "Kristol Memos," Kristol advised leading Republicans:

---

65. Starr, "The Hillarycare Mythology."

66. Steve Bowers, "Health Care Reform: What Will It Mean for You and MMA?" *Sharing*, Winter 1993, 6.

67. Klein, "The Lessons of '94."

68. Senator Bob Dole (R-Kan.), quoted in Starr, "What Happened to Health Care Reform?"

> The Clinton proposal is a serious political threat to the Republican Party. Republicans must therefore clearly understand the political strategy implicit in the Clinton plan—and then adopt an aggressive and uncompromising counterstrategy designed to delegitimize the proposal and defeat its partisan purpose.[69]

Expecting big gains in the 1994 congressional elections, Republicans had fewer and fewer reasons to support the measure, and a growing number of political reasons to oppose it.

Meanwhile, businesses and interest groups also began organizing against the plan. The U.S. Chamber of Commerce reversed its earlier endorsement of an employer mandate and other business organizations quickly followed. The American Medical Association and Health Insurance Association of America both reversed their positions and came out strongly against employer mandates and government intervention in health care. According to Steven Jonas, a health care expert, "most of the medical, hospital, and insurance/managed care industry groups were arrayed against [the H.S.A.], for a variety of reasons, ranging from an antagonism to 'government regulation' to a concern with potential limitations on profit-making ability."[70]

Opponents of the Health Security Act were not limited to Republicans or conservatives. The left wing of the Democratic Party primarily favored a Canadian-style "single-payer" plan, whereby a single fund—generally the government—would be responsible for managing and paying for all health care costs. Single-payer systems were touted as an extremely simple way to ensure universal access to health care with low overhead costs, but were criticized for being characteristic of "Big Government" programs that supposedly suppressed the quality and innovation normally brought about by free market competition. Disappointed by the presence of health provider organizations in the H.S.A., single-payer advocates generally opposed the Clinton proposal in hopes that Congress would seriously consider their plan.[71] Already in March 1993, Senator Paul Wellstone, a Democrat from Minnesota, had introduced the American Health Security Act, the most comprehensive and feasible single-payer proposal in Congress.[72] While many analysts claimed that a single-payer plan would be too expensive, the

---

69. William Kristol, "Memorandum to Republican Leaders: Defeating President Clinton's Health Care Proposal," Dec. 2, 1993, Washington, D.C., quoted in Jonas, *An Introduction to the U.S. Health Care System*, 181.

70. Jonas, *An Introduction to the U.S. Health Care System*, 181.

71. Ibid.

72. U.S. Congress, Senate, *American Health Security Act of 1993*, Mar. 3, 1993, 103d Cong., 1st sess., S 491.

nonpartisan Congressional Budget Office commended Wellstone's plan for cost containment and estimated that its minimal overhead could save nearly $319 billion in federal health care costs over five years.[73] Dismissing the government as unable to manage such a large system, conservative Democrats favored a market-oriented system with little concern for universal coverage or spending caps. While attempting to develop a "workable compromise between market and regulatory approaches that could attract support from conservatives and liberals and thereby overcome the divisions that stood in the way of change," the Health Security Act failed to gain expected support from either side of the political spectrum.[74]

Lawmakers introduced many compromise proposals in an effort to garner enough bipartisan support for passage of a health care plan. Particularly notable were the Managed Competition Act (S 1579; HR 3222) spearheaded by Rep. James Cooper (D-Tenn.) and Sen. John Breaux (D-La.); the Affordable Health Care Now Act (S 1533; HR 3080) introduced by Sen. Trent Lott (R-Miss.) and Rep. Robert Michel (R-Ill.); and the Health Security and Access Reform Today Act (S 1770) introduced by Sen. John Chafee (R-R.I.). Both the Cooper/Breaux and Chafee bills rejected employer mandates, and were criticized for having inadequate proposals to finance the broad coverage provided.[75] Chafee's plan embraced a strong mandate on individuals to purchase insurance without employer assistance, but lacked money for the subsidies required to assist low-income persons. The weak Michel/Lott plan retained much of the current health care system unchanged, and simply limited premium increases to 15 percent per year.[76] When these compromise proposals failed to gain enough congressional support to be enacted, other leading legislators introduced more moderate proposals. These various proposals—introduced by Senators Daniel Patrick Moynihan (D-N.Y.), George Mitchell (D-Me.), Fred Grandy (R-Iowa), and Edward Kennedy (D-Mass.)—limited the percentage of health care costs that employers would have to pay in an attempt to reach agreement over the contentious issue of employer mandates.[77] Like Clinton's bill, all of these compromise plans failed to gain much public

73. Patrick Conover, Stephen Lee and Jeffrey Roth Martin, "Health Care Reform Advocacy Needed," Interreligious Health Care Access Campaign, Dec. 1993, 2, in file "Mennonite HCR Responses," from the personal files of Willard S. Krabill, Goshen, Ind. [hereafter cited as Krabill Files].

74. Starr, "The Hillarycare Mythology."

75. Starr, "What Happened to Health Care Reform?"

76. Conover, Lee and Martin, "Health Care Reform Advocacy Needed," 4.

77. Starr, "What Happened to Health Care Reform?"

support, and were generally considered unacceptable by both those supporting government regulation and those against it.

MENNONITE INVOLVEMENT IN HEALTH CARE REFORM

Far from passively observing the national proceedings, Mennonites in the early 1990s actively sought to "seize this historic opportunity" by putting forward a distinctly Mennonite position on health care reform.[78] Mennonite involvement in the health care industry included not only Mennonite Mutual Aid, but also thousands of Mennonite health care professionals and numerous Mennonite hospitals, nursing homes and mental health centers.[79] Until the election of Harris Wofford and the ensuing national focus on health care reform in early 1991, these groups had not developed a formal response. But in April 1991, the Council of Moderators and Secretaries—leaders of the Mennonite Church, the General Conference Mennonite Church and the Brethren in Christ—held a consultation in Chicago at the request of Mennonite Health Services, the organization of Mennonite health care institutions. At this meeting, the Council of Moderators and Secretaries encouraged Mennonite Health Association, the umbrella organization of all Mennonite health-related institutions, to "provide leadership for a Mennonite response to the health issues facing us today."[80] Responding to this request, Paul Kraybill, president of the Mennonite Health Association, organized a weekend conference—"Dialogue '92"—to take place on March 6 to 8 in Indianapolis, with the goal of bringing together Mennonite and Brethren in Christ pastors, conference leaders, health professionals, health care providers and caregivers to address the impending health crisis.[81]

The Dialogue '92 conference marked the beginning of an organized movement within Mennonite denominations to formally respond to the crisis. More than 160 participants attended the meeting—including representatives from both MMA and the Washington Office—and one of their dominant themes was the need for mutual accountability between the church and both health care and mutual aid institutions.[82] Amid a growing sense of disunity among the various Mennonite committees and

78. Health Dialogue Steering Committee, letter from various Mennonite institutions to legislators on Capitol Hill, June 15, 1994, in file "HC and Mennos, 1990s," Shelly Files.

