

Denominational Health Task Force

Summary Report
March 2007



Living Abundantly

*"I came that they may have life,
and have it abundantly."*

John 10:10b



GENERAL BOARD OF PENSION AND HEALTH BENEFITS
OF THE UNITED METHODIST CHURCH

Caring For Those Who Serve

March 2007

General Conference 2004 directed the General Board of Pension and Health Benefits (General Board) to examine the feasibility of a unified health plan for the denomination. To conduct the study, the General Board assembled the Denominational Health Task Force (Task Force).

Wesleyan values and theology guided the efforts of the Task Force to focus on health as a communal endeavor requiring both compassion and accountability.

As the Task Force, we began our work by establishing broad objectives to guide our assessment of the Church's progress toward improved health across the denomination.

Our findings, and the conclusions we drew from them, resulted in four recommendations that focus on clergy and lay employee health in support of the mission and ministry of the Church.

We explored approaches across the denomination to support the health of clergy and lay employees; examined the employment systems and culture that affect their health; considered ways to ensure group health plan access for full-time clergy and lay employees; and sought to foster the health and wholeness of retired clergy, lay employees and their spouses.

This *Summary Report* brings the denomination's health challenge to you in practical terms in preparation for General Conference 2008. Health will become a central focus for us in the coming years, as it will for the U.S. and the world-at-large. In order for the Church to strengthen its ministry, health is an issue we must address now because it will impact us all.

Respectfully submitted,

The Denominational Health Task Force

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Overview

General Conference 2004 directed the General Board to examine the feasibility of a unified health plan for the denomination. To conduct the study, the General Board assembled the Task Force.

Task Force Charge

The work of the Task Force was guided by the mission of The United Methodist Church to make disciples of Jesus Christ for the transformation of the world. The highest value is to faithfully fulfill the mission of the Church, ensuring a healthy leadership.

The Task Force embarked on this denominational journey to better health by considering the *broader issues* related to the health of clergy and lay employees of the Church and the assets available for addressing them.

Process and Conclusion

The Task Force found that it could *not* recommend a unified health insurance plan for the denomination at this time. The United Methodist Church has a “health” problem, not merely a “health insurance” problem. If a unified plan were approved and upheld by the Judicial Council, the expected cost savings (premium increase would be reduced by 3% to 5%) would be achieved primarily by pooling or group purchasing administrative services. The biggest factor contributing to the high cost of a unified plan is the ill health of clergy and lay employees.

Other Task Force considerations as to why a unified plan is not feasible include conference autonomy, political issues regarding access and delivery of health care and the desire to gain the advantages of a unified plan in other ways.

After two and a half years of research, discussion and feedback between the Task Force and groups across the denomination, four recommendations emerged. The Task Force concluded that the denomination should focus on improving the health of employees to ensure the vitality of the Church’s ministry, rather than focusing on cost (a symptom of broader, underlying issues). The four Task Force recommendations focus on a new, unified effort to foster better health for the employees of the Church in order to strengthen ministry around the world.

Recommendations

The Task Force has presented the recommendations and draft legislation to the Board of Directors of the General Board of Pension and Health Benefits.

Although the Task Force has provided a framework for encouraging better health, the recommendations must be carried out in connection. The annual conferences, the Council of Bishops, the general agencies and the local churches each have a role in taking actions to improve the health of clergy and lay employees of the Church.

Summary Report

This report summarizes the work of the Denominational Health Task Force.

Values and Theology

Wesleyan values and theology guided the efforts of the Task Force to focus on health as a communal endeavor requiring both compassion and accountability.

Values

Wesleyan tradition and values guided the work of the Task Force. These values are:

- defining health as wholeness through and for God's mission,
- providing stewardship for health,
- acting connectionally,
- balancing compassion and accountability, and
- offering prophetic witness.

(See Appendix for details.)

Theology

The Task Force recognized that an aspect of the General Conference charge was to support the health of Church employees and, in doing so, strengthen the vital ministry of clergy and lay employees. Their work was rooted in Wesleyan theology—to call the Church to mission and to participate in the reconciliation and healing that is understood as God's relationship with creation.