79. Scot D. Yoder, "What is the Church Doing About the U.S. Health Care Crisis?" *Gospel Herald*, Oct. 20, 1992, 7.

80. Carl L. Good, "Dialogue '92 Steering Committee Meeting Minutes," Apr. 22, 1992, 1, in file "HDSC Minutes, 1992-94," Krabill Files.

81. Paul Kraybill, "Dialogue '92 Summary Task Force Report (Cover Letter)," Mar. 26, 1992, in file "Steering Committee, HDSC," Krabill Files.

82. Myron Ebersole et al., "Dialogue '92 Summary Task Force Report," Mar. 6-8, 1992, 2, in file "Steering Committee, HDSC," Krabill Files.

organizations, Dialogue '92 reflected a desire to increase intra-Mennonite cooperation on health care issues.

In an April 1992 meeting, the Dialogue '92 Steering Committee—a group of leaders from various Mennonite health-related organizations and denominational leadership—agreed to continue as an ad hoc group to "coordinate and lead Mennonite strategies of response to the health care issues and crisis and to challenge the people of our churches to take positive action toward these health issues."[83] After changing its name to the Health Dialogue Steering Committee in June 1992, the group continued to foster coordination among Mennonite institutions, and to educate Mennonites about health care issues.[84]

After Dialogue '92, the steering committee was asked to prepare a statement on health and healing to be considered as a denominational resolution on health care at the General Conference Mennonite Church's triennial assembly, July 22 to 26, 1992. The group agreed to do this, and delegates at that assembly adopted "A Resolution on Health Care," written by members of the Health Dialogue Steering Committee. The resolution recognized the growing health care crisis, and began by calling for a health care system that would provide "access to basic health care to everyone, everywhere in the United States . . . regardless of ability to pay."[85] Other emphases included the need for preventative care, greater acceptance of mortality and the limits of financial resources, and a desire to control costs. One year later, the Mennonite Church General Assembly adopted a similar resolution—also drafted by the steering committee—which included stronger language directed at Mennonite health-related institutions. Continuing to promote universal access to health care, the 1993 Mennonite Church resolution specifically called for "the personal and institutional sacrifices necessary to provide justice in the health care system." Futher, it asked institutions to "go beyond professional self-interest in responding to the health care

83. Good, "Dialogue '92 Steering Committee Meeting Minutes," Apr. 22, 1992, 2.

84. In June 1992, the H.D.S.C. was composed of James Waltner (chair), pastoral representative; Lawrence Greaser, Mennonite Health Association; Paul Kraybill, Mennonite Health Association; Gene Yoder, Mennonite Health Association board member and president of Greencroft, Inc. (a Mennonite retirement community); Anne Hershberger, Mennonite Nurses Association; Virginia Christophel, Mennonite Nurses Association; Vyron Schmidt, MMA; Carl Good, Mennonite Health Association; James Lapp, Council of Moderators and Secretaries; and Willard S. Krabill, Mennonite Medical Association. Virginia Christophel ceased to participate after February 1993. Dean Preheim-Bartel joined as the new executive director of Mennonite Health Association (replacing Paul Kraybill) in November 1992, and Scot D. Yoder regularly participated as a staff assistant assigned by MMA.

85. "A Resolution on Health Care," adopted at the U.S. Assembly of the General Conference Mennonite Church, Sioux Falls, S.D., July 22, 1992.—Available in the Mennonite Church USA Archives, North Newton, Kan.

crisis."[86] As both of these two largest Mennonite denominations adopted resolutions, the steering committee asked Mennonite institutions to seriously consider these official Mennonite statements when assessing strategies for health care reform.[87]

During the summer of 1992, the steering committee also acknowledged that both MMA and the Washington Office were participants in the Washington-based Interreligious Health Care Access Campaign, an ad hoc group representing a variety of religious faith organizations and Protestant denominations.[88] The steering committee was primarily concerned that Mennonite participation in the interreligious campaign should be coordinated between MMA and the Washington Office, and that the Washington Office should be responsive to the perspectives of other Mennonite groups working on health advocacy issues. Eldon Stoltzfus of MMA and Jalane Schmidt of the Washington Office both attended annual meetings of the Interreligious Health Care Access Campaign beginning in 1991, and the Washington Office actively pushed M.C.C.-U.S. to officially become a member of the organization.[89] Much like the positions of the Health Dialogue Steering Committee and both the General Conference and the Mennonite Church denominations, the interreligious campaign highlighted universal coverage as its primary guiding principle in evaluating legislative initiatives for health care reform. Thus, in late 1992 Mennonite groups seemed to be on the same page regarding health care reform, as the steering committee, the Washington Office and MMA all promoted universal coverage and recognized the need for significant reform involving "a new way of thinking about health care."[90]

Before long, however, disagreements over the best legislative proposal and the most appropriate way to publicly engage health care

---

86. "Resolution on Health Care in the United States," adopted at the Twelfth Mennonite Church General Assembly, Philadelphia, July 30, 1993. See *Proceedings: Twelfth Mennonite Church General Assembly*, 36-37; and *Workbook: Mennonite Church Convention and General Assembly*, 91-92, available in the AMC. The M.C. resolution also specifically questioned the ethics of MMA policies. It asked "the church and Mennonite Mutual Aid to reconsider the justice of commercial underwriting practices and find alternatives which embody the biblical ideals of justice and mutual aid."

87. See, e.g., Lawrence Greaser, "Health Dialogue Steering Committee Minutes," Feb. 24, 1994, 2, in file "HDSC Minutes, 1992-94," Krabill Files; Shelly, "Health Care Reform: MMA & MCC U.S."; and Scot D. Yoder, "What is the Church Doing About the U.S. Health Care Crisis?" 6-8.

88. See, e.g., Good, "Dialogue '92 Steering Committee Meeting Minutes," Apr. 22, 1992, 4; and Eldon Stoltzfus, "Report on the Annual Meeting of the Interreligious Health Care Access Campaign: Houston, Texas," June 28-30, 1992, in file "Mennonite HCR Responses," Krabill Files.

89. Good, "Dialogue '92 Steering Committee Meeting Minutes," Apr. 22, 1992, 4.

90. Mennonite Mutual Aid, "Guiding Principles," 2.

reform overshadowed whatever apparent unity had existed among Mennonite institutions. The split first became evident in early 1993 when the Interreligious Health Care Access Campaign formally endorsed the American Health Security Act—a proposal for a publicly-financed single-payer health care system—as the legislation best suited to provide universal and equal access to care, maintain quality benefits for all citizens, and preserve individual choice at limited cost. The Washington Office fully supported this endorsement and continued to participate actively in the interreligious campaign promoting the American Health Security Act. MMA, however, disagreed and withdrew from the Interreligious Health Care Access Campaign. Later that year it began working with a private legal consultant, Walter Vinyard, to promote a different sort of legislative solution to the health care crisis.[91]

Explaining the Washington Office's decision to support the American Health Security Act, Karl Shelly, a Washington Office legislative associate, wrote:

> MCC U.S. involvement in health care reform grows out of its work with the poor and marginalized in this country. . . . From the MCC U.S. office on Capitol Hill, we analyzed legislative reform proposals primarily seeking to discern their effect on poor and marginalized people.[92]