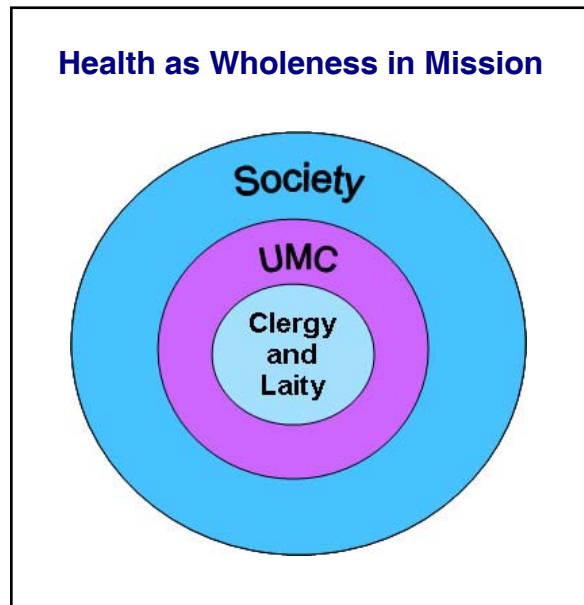
John Wesley's strong views on health and gospel connections, uniting faith, health and community were underlying tenets of the charge: *Body and soul are meant to work in harmony and are able to influence one another. Therefore, as the soul opens more and more to the salvific action of God, the body benefits.*

In the preface to Wesley's *Primitive Physic, or An Easy and Natural Method of Curing Most Diseases*, he posits that properly treating an illness or injury is only one part of how God's concern for physical health is honored. The more fundamental way is to adopt healthy practices that promote wellness, such as diet, lifestyle, exercise and prayer.

Health as Wholeness in Mission

The Task Force based its work on an initiative called “Health as Wholeness in Mission” that builds on Wesley’s holistic approach to health. Health is defined as *what is necessary for the individual to be in mission (i.e., engaged with our whole selves in carrying out a life of purpose in relationship with and as directed by God and in community and service to others).*

The phrase “Health as Wholeness in Mission” captures the vision of a preferred future for all United Methodists, and for everyone, everywhere—three concentric circles that illustrate a commitment in connection with clergy and laity, the Church and society.



1. **The first circle is the clergy and laity**—Clergy and laity, through educational and informational opportunities, will convey a theory and practice of healthy pastoral leadership. They will discover a balanced way of attending to their spirit, their family and close relationships, their pastoral responsibilities and their physical and mental well-being. Faith and spiritual practices will energize their ministerial activities and support their personal well-being.
2. **The second circle is the Church**—Church policies that directly affect clergy and laity will be reviewed and changed, if necessary, to serve the whole person. In light of this examination, clergy and laity will make changes to improve their own health. They will see health concerns as an essential part of Christian revelation and the community of the Church.
3. **The third circle is the larger society**—As United Methodist leaders and communities develop ways to integrate faith, community and health, others will learn from them. In an American culture, pushed toward fragmentation, the Task Force believes integration of faith, community and health will be welcome. This integration flows from the wholeness of the community’s faith-grounded life.

Health and Community

In today's culture, health is viewed as individual fulfillment, a quest for beauty, strength and capability. The Task Force, on the other hand, defined health as communal fulfillment. Good health is as much determined by the interaction of individuals in communities as by individuals experiencing the absence of disease. It is in community that one participates in God's saving grace; it is as the Church that the denomination lives out God's mission. By acting in connection to ensure vital ministry, each individual becomes a steward of mind, body and spirit by practicing spiritual health disciplines.

Connectional support and accountability is needed, not just for the individual or the Church, but also for the mission to participate in God's saving work in the world. The clear biblical and Wesleyan balance is to value personal health as wholeness by our actions, our example and our witness in seeking to promote the reconciliation and healing that we understand as God's work in creation. United Methodists are called to promote a healthy society of whole persons—incorporating mental, physical, emotional, spiritual and communal health.

"It will be a double blessing if you give yourself up to the Great Physician, that He may heal soul and body together. And unquestionably this is His design. He wants to give you ... both inward and outward health"

—John Wesley
Letter to Alexander Knox, October 26, 1778

Objectives

Improve the Health of the Employees of the Church

The Denominational Health Task Force began its work by establishing the following objectives to guide an assessment of the Church's progress toward improved denominational health.

Relationships

- Build more effective relationships among faith, community and health.
 - Model health as wholeness in mission.
 - Decrease the incidence of stress-related illnesses.
 - Increase health practices among the employees of the Church.
 - Increase the teaching and practice of health-related spiritual formation throughout the connection.

Information Sharing

- Standardize information sharing and promote dissemination of knowledge throughout the Church.
 - Identify the annual conferences and churches that are struggling with the costs and delivery of health care.
 - Increase access throughout the Church to information about health care industry standards, best practices, plan designs and benefit levels.

Employment Systems

- Transform the essential employment systems and structures of the Church that have an impact on the health of its employees.
 - Increase awareness of the impact Church systems are having on the health of its employees.
 - Reduce negative impact of Church systems on the health of its employees.

Group Health Plan—Participation

- Ensure participation for active clergy and full-time employees in a group health care plan.
 - Enable access to health care coverage for all clergy and full-time employees of the Church.
 - Establish minimum levels of health care coverage for clergy and full-time employees of the Church.
 - Increase the cost-effectiveness of quality health care coverage.

Group Health Plan—Access

- Provide access to group health care plans for all employees of the Church in the U.S. and design health systems and support systems that are inclusive of all employees of the Church.

Retiree Health Care—Access

- Fulfill any promises made to retired clergy, lay employees and their spouses for adequate health care in retirement.
 - Address retirees' ability to pay for health care.
 - Provide access to Medicare supplement and prescription drug plans.
 - Plan for and fund medical liabilities for retirees.

Findings and Conclusions

The five findings and the conclusions the Task Force drew from them focus on clergy and lay employee health in support of the mission and ministry of the Church. The findings and conclusions include:

- current state of clergy and lay employee health,
- current access to a group health care plan,
- health care coverage in retirement,
- impact of the Church employment systems and structures on clergy and lay employee health, and
- access to information to protect and promote health.

Current State of Clergy Health

According to a research study involving 250 religious professionals, Protestant clergy, compared with other professions, had the highest overall work-related stress and were next to the lowest in having personal resources to cope with occupational strain.¹

A 2002 study found that clergy have a high-incidence of stress-related conditions, including high blood pressure, cardiovascular disease, depression, gastrointestinal disease and neuromuscular disorders. Clergy are in the top 10 occupations dying from heart disease.² According to a *General Board of Pension and Health Benefits Claims Report*, the top drugs used by *HealthFlex* clergy participants are those used to lower cholesterol and treat diabetes and other endocrine conditions.^{3,4} Lipitor, a cholesterol-lowering medication, is the number one drug for both the number of claimants and total cost.⁵

¹ *Ministerial Health and Wellness, Evangelical Lutheran Church in America, Gwen Wagstrom Halaas, February 2002, p. 18.*

² *Ministerial Health and Wellness, Evangelical Lutheran Church in America, Gwen Wagstrom Halaas, February 2002, p. 6.*

³ *Note: HealthFlex is a health care plan administered by the General Board of Pension and Health Benefits and offered to plan sponsors within the denomination.*

⁴ *General Board of Pension and Health Benefits HealthFlex Participants 2005 Medical and Rx Claims by Relationship Report, November 2006.*

⁵ *General Board of Pension and Health Benefits HealthFlex Participants 2005 Medical and Rx Claims by Relationship Report, November 2006.*

Health Status Comparison

The prevalence of disease in several major categories (including congestive heart failure, coronary artery disease, high blood pressure and diabetes) was higher for UMC plan participants compared with age-adjusted national benchmarks.^{6,7}