This focus on the "poor and marginalized" led the Washington Office to join the Mennonite denominations, MMA and the interreligious campaign in promoting universal coverage as a primary goal for any reform proposal. While later careful to clarify that it did not specifically endorse any one piece of legislation, the Washington Office (along with the interreligious campaign) clearly identified the American Health Security Act as the legislative proposal most closely aligned with its principles of universal coverage, cost containment, fair financing and comprehensive benefits. In May 1993, the M.C.C.-U.S. Executive Committee passed a motion, stating, "We support the Washington Office's continued involvement with the publicly financed (single payer)

---

91. For more on MMA's withdrawal from the I.H.C.A.C., see Ruth Harder, "Mennonite Mutual Aid: Ethics of Stewardship," May 2003, 4, in file "HC and Mennos, 1990s," Shelly Files; and Shelly, "Health Care Reform: MMA & MCC U.S." In a letter to Howard Brenneman on Dec. 8, 1993, Jeffrey Roth Martin (I.H.C.A.C.) stated that MMA was still a member of the I.H.C.A.C. However, other sources implied that MMA had never been an official member but had simply participated in the ad hoc group throughout 1991 and 1992. Regardless of its membership status, MMA ceased participation in the I.H.C.A.C. in 1993, apparently as a result of the group's endorsement of the A.H.S.A. See Jeffrey Roth Martin, letter to Howard Brenneman, Dec. 8, 1993, in file "HC and Mennos, 1990s," Shelly Files.

92. Karl Shelly, "Mennonites & the 1994 Health Care Debate," Apr. 1, 1995, 1-2, in file "HC and Mennos, 1990s," Shelly Files.

plan and [encourage it] to continue membership with the Interreligious Health Care Access Campaign."[93]

Earlier that same year, the Mennonite Health Association organized a second conference. Meeting in February 1993 in Anaheim, California under the title "Dialogue '93, Creating the New Community: From Dialogue to Action," the conference aimed to facilitate intra-Mennonite communication regarding health care reform. Willard S. Krabill, medical professional and Mennonite Medical Association representative on the steering committee, called the church to rally behind the Washington Office in support of the American Health Security Act. Krabill gave a side-by-side comparison of major health legislation proposed at the time and used the church's values (as outlined in the 1992 General Conference Mennonite Church resolution) as criteria to judge the proposals. In a challenge to those present, he argued, "If a single-payer health plan is obviously the best and most just policy approach, why then do we not go on record as supporting such a plan? Let's be honest and not resist change which is in the common good."[94] The Mennonite Health Association and the Health Dialogue Steering Committee were more cautious than Krabill, however, and were reluctant to give formal support to a specific legislative proposal. Jalane Schmidt from the Washington Office wrote that at the close of the conference, the steering committee decided "it would have to be 'very careful' with how it publicized some of Willard Krabill's address."[95] According to Schmidt, who clearly agreed with many of Krabill's conclusions, Krabill's informative and passionate presentation was not enough to convince the church to move "From Dialogue to Action."[96]

A primary cause of the hesitancy of the Mennonite Health Association and the steering committee to endorse the American Health Security Act was the fact that not all Mennonite institutions agreed that a single-payer plan was the best legislative option. Mennonite Mutual Aid, in particular, was pursuing a different strategy on Capitol Hill. In May 1992, MMA had adopted four "Guiding Principles for Responding to the Health Care Crisis," which were strikingly similar to those outlined in the resolutions later passed by the General Conference and Mennonite Church denominations.[97] Like the steering committee's resolution,

93. As quoted in Karl Shelly, letter to Jane White, Apr. 18, 1994, "MCC U.S. & Health Care Reform," in file "HC and Mennos, 1990s," Shelly Files.

94. Willard S. Krabill, quoted in Jalane Schmidt, "Notes on Dialogue '93: Anaheim, CA; Feb. 13, 1993," Mar. 22, 1993, in file "HC and Mennos, 1990s," Shelly Files.

95. Ibid.

96. Ibid.

97. Mennonite Mutual Aid, "Guiding Principles." The similarities between this document and the forthcoming H.D.S.C. resolutions were not coincidental; Vyron Schmidt

MMA's first principle called for a health care system able to provide "access to a basic level of care to everyone, everywhere in the United States."[98] Using these principles and MMA's mission statement, Scot D. Yoder, an MMA employee and staff assistant to the steering committee, evaluated the three predominant types of health care reform bills: free-market insurance reform; mandated employer coverage; and publicly financed (single-payer). Emphasizing that his report was neither scientifically conducted nor comprehensive—and that his results were therefore "as much hypotheses as conclusions"—Yoder concluded that "a shift to publicly financed health care would [be] more consistent with MMA's *Guiding Principles* than either free-market insurance reform or employer mandated coverage," but that it would also "have the most negative impact [on] MMA as a health insurer."[99] Yoder recognized that his analysis did not consider the political feasibility of any plan or whether a publicly financed system would be financially viable. Nevertheless, he argued that MMA's mission statement required it to give primary attention to "the biblical principles of stewardship and mutual aid," and that therefore the continued sale of insurance was of secondary concern.[100] Yoder also noted that the guiding principles adopted by MMA likely did not represent "the full range of values or considerations which are important to MMA." He continued, "Loyalty to the health insurance profession, loyalty to employees, and the natural tendency toward self-preservation are powerful forces influencing the organization."[101] There is little evidence that MMA's leadership seriously considered Yoder's report. Throughout 1992 and 1993 MMA continued to emphasize its guiding principles of universal coverage, preventative treatment, recognition of human mortality, and the necessity of some level of government involvement in health care.

When the Clinton proposal was announced in the fall of 1993, however, MMA's strategy shifted significantly. While both the Health Security Act and American Health Security Act contained aspects of universal coverage, MMA essentially ignored the American Health Security Act and quickly voiced three concerns about the Health Security Act. First, the regional Health Care Alliances proposed by Clinton would have the authority to decide which plans to offer in each area; so if not

---

from MMA wrote the first draft of what would later become the G.C. resolution of 1992.

98. Ibid.

99. Scot D. Yoder, "Evaluation of Health Care Reform Proposals Using Mennonite Mutual Aid's *Guiding Principles for Responding to the Health Care Crisis*" (Draft), July 1992, 12, 14, in file "HC and Mennos, 1990s," Shelly Files. Emphasis in the original. As a draft copy, the report was not likely distributed in this exact form.

100. Ibid., 16.

101. Ibid., 15.

approved by an alliance, MMA's plans would not be available to anyone in that area of service. Second, any health plan approved by an alliance would be forced to accept all who applied. Proponents of universal and equal access to health care viewed this as a positive aspect of the alliances, as it would no longer allow insurance agencies to deny coverage to applicants based on preexisting medical conditions. However, MMA received tax benefits as a nonprofit fraternal organization serving only Mennonites and other Anabaptist-related denominations; and it used the tax benefit money to provide grants to Mennonite congregations and individuals. Under the Health Security Act, "MMA would have to accept anyone who applied, regardless of religious affiliation."[102] Therefore MMA would no longer be allowed to operate as a fraternal organization, and would essentially be forced to operate like any other insurance organization or else pull out of the health insurance business entirely. Finally, MMA was concerned that some of its members—especially rural Mennonites—would refuse to participate in "a large [alliance] with many people who do not share our beliefs and values."[103] In feedback to MMA, Mennonite constituents often expressed concern about the proposed drastic changes in the health insurance field and indicated a desire to continue purchasing insurance through MMA.[104] This skepticism among constituents contributed to MMA's uneasiness regarding the Health Security Act.