- **Demographics of the population in a health care plan affect the cost and coverage of health care.** (See *A Person's Health Care Costs Increase with Age*, page 8.)
 - Median age of active UMC clergy is 53.
 - Median age for similar occupations ranges from 42 to 47.⁸
 - (See *Median Age by Similar Occupations*, page 8)
 - Health care spending and benefits paid per claimant tend to increase with the age of the claimant.
 - The older profile presents serious challenges regarding future costs.⁹
- **The risk for metabolic syndrome steadily increases with age for both men and women.**
 - The incidence of *metabolic syndrome* increases with age for both men and women from less than 10% in the 20-year-old age group to greater than 40% in the 60-year-old age group.¹⁰
 - When the prevalence of metabolic syndrome increases, the incidence of diabetes, stroke and heart disease increases, resulting in an average annual cost for patients of \$5,928.¹¹
 - This statistic is of particular importance because the median age of UMC clergy is 53.
- **The health of clergy and other employees in the Church affects the cost of health insurance.** (See *Mercer Health Insurance Survey Cost Comparison*, page 9.)
 - UMC employees have significantly higher health-related expenditures (16%) than comparable groups of the same age and gender with comparable health care coverage, as indicated in the analysis *Health Insurance Survey of United Methodist Conferences*, conducted by Mercer Health & Benefits Consulting.¹²
 - This 16% average higher expenditure is due primarily to a higher illness burden.
 - The 16% cost differential exists after taking the following into account: plan design, number of plan participants, age and gender characteristics.
 - This gap presents serious issues considering the lifetime covenant, the demographic profile of the current UMC clergy population and recent “entering clergy” trends.¹³
- **This cost gap is likely to increase without active management of UMC plans and improved health of UMC participants.**¹⁴

⁶ Note: UMC participants are in HealthFlex, a UMC health care plan administered by the General Board of Pension and Health Benefits and offered to plan sponsors within the denomination.

⁷ Mercer Health Insurance Survey, January 2006, p. 2.

⁸ From the Richard Day presentation, December 2005, p. 30.

⁹ Mercer Health Insurance Survey, January 2006, p. 2.