While supporting the general principles behind health care reform and universal coverage, MMA wanted to be able to continue to serve its constituents in a similar manner under a reformed system—to "continue its purpose."[105] Predicting that the Clinton proposal was the reform legislation most likely to pass Congress, MMA therefore began contacting legislators and advocating for a "special legislative exemption" to allow it to "operate as a closed health plan for members of the Mennonite and related Anabaptist faith community."[106] MMA wanted to opt out of the alliances in order to continue to operate as a

102. Bowers, "Health Care Reform," 4.

103. Mennonite Mutual Aid, "Statement," Feb. 4, 1994, 2.

104. MMA Vice President Karl Sommers stated that at the time, he perceived overwhelming support from constituents for MMA's legislative strategy, and general uneasiness about the H.S.A. and other proposed reform bills.—Interview with Karl Sommers, Feb. 29, 2008. For raw data on the impressive results of a related MMA letter-writing campaign, see Keith Neuenschwander, "Grass Roots Mailing Response in Support of MMA Brown/Slattery Amendment to Members of the Energy and Commerce Committee," in the personal files of Karl Sommers, Goshen, Ind.

105. Sommers, interview by author, Feb. 29, 2008.

106. Mennonite Mutual Aid, "Health Care Reform: What You Need to Know," Nov. 1993, 2, in file "HDSC Minutes, 1992-94," Krabill Files; Mennonite Mutual Aid, "Statement," Feb. 4, 1994, 2.

closed market, "not open to members of the general public who do not share our beliefs and values."[107] The Health Security Act already contained an exemption allowing employers of more than 5,000 people to establish their own alliance; with 47,000 members (approximately 8 percent of eligible Anabaptists), MMA simply requested a similar exemption based on religious faith instead of an employer-employee relationship.[108]

In a November 1993 letter to Mennonite church leaders explaining MMA's approach to health care reform, MMA President Howard Brenneman attempted to convey three points: that MMA was supportive of universal coverage; that it had specific concerns with the Clinton plan as well as general concerns about any single-payer plan; and that MMA as an institution wanted to survive health care reform.[109] Workers in the Washington Office and the Interreligious Health Care Access Campaign expressed concerns that MMA's latter two points (criticizing the American Health Security Act and parts of the Health Security Act, as well as stating a desire for institutional self-preservation) were perhaps inconsistent with its first point (a continuing desire for universal coverage).[110] Karl Shelly, who was in charge of the Washington Office's involvement in health care reform, wrote:

> It is unclear to me how MMA's lobbying strategy of creating an exemption for itself in the Clinton plan benefits the millions of people without adequate health care. If MMA isn't taking the lead on this crucial aspect of the reform debate, we [M.C.C.'s

107. Mennonite Mutual Aid, "Statement," Feb. 4, 1994, 2.

108. Mennonite Mutual Aid, "Health Care Reform," 3. MMA claimed a membership of 47,000 out of approximately 600,000 people belonging to Mennonite and related Anabaptist churches. See also Mennonite Mutual Aid, "Statement," Feb. 4, 1994. Sommers strongly emphasized that MMA was not pursuing an exemption in order to take itself out of health care reform—or even out of the H.S.A.—but simply wanted permission to participate in the plan as a fraternal insurance organization. He regularly referred to MMA's strategy as an attempt to "continue its mission [of serving only Anabaptist-related groups] as part of the H.S.A." MMA was pursuing an "exemption" in the sense that it wanted to be exempt from the open membership requirements of the H.C.A.'s, as proposed in the H.S.A. In statements and press releases, MMA used various terms to describe what exactly it was pursuing: "a special exemption," "a legislative solution," an "exception," "the ability to opt out of the regional health alliances," or permission for members to "continue receiving their health coverage through Mennonite Mutual Aid." See, e.g., Mennonite Mutual Aid, "Health Care Reform," 3; Bowers, "Health Care Reform," 4; Bowers, "What Will U.S. Health Care Reform Mean for the Church?" 4; Mennonite Mutual Aid, "Statement," Feb. 4, 1994, 2; and U.S. Congress, House, *Resolution to Recognize Mennonite Mutual Aid*, July 14, 1994, 103d Cong., 2d sess., HR 478, 2, available in file "HC and Mennos, 1990s," Shelly Files.

109. Mennonite Mutual Aid, "Health Care Reform."

110. See, e.g., Karl Shelly, letter to Harold Nussbaum, Dec. 7, 1993, "MMA Letter Re: Health Care Reform," in file "HC and Mennos, 1990s," Shelly Files; and Martin, letter to Howard Brenneman, Dec. 8, 1993.

> Washington Office] should be explicitly providing an alternative message to our constituency.[111]

Brenneman maintained that a desire for universal coverage was consistent with MMA's specific concerns about the Health Security Act, and replied, "We believe universal access can be achieved by means that do not require a complete restructuring of the system such as the single payer approach would require."[112] Recognizing that MMA and the Washington Office were expressing different views on both the need for comprehensive reform to achieve universal coverage and the strength of a single-payer plan, Brenneman asked Karl Sommers, MMA's vice president of corporate planning, to begin regular discussions with Shelly and the Washington Office.[113]

In February 1994, representatives from the Washington Office and the Interreligious Health Care Access Campaign traveled to Rep. James Greenwood's office to encourage him to support the single-payer proposal or to strengthen universal coverage in Clinton's proposal. When Greenwood's aide informed them that neither Greenwood nor the Mennonite Church was interested in universal coverage, this misinformation confirmed Shelly's fears that mixed messages from Mennonite institutions were causing some confusion on Capitol Hill. Not only was Greenwood uninformed about the variety of Mennonite positions on health care reform, but he was also apparently unaware of MMA's official support for universal coverage.[114] After the Interreligious Health Care Access Campaign visit to Greenwood's office in February 1994—and the ensuing confusion among legislators about divergent Mennonite voices on Capitol Hill—the need for regular communication between MMA and the Washington Office became readily apparent, and the two institutions held a series of meetings throughout 1994 to discuss their differing approaches.[115]

---

111. Shelly, "MMA Letter Re: Health Care Reform."

112. Howard Brenneman, president and CEO of MMA, to Lynette Meck, executive secretary of M.C.C.-U.S., Jan. 6, 1994, in the personal files of Karl Sommers, Goshen, Ind.

113. Ibid.

114. This event is most clearly and succinctly outlined in Karl Shelly's letters to Lynette Meck and Harold Nussbaum, as well as Meck's personal notes from a phone conversation with Karl Sommers.—See Lynette Meck, "Notes from My Phone Conversation with Karl Sommers," Mar. 4, 1994, in file "HC and Mennos, 1990s," Shelly Files; Shelly, "MMA & Health Care Reform"; Shelly, "Health Care Reform & MMA"; and Karl Shelly, letter to Lynette Meck, May 24, 1994, "MMA's Exemption Strategy," 4-5, in file "HC and Mennos, 1990s," Shelly Files. For a slightly different version, see the notes of Karl Sommers, "The MCC Problem." The event was also conveyed in interviews with both Shelly (Feb. 11, 2008) and Sommers (Feb. 29, 2008). For summaries of this story—which was also widely retold in Mennonite news articles—see Harder, "Mennonite Mutual Aid"; and Shelly, "Health Care Reform: MMA & MCC U.S."

115. In addition to many phone conversations, letters and regular H.D.S.C. meetings,

Despite the fact that this was its first experience directly lobbying on Capitol Hill, MMA was quick to find congressional support for a special legislative exemption.[116] Working closely with lobbyist Walter Vinyard, MMA encouraged key legislators from Mennonite areas to support an amendment to Clinton's Health Security Act that would allow for MMA to operate as a religiously-based alliance.[117] With Vinyard's help, MMA staff members testified before a subgroup of the task force that helped shape the Clinton proposal, as well as at a series of congressional hearings sponsored by two Kansas Republican senators, Robert Dole and Nancy Kassebaum, and Representative Pat Roberts.[118] When talking with prominent legislators, as Greenwood's statements suggest, MMA's desire for an amendment to the Health Security Act overshadowed its secondary goal of universal coverage.[119] While MMA maintained that its desire for an exemption went hand-in-hand with a desire for universal coverage, it remained hesitant to vocally support universal coverage on Capitol Hill—or even to encourage constituents to advocate for universal coverage, comprehensive benefits and cost containment—out of fear that this message might interfere with its amendment strategy.[120]

---

the primary meetings between representatives of MMA and the Washington Office during 1994 took place on Jan. 12 (between Karl Shelly, Washington Office; Nancy Chupp, Church Women United; and Karl Sommers, MMA) and March 1 (Karl Shelly and Ken Martens Friesen, Washington Office; Karl Sommers, MMA) in Washington, D.C.; March 22 in Indianapolis, Ind. (Karl Shelly, Washington Office; Harold Nussbaum, M.C.C.-U.S.; Steve Bowers and Karl Sommers, MMA); April 8 in conjunction with the M.H.A. Assembly in Columbus, Ohio (Karl Shelly, Washington Office; Jeffrey Roth Martin, I.H.C.A.C; Howard Brenneman, Vyron Schmidt, Karl Sommers and Scot D. Yoder, MMA); and July 11 in Pittsburgh, Pa. (three members of the MMA board; Howard Brenneman, MMA; three members of the M.C.C.-U.S. executive committee; Lynette Meck, M.C.C.-U.S. executive secretary). Karl Sommers later added that during this period, he visited the Washington Office to touch base every time he was doing business in Washington.

116. Sommers, interview by author, Feb. 29, 2008.

117. While his assertion remains unsubstantiated, Graber Miller claimed that MMA spent more money pursuing its legislative solution than the Washington Office's entire annual budget. According to Graber Miller, the annual budget of the Washington Office was approximately $175,000. See Graber Miller, *Wise as Serpents*, 114, 233, fn. 113.

118. Mennonite Mutual Aid, "Health Care Reform," 3.

119. In a meeting with the Washington Office, representatives from MMA stated that "MMA informs the congressional offices [we] visit that MMA is for universal access," and continued to assert that their desire to be included in the H.S.A. implicitly expressed support for universal coverage. See Karl Shelly, "MCC U.S./MMA Meeting in Indianapolis, Ind.," Mar. 22, 1994, in file "HC and Mennos, 1990s," Shelly Files.

120. See Karl Shelly, "Mennonite Health Association Assembly: Columbus, OH, Apr. 7-10, 1994," 3, in file "HC and Mennos, 1990s," Shelly Files; and Shelly, "MMA's Exemption Strategy," 5. MMA later cooperated with the Washington Office to write a letter encouraging Mennonites to advocate for universal coverage, among other things. See Health Dialogue Steering Committee, "Health Care Reform Call to Action," May 1994, in file "HDSC Minutes, 1992-94," Krabill Files. In private conversations with certain legislators—e.g., Rep. Pete Stark (D-Calif.)—MMA made its position on universal coverage clear. See Shelly, "Mennonite Health Association Assembly," 1; and Steve Bowers,

Karl Shelly from the Washington Office and Karl Sommers from MMA disagreed about the relationship between MMA's desired exemption and the broader goal of universal coverage. Sommers emphasized that MMA supported both health care reform and the Health Security Act, but the agency did not want to be excluded from the health insurance business as a fraternal organization serving only Anabaptist-related denominations. According to Sommers, MMA took the most practical approach to supporting universal coverage by trying to become a part of the Health Security Act, which MMA believed would likely pass Congress. "We were quite willing to be subject to the rules of the plan," Sommers said, except the requirement "that we had to accept everyone. As a fraternal organization, we wanted to be able to participate. Our only concern was being able to exclude people."[121] MMA wanted to support the principle of universal coverage, while in practice continuing to serve only Anabaptist-related denominations.

Karl Shelly and the Washington Office worried that MMA's policy of seeking an exemption was undermining the broader goal of universal coverage. In Clinton's proposal, the health care alliances were crucial in providing universal access. With the creation of large risk pools—including the young and old, healthy and sick—the alliances would be able to adequately spread risk and maintain the resources to care for the sick. By seeking to be exempt from participation in the alliances, MMA was in effect refusing to take part in helping provide universal coverage. Shelly argued that if MMA withdrew from the alliances and formed a smaller risk pool exclusively of Mennonites—who were statistically healthier and less likely to have high health care costs—those left behind would be less able to care for each other.[122] In a presentation at the Mennonite Health Assembly in April 1994, Jane White—a Mennonite editor of the health policy journal *Health Affairs*—described the creation of health care alliances as "the federal government picking up the role of mutual aid and providing coverage for the millions [who] don't now have it."[123] As the Washington Office saw it, by seeking an exemption from mandatory alliances, MMA was withdrawing from the system that would provide universal coverage. While the Health Security Act would theoretically continue to operate and provide universal coverage without the involvement of MMA, Shelly wrote, "The MMA strategy is *at best* irrelevant to most of those in need and to the issue of universal

---

"Meeting Summary: Mennonite Central Committee and Mennonite Mutual Aid; First Mennonite Church, Indianapolis, Ind.," Mar. 22, 1994, in the personal files of Karl Sommers, Goshen, Ind.

121 Sommers, interview by author, Feb. 29, 2008.

122. Shelly, "MMA's Exemption Strategy," 5.

123. Jane White, quoted in Shelly, "Mennonite Health Association Assembly," 1-2.

coverage."[124] Although MMA staff insisted that they consistently informed congressional offices of their support for universal coverage, legislators interpreted MMA's message as confusing, if not contradictory.[125] It was quickly becoming clear that even though both organizations were using the language of universal coverage, MMA and the Washington Office were pursuing different goals for health care reform.