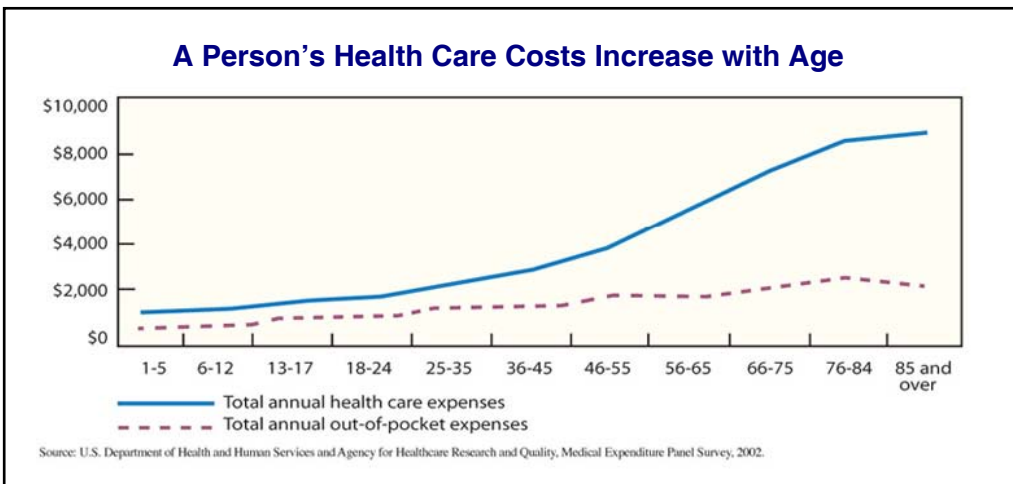
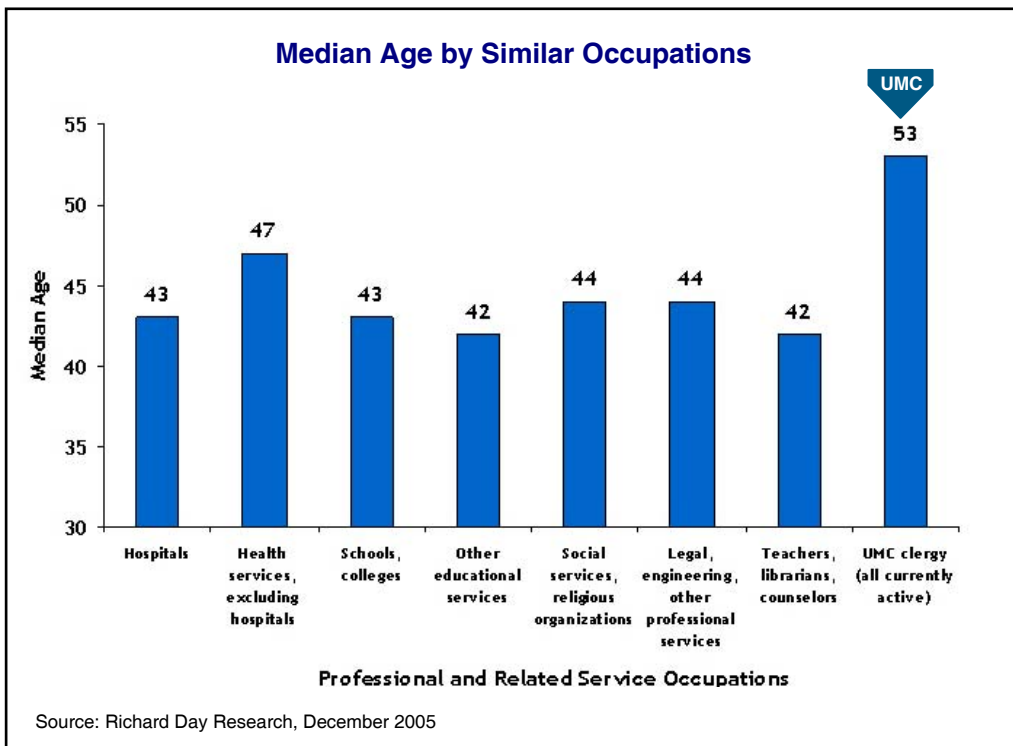
¹⁰ From the Judy Johnston presentation, December 2005, p. 11; Ford ES, et al. JAMA 2002; 287: 356-9. According to the American Heart Association, metabolic syndrome is a group of metabolic risk factors that includes abdominal obesity, blood fat disorders, elevated blood pressure, insulin resistance or glucose intolerance and prothrombotic and proinflammatory state. The presence of three or more of any of these components increases a person's risk of coronary heart disease and other diseases related to plaque buildup in artery walls (e.g., stroke and peripheral vascular disease) and type 2 diabetes.

¹¹ From the Judy Johnston presentation, December 2005, p. 15.

¹² The Denominational Health Task Force engaged Mercer Human Resource Consulting to provide an actuarial assessment of the health plans sponsored by the conferences of The United Methodist Church. A survey was distributed to all U.S. conferences to obtain detailed information about the various plans. The survey requested information regarding a number of topics including but not limited to plans offered, plan design(s), claims (total claims, claims over \$50,000, and claims by major diagnostic category), plan administration, enrollment, demographics, contributions from participants, and funding approach.

¹³ Mercer Health Insurance Survey, January 2006, p. 25 (Also see Mercer Health Insurance Survey Cost Comparison, p. 9).

¹⁴ Mercer Health Insurance Survey, January 2006, p. 1.