Analyzing Institutional Differences

While there were many differences between MMA and the Washington Office—and many reasons for their divergent views on health care reform—their disagreements primarily stemmed from two related organizational differences. First, MMA and the Washington Office acted out of different operational models drawn from their respective organizational fields. By responding only to the Health Security Act—the plan that was perceived as the most likely to pass Congress—MMA took a pragmatic approach that would allow the institution to continue operating and serving its clients. In his notes from a March 22 meeting in Indianapolis, an MMA employee, Steve Bowers, wrote, "MMA has chosen to plug in at a point that it believes is the most likely outcome and to push toward universal access from that point."[126] Sommers recognized this approach as "simply a business decision like any other." He recalled thinking, "[The Health Security Act] looks like it's gaining ground, so let's become a part of it."[127] As a business, MMA also had a vested interest in institutional self-preservation and in responding to the desires of its members. In a letter to M.C.C.-U.S. Executive Secretary Lynette Meck, Howard Brenneman wrote:

> We believe Mennonites expect MMA to reflect the values relating to stewardship and mutual aid in the delivery of health care. We know the church expects us to do all we can to see that our unique values are expressed. Were it not for our strong beliefs about stewardship and mutual aid issues, we may not feel as strongly about the need to survive in health care long term.[128]

---

124. Shelly, "MMA's Exemption Strategy," 2, emphasis in the original.

125. See, e.g., J. Lorne Peachey, "White to MMA and MCC: 'Get Your Acts Together,'" *Gospel Herald*, Apr. 26, 1994, 10; and Shelly, "Mennonite Health Association Assembly." See also Shelly, "MMA's Exemption Strategy," 4. Greenwood's statements are the clearest examples of the confusion caused by MMA's legislative strategy.

126. Bowers, "Meeting Summary."

127. Sommers, interview by author, Feb. 29, 2008.

128. Brenneman, letter to Lynette Meck, Jan. 6, 1994.

Perceiving a clear mandate from its members and the church to stay in business, MMA openly recognized its desire to continue operating as an insurance agency. In that context, actively promoting universal access to health care became secondary to concerns about the future of the organization and its continuing ability to serve the Mennonite Church. To be sure, MMA refused to join most other insurance organizations—despite being a member of the Health Insurance Association of America—in attacking the Health Security Act; but by withdrawing from health care alliances and refusing to support non-Mennonites, MMA's pursuit of a legislative exemption tended to weaken aspects of universal coverage in the Health Security Act. Additionally, like most insurance companies, the leaders of MMA were skeptical of the ability of the government to efficiently manage a single-payer health care system.[129]

The Washington Office, by contrast, operated out of a conceptual framework that led it to "plug into the legislative process at a point that is ahead of what is likely to emerge as final legislation in hopes of pulling the outcome toward universal access."[130] By supporting the plan that best represented its primary goal of universal coverage, the Washington Office pushed both the church and MMA to consider the needs of those outside the church above the interests of Mennonite constituents. The Washington Office recognized that the single-payer proposal was not likely to pass Congress, but saw this as an opportunity to push legislators to include universal coverage in any new proposal for health care reform. As evidenced by the work of the Interreligious Health Care Access Campaign, many religious lobbying groups in the nation's capital took a similar stance in calling the government to care for the poor and the uninsured.

Second, MMA and the Washington Office had different understandings of their roles on Capitol Hill. They sought to represent the conflicting interests of different groups of people. MMA acted out of its own institutional self-interest and what it perceived to be the interests of its constituents, based on the belief that it provided a unique and distinctly Mennonite approach to health insurance. Having been given approval from the Mennonite Church for its mission of leading "Mennonites and related groups toward greater practice of the biblical principles of stewardship and mutual aid," MMA sought primarily to

129. See, e.g., Karl Shelly, "Meeting with Karl Sommers (MMA Vice President); Nancy Chupp; Karl Shelly," Jan. 12, 1994, in file "HC and Mennos, 1990s," Shelly Files.

130. Bowers, "Meeting Summary." Karl Shelly emphasized that by strengthening the position of a single-payer system and making the eventual goal of universal coverage more possible, the Washington Office was taking a "pragmatic" approach as well. See Shelly, "MCC U.S./MMA Meeting," 2.

"serve and support those who are already part of the church."[131] While promoting universal coverage, MMA understood its primary mission to be providing insurance coverage for Anabaptists, not for uninsured people outside the church community. Karl Sommers clarified this point:

> We felt that our purpose was to serve our own members, and if we could provide in some way universal coverage for them, we were doing our share of the total. . . . Our role was to care for our community of faith. . . . We were really trying to do all we could to carry that part out. We were trying to be responsible for that part.[132]

When questioned about MMA's role in caring for the poor, Sommers responded, "It is the role of the church to reach out to the poor and oppressed. It is the role of MMA to support church members in this activity with various mutual aid programs."[133] By responding to the needs and concerns of its constituents, MMA strove to fulfill its mission of providing mutual aid and stewardship for the church.

The Washington Office, on the other hand, was more explicitly outward focused in its mission to "stand with the poor through advocacy on Capitol Hill."[134] While acting out of the Mennonite Church and General Conference Mennonite Church resolutions on health care and representing what it understood to be "the best of Mennonite theology," the Washington Office did not claim to support health care reform that would best serve and benefit Mennonites.[135] In fact, the Washington Office explicitly recognized an apparent tension between Mennonite middle- and upper-class interests and its role of advocacy for the poor. In an interview with Keith Graber Miller, M.C.C.-U.S. board member Susan Goering said, "If we were talking about just representing our interests . . . it would be a very different message [than we have now], because our interests would be with an unjust system that favors rich or middle-class North Americans." She continued, "I hope that [the Washington Office] represents our faith perspective as we best understand it. The Washington Office shouldn't be for the economic interests or even the social welfare interests of Mennonites."[136]

---

131. The first quote is from MMA's mission statement, quoted in Scot D. Yoder, "Evaluation of Health Care Reform Proposals," 1. The second quote is from Bowers, "Meeting Summary."

132. Sommers, interview by author, Feb. 29, 2008.

133. Karl Sommers, memo to Howard Brenneman, July 8, 1994, "MMA-MCC Meeting Materials for July 11," 5, in the personal files of Karl Sommers, Goshen, Ind.

134. Karl Shelly, facsimile to Lynette Meck, Mar. 9, 1994, "MCC U.S. Board & Health Care Reform," in file "HC and Mennos, 1990s," Shelly Files.

135. Shelly, interview by author, Mar. 3, 2008.

136. Susan Goering, interview with Keith Graber Miller, Nov. 8, 1992, quoted in Graber Miller, *Wise as Serpents*, 113.

Considering the question of whom the Washington Office should "speak for" in Washington, Karl Shelly summarized his analysis of the situation:

> The key question should be "does our self-interest work against the interests of the poor?" If so, we need to be willing to sacrifice our self-interest or find ways in which our self-interest does not adversely affect those already hurting. Health care reform has proved to be an issue where the self-interest of many Mennonites is competing with the interests of those most in need.[137]

When Mennonite self-interests were found to be in conflict with the interests of the poor and oppressed, the Washington Office consciously chose to continue advocating on behalf of the poor. As a business, MMA made the opposite decision. In a memo to Howard Brenneman, Sommers wrote, "It is not feasible nor is it responsible for MMA to advocate strongly for legislation that would be adverse to its members."[138]

Because they were representing different interests, MMA and the Washington Office brought different messages to Capitol Hill. The Washington Office analyzed health care reform from the perspective of the poor, while MMA was primarily concerned with how reform would affect its Mennonite constituents.[139] These differences were not arbitrary, but grew directly out of the mission statements of each institution. After a meeting between board members of both MMA and M.C.C.-U.S. in July 1994, M.C.C.-U.S. Executive Secretary Lynette Meck concluded:

> MMA analyzes healthcare reform from the perspective of a health insurance and mutual aid agency that was established to carry out a Mennonite tradition of mutual care within the church. MCC U.S.' mission is to address human need in the United States. It analyzes healthcare from the perspective of what best serves the needs of the "poorest of the poor" in the United States.[140]

MMA tried to maintain its tradition of serving the church with health insurance, while the Washington Office pushed MMA to widen its perspective and consider the plight of those outside the church.

MENNONITE COOPERATIVE EFFORTS AND THE COLLAPSE OF COMPREHENSIVE REFORM

Mennonite reactions to the tensions between MMA and the Washington Office were mixed. In late 1993, the Mennonite Church

137. Shelly, "MCC U.S. Board & Health Care Reform," 2.

138. Sommers "MMA-MCC Meeting," 3.

139. Shelly, "Meeting with Karl Sommers."

140. Lynette Meck, "Meeting of MMA and MCC U.S. Board Members; Pittsburgh, Pennsylvania," July 11, 1994, in file "HC and Mennos, 1990s," Shelly Files.

General Board performed an in-depth review of MMA and approved its legislative strategy for health care reform.[141] The general secretary of the Mennonite Church, James Lapp, wrote, "The General Board gave strong affirmation to MMA's work on health care reform and encouraged them to continue working with government to find acceptable solutions to the concerns."[142] Specifically, the General Board affirmed MMA's legislative exemption as a "responsible solution" to the health care crisis.[143] After the event at Rep. Greenwood's office in February 1994, Lapp complied with a request from MMA to lend credibility to its exemption strategy by writing to Representatives Sherrod Brown (D-Ohio), James Slattery (D-Kan.) and James Greenwood (R-Pa.). In his letters of March 11, 1994, Lapp clarified MMA's status as an official program board of the Mennonite Church, and encouraged the representatives to support MMA's request for a legislative exemption.[144]

In January 1994, the Health Dialogue Steering Committee released a report exploring the various options for health care reform and essentially approved the strategy of the Washington Office. While recognizing that Mennonite groups would not agree on specific legislative proposals, the report once again emphasized the primacy of universal access and the responsibility of the church to speak on behalf of the poor.[145] Some members of this group were frustrated when they later discovered that Lapp had conveyed his approval of MMA's strategy to legislators. They feared that the representatives would interpret the General Board's support as an endorsement of the Health Security Act as opposed to a single-payer solution such as the American Health Security Act.[146]

---

141. Mennonite Church General Board, "Response to the MMA Indepth Review," in file "Mennonite Mutual Aid, 1993-1995," Mennonite Church General Board Official Records, 1993-1995 (I-6-5, Box 3, Set 8), AMC. The report affirmed MMA for "active contributions to the health care reform process, and the variety of efforts being made to enable MMA's health plans to continue."

142. James M. Lapp, letter to Sherrod Brown, Mar. 11, 1994.—Available in the AMC, file entitled "Mennonite Mutual Aid, 1993-1995," Mennonite Church General Board Official Records, 1993-1995 (I-6-5, Box 3, Set 8).

143. Ibid.

144. See Lapp's letters to Sherrod Brown, James Greenwood and James Slattery, Mar. 11, 1994. Available in the AMC, file entitled "Mennonite Mutual Aid, 1993-1995," Mennonite Church General Board Official Records, 1993-1995 (I-6-5, Box 3, Set 8). This expression of "official support" was possible partially because MMA had direct organizational ties to the Mennonite Church. It may have been more difficult for the Washington Office to receive this type of formal affirmation, given its structural independence from the Mennonite Church.

145. Health Dialogue Steering Committee, "Health Care Reform: An Opportunity for the Church," Jan. 18, 1994, 13, in file "HDSC Minutes, 1992-94," Krabill Files.

146. Specifically, Willard S. Krabill (Mennonite Medical Association representative on the H.D.S.C.), Ted Koontz (MMA board member) and Norman Kauffmann (dean of

As both MMA and the Washington Office advocated for different forms of legislative action on Capitol Hill, questions of the importance of speaking with a "united voice" continued to surface. Many church leaders and external observers urged MMA and the Washington Office to present a more unified position.[147] In response to requests for unity, Karl Shelly wrote, "In a non-hierarchical church like ours, with a diverse constituency, we need to tolerate the occasional uncomfortableness that will come with speaking to an issue with more than one voice."[148] In mid-1994, however, as the national debate shifted from specific legislative proposals to the sacrifices necessary to ensure universal coverage, MMA and the Washington Office strove to bridge their differences, and cooperated in specific joint efforts for health care reform. To foster better communication between the institutions, Karl Shelly joined the Health Dialogue Steering Committee in April 1994 as a representative of M.C.C.-U.S.[149] After encouragement from Jane White at the Mennonite Health Assembly in April 1994, MMA and the Washington Office decided to publicly emphasize their common desire for universal coverage. With the help of the steering committee, the two institutions drafted a joint "call to action" that was sent to Mennonite pastors and leaders in May 1994. This letter, which was officially sent from the steering committee, encouraged Mennonites to write to their legislators in support of universal coverage and comprehensive reform.[150] The two institutions also issued a joint press release recognizing their "differing points of emphasis," but ultimately highlighting their unified support of universal coverage.[151] Following these joint efforts, Shelly—on behalf of the committee—drafted a letter to legislators encouraging support of universal coverage, comprehensive basic benefits, fair and equitable financing, and cost containment (with the stipulation that it was not to be achieved "by denying coverage to people or undermining quality care").[152] This letter, dated June 15, 1994,

---

students at Goshen College, Goshen, Ind.) expressed these concerns to James Lapp on May 5, 1994.—See Lapp's handwritten notes on James M. Lapp, "Health Care Concerns," May 6, 1994, in file "Mennonite Mutual Aid, 1993-1995," Mennonite Church General Board Official Records, 1993-1995 (I-6-5, Box 3, Set 8), AMC.

147. See, e.g., Jane White's address to the M.H.A. Assembly in April 1994, reported in Peachey, "White to MMA and MCC: 'Get Your Acts Together,'" 10. This desire for unity was present from the early stages of Mennonite involvement in health care reform, and was a central motivation for the organization of the Dialogue '92 and '93 conferences as well.

148. Shelly, "MCC U.S. Board & Health Care Reform," 3.

149. Greaser, "Health Dialogue Steering Committee Minutes," Apr. 15, 1994.

150. Health Dialogue Steering Committee, "Health Care Reform Call to Action."

151. Mennonite Mutual Aid, "MCC U.S.-MMA Call for Universal Heath Care Coverage," May 9, 1994, in file "HDSC Minutes, 1992-94," Krabill Files.