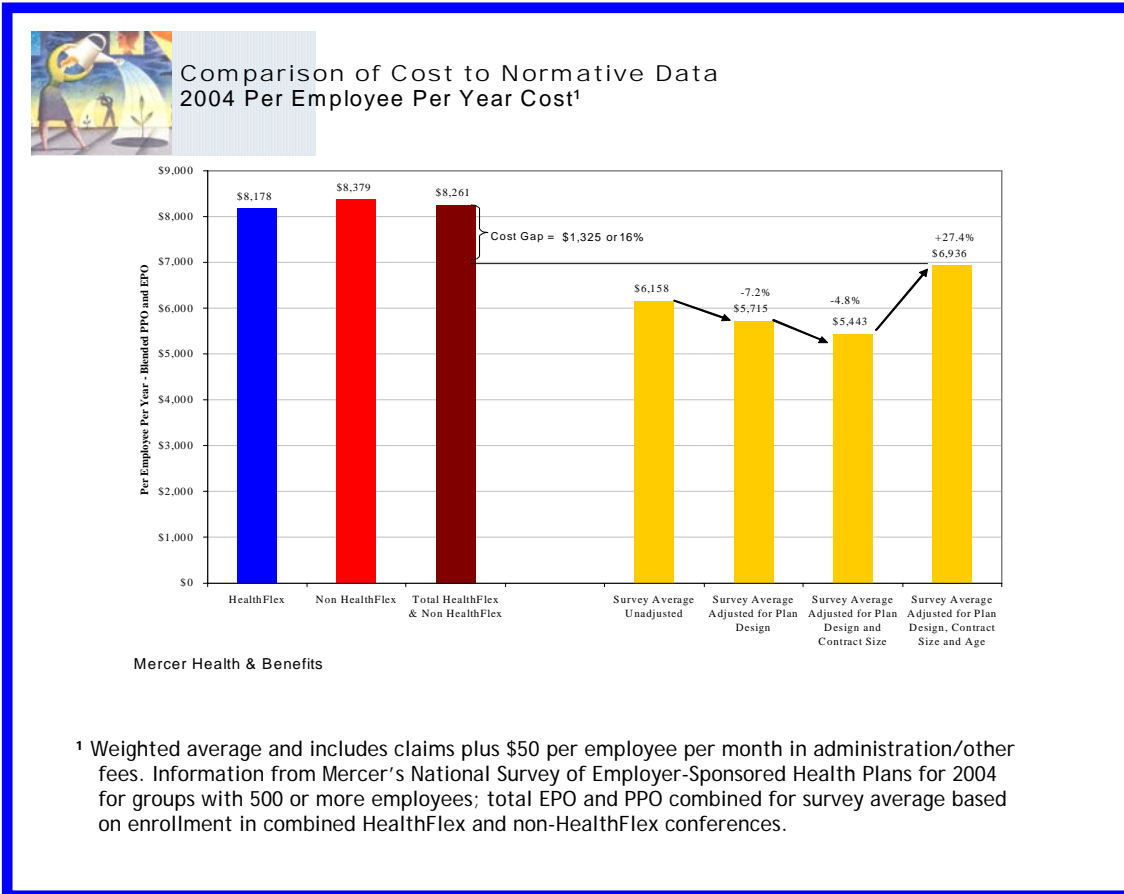


Health care expenses are relatively low during childhood. In fact, only one-fifth of all lifetime health care expenses occur during the first half of life. As we age, however, our health care needs increase, especially between ages 65 and 85:¹⁵

- About half of all health care expenses in a person's lifetime occur after age 65.
- Medicare beneficiaries age 65 and older are more than twice as likely to use hospital services as are younger adults.
- The annual average cost for the care of adults age 76 to 84 is \$8,000—nearly eight times the average health care cost for children age 1 to 5.
- Each year, for every 100 seniors (age 65 and older), there are more than 650 visits to doctors' offices, approximately 40 visits to hospital outpatient departments and roughly 50 visits to emergency rooms.
- In addition to receiving health care at doctors' offices and hospitals, one out of seven people age 65 and older and one out of two people age 85 and older need long-term care.

¹⁵ *The Health Report to the American People, Citizens' Health Care Working Group, October 14, 2005, pp. 13-15.*

Mercer Health Insurance Survey Cost Comparison



The first three bars show the 2004 annual cost per household for UMC plans (HealthFlex, Non-HealthFlex and total UMC, respectively). The four bars to the right show Mercer benchmark costs (500+ employees) adjusted to be comparable to UMC costs. Progressively, the chart adjusts for:

- plan design (7.2% reduction to benchmark to reflect less rich UMC plans),
- average contract size (4.8% further reduction to benchmark to reflect the lower average number of covered dependents per UMC household), and
- age and gender characteristics of UMC participants (27.4% increase to benchmark adjustments 1 and 2 to reflect the higher demographic burden of UMC participants).

After the above adjustments, a 2004 cost gap of approximately 16%, or \$1,325, remains. This cost gap is due primarily to a higher illness burden beyond that reflected by the traditional adjustment factors detailed above. This cost gap is similar to Mercer's experience in working with other denominational plans and is not unique to UMC plans.

However, given the persistent nature of historical medical cost trends (200% to 400% of base inflation as measured by CPI), this is a troublesome gap. It presents serious issues considering the lifetime covenant, the demographic profile of the current UMC population and recent trends regarding new clergy entrants. A study by Richard Day Research showed a steady and continued increase in the average age of new UMC clergy entrants.

Current Access to Group Health Care Plans

The Task Force believes that all employers within the Church should strive to facilitate access to group health care plans for all employees.

We affirm the current *Book of Discipline*, which states that each local church committee on pastor-parish relations or staff-parish relations “shall further recommend to the church council a provision for adequate health and life insurance and severance pay for all lay employees.” The Task Force recognizes, however, the relationship of health care benefits and compensation.

- **Health care benefits are part of the compensation package of the local salary-paying unit.**
 - Control over health care plans and programs is administered most effectively at the local church and annual conference levels.
 - Annual conferences make coverage and eligibility decisions for their appointed clergy.
 - The salary-paying unit makes coverage and eligibility decisions about laity.
- **Annual conferences need the flexibility and the autonomy to address the financial burdens the local churches may face in the coming years.**
 - Annual conferences accept claims liability for clergy; they must determine how to fund health care plans for conference clergy.
 - There is a perception that a denomination-wide health care system may or may not recognize local differences.
- **Health care programs become more affordable when the participants in the plan are healthier and risk is shared.**
- **Effective health care plans and programs:**
 - provide participants with the resources they need for preventive care and to maintain and improve their health,
 - reduce health care costs, and
 - improve the effectiveness of clergy and lay employees in support of the mission and ministry of the Church.
- **The Church could anticipate an ongoing 3% to 5% reduction in the increase of premiums as a result of a shared-risk health care plan, according to the Mercer Health Insurance Survey.**
 - Annual conferences and local churches would realize the cost reduction through smaller premium increases.
- **Health care costs are increasing faster than the rate of inflation.**

In 2005, a *Henry J. Kaiser Family Foundation Study* found that employer health insurance premiums increased by 9.2%—more than twice the rate of inflation and more than three times faster than employees’ earnings. (See *Medical Consumer Price Index Compared with Other Categories*, page 11.)

“While the rate of increase has been flattening for the past two years, the premiums for family coverage have climbed 73% since 2000... While the percentage of premiums that the average covered employee pays remains the same or is slightly less, it is clear that health care insurance rates are increasing faster than employees’ compensation; more companies are requiring employees to pay more out of pocket for actual health-care costs, and fewer companies are offering health insurance.”¹⁶

Even if medical cost trends were flat, the stability and aging of the UMC population would result in higher health care costs.

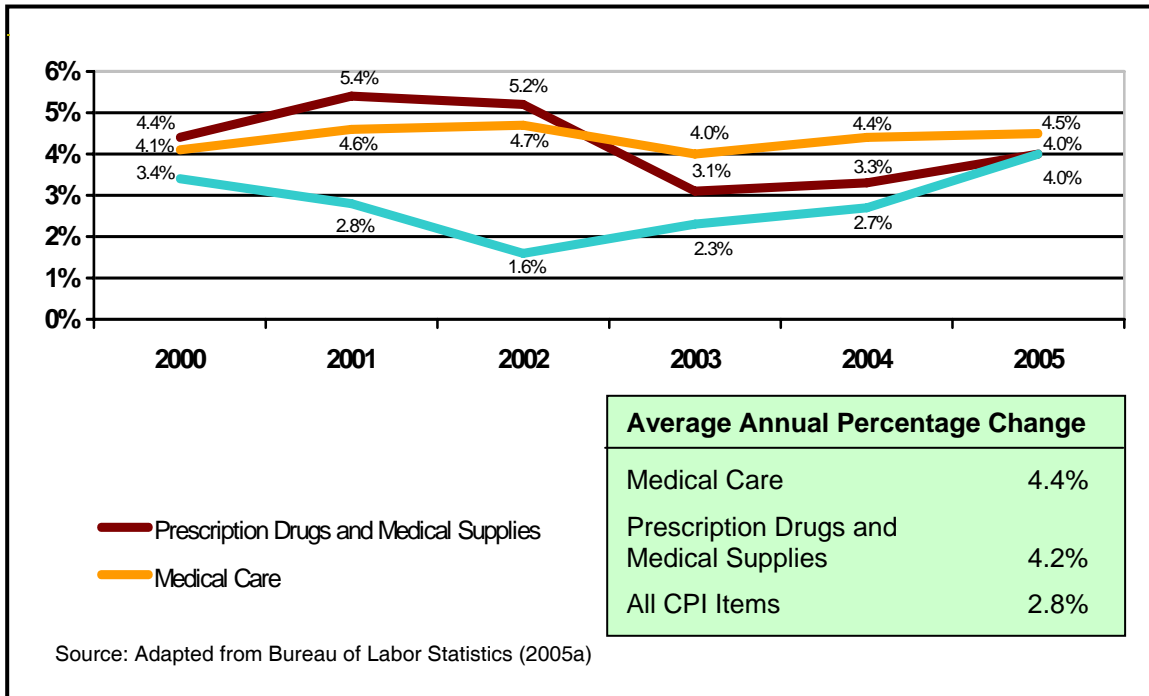
¹⁶ *Staying Healthy, FaithLink, January 22, 2006.*

- **Increased health care cost sharing by clergy and retirees will continue.**

As local churches struggle to pay more for health care, in lieu of using those same funds for direct mission and ministry programs, they are seeking less costly health care options.

Medical Consumer Price Index Compared with Other Categories, 2000-2005

Medical care prices have risen faster than the overall Consumer Price Index (CPI). However, the difference has narrowed since 2002.



- **The cost of benefits is a major consideration in an increasing number of appointments.**

This cost consideration is leading to an increase in appointing retired pastors and part-time local pastors; these appointments often do not include benefits. As a result, some local churches feel pressured to change their clergy's status in response to the need and willingness to pay for benefits. The cost of benefits is already influencing the appointment systems of the Church.

- **Plan sponsors typically self-insure when they reach 1,000 or more employees (households).**

The results of the Mercer Health Insurance Survey of annual conferences revealed that 13 annual conferences are self-insured, despite being significantly below the threshold of 1,000 households. While self-insurance is a less expensive form of funding (especially for large groups), it is a more volatile and risky approach for mid-sized plan sponsors (500 to 1,000 households). Although stop-loss insurance can help manage this volatility, it has become more expensive in the last few years. Due to cost pressures, some United Methodist-related plan sponsors are taking more risk via self-insurance than would commonly be found in the market,¹⁷ thus calling into question the sustainability of their plans.

¹⁷ Mercer Health Insurance Survey, January 2006, p. 20

- **The Task Force’s research identified significant financial considerations to providing access to lay employees.**
 - Health care access for lay employees can create adverse selection. Based on 2005 full-year data from HealthFlex, average *clergy* benefits paid per claimant were \$3,986, while average *lay participant* benefits paid per claimant were \$2,928. However, *lay spouse* claims