152. Health Dialogue Steering Committee, letter from various Mennonite institutions to legislators on Capitol Hill, June 15, 1994. The letter was signed by Vern Preheim, general

was signed by the leaders of the General Conference and Mennonite Church denominations, the steering committee, M.C.C.-U.S., MMA, Mennonite Health Association, Mennonite Health Services, Mennonite Medical Association and Mennonite Nurses Association.

Despite these joint efforts by MMA and the Washington Office, both groups continued pursuing different legislative strategies aimed at achieving different legislative goals. MMA pursued its legislative exemption, and the Washington Office continued working with the Interreligious Health Care Access Campaign to promote the American Health Security Act or another single-payer solution. Rep. Sherrod Brown (D-Ohio) introduced MMA's amendment into the House of Representatives in July, but by that time Congress had essentially refused to enact any plan that included mandatory health care alliances.[153] Throughout 1994, Congress failed to support any bill addressing comprehensive health care reform. On September 26, 1994, Senate Majority Leader George Mitchell (D-Me.) held a news conference in which he proclaimed that the initiative was dead for the current congressional year. Public opinion surveys continued to show strong support for many of the ingredients of reform, but, as Paul Starr wrote, "the complexity of the plans and onslaught of criticism had even left many supporters bewildered and uncertain."[154] By November 1994, a newly-elected Republican majority in both chambers essentially assured the end of the reform effort.

Following the collapse of comprehensive health care reform, analysts put forward various arguments explaining the failure of a reform movement whose success in late 1992 and early 1993 had seemed almost inevitable: biased media coverage; the complexity of the reform bills; the negative media and lobbying campaign by the insurance industry; various failures of the Clinton Administration in the planning and promotion of the Health Security Act; congressional partisanship; and a general public fear of "Big Government."[155] Explaining the failure of universal coverage, Starr wrote, "Congress would not enact the

---

secretary, G.C.; Lynette Meck, executive director, M.C.C.-U.S.; Donella Clemens, moderator, M.C.; James M. Lapp, general secretary, M.C.; Dean Preheim-Bartel, executive director, M.H.A.; James H. Waltner, chair, H.D.S.C.; Carl L. Good, executive director, M.H.S.; Milton Claassen, president, Mennonite Medical Association; Howard L. Brenneman, president, MMA; and Mary J. Dyck, president, M.N.A.

153. The amendment read, in part, "*Resolved*, That in any national health insurance reform legislation that provides for universal coverage, there be a provision that permits Mennonites to continue receiving their health coverage through Mennonite Mutual Aid." See U.S. Congress, *Resolution to Recognize Mennonite Mutual Aid*, emphasis in the original.

154. Starr, "What Happened to Health Care Reform?"

155. Leichter, ed., *Health Policy Reform in America*, 4. See also Klein, "The Lessons of '94"; Starr, "What Happened to Health Care Reform?" and Starr, "The Hillarycare Mythology."

employer mandate in any form, and when the mandate failed, so did universal coverage, because there was no willingness to consider a broad-based tax."[156] While special interest groups (such as the Health Insurance Association of America, the American Medical Association and the U.S. Chamber of Commerce) were willing to support an employer mandate instead of a tax-financed system in 1993, no group was willing to actively promote it in the face of resistance from the small-business lobby in 1994.[157] In a 1995 article for a Mennonite Medical Association newsletter, Karl Shelly wrote, "Interestingly, special interest groups never directly lobbied against universal health insurance coverage; rather, they each argued that they should be exempt from sacrifice."[158] Despite widespread support for universal coverage, this consistent unwillingness of various parties to sacrifice in the interests of others ultimately undermined any hope for the implementation of a system ensuring such coverage.

CONCLUSION

In this analysis of the responses of MMA and the Washington Office to health care reform, a natural tension emerges between self-interest and other-interest. While MMA faithfully represented the self-interests of many of its members—and thus claimed to be "speaking for" Mennonites—the Washington Office sought to push Mennonites by advocating for the interests of the poor and oppressed, representing what it understood to be the "best of [Mennonite] theological-ethical traditions."[159] Each institution, in a way, did represent Mennonites and the Mennonite Church. In most circumstances, both institutions recognized that a lively balance between self-interest and other-interest would be a necessary and ethically-sound goal. In the case of health care reform, Mennonites were forced to consider what would be a responsible position when Mennonite interests seemingly come in direct conflict with the interests of the larger society. MMA and the Washington Office were charged with the difficult task of weighing the loss of Mennonite Mutual Aid's fraternal health insurance organization against the possible benefits of a health care system that would "provide access to basic health care for everyone, everywhere in the United States."[160] As

156. Starr, "What Happened to Health Care Reform?"

157. Ibid.

158. Shelly, "Mennonites & the 1994 Health Care Debate," 5. See also Willard S. Krabill, "U.S. Health Care in Crisis: Wanting Everything, and Wanting It Now," *Gospel Herald*, Sept. 1, 1992, 8.

159. Graber Miller, *Wise as Serpents*, 115.

160. "Resolution on Health Care in the United States," July 30, 1993.

relatively small presences on Capitol Hill, neither MMA nor the Washington Office had a substantial influence on the congressional decision-making process, but they each had significant influence on the perspectives of Mennonite constituents.

Fifteen years later, national health care reform remains a frequent topic in American political and public discourse. In 2003, the Anabaptist Center for Healthcare Ethics—an organization sponsored by MMA, Mennonite Health Services, Mennonite Medical Association, Mennonite Nurses Association and the Mennonite Chaplains Association—asked Mennonite Church USA (MC-USA) delegates to adopt a new "Resolution on Health Care in the United States," and to approve an "Access Initiative" focused on promoting "access to health care for all persons," beginning with Anabaptist congregations.[161] Growing out of this initiative, delegates to the MC-USA assembly in 2007 approved a plan to provide "basic health insurance for all eligible pastors."[162] While this represents only a small part of the universal coverage called for in the early 1990s, it reveals that both the health care crisis and demands for universal coverage remain present. Mennonite institutions will continue to struggle with tensions between business and church, between group-interest and the interests of the broader society. When comprehensive health care reform again becomes a subject of congressional attention, how will Mennonites respond? The past discussion over health care reform provided a lesson emphasizing the need for communication and accountability among various Mennonite agencies, especially when lobbying on Capitol Hill. When health care reform enters the political agenda again, the challenge for the Mennonite Church will be to have structures and understandings in place to anticipate and respond to the inevitably varied messages from Mennonite institutions.

161. "Health Care Access Resolutions for Delegates," adopted at the Mennonite Church USA Delegate Assembly, Atlanta, Ga., Apr. 17, 2003. See *Delegate Workbook: Assembly of Mennonite Church USA*, 66-71; and *Minutes: Assembly of Mennonite Church USA*, 35-40, available in the AMC.

162. "Mennonite Church USA Healthcare Access Summary," adopted at the Mennonite Church USA Delegate Assembly, San José, Calif., July 6, 2007. See *Minutes: San José 2007 Mennonite Church USA Delegate Assembly*, 33-34; and "Healthcare Access" in *Delegate Assembly Workbook: San José 2007 Mennonite Church USA Delegate Assembly*, 92-105, available in the AMC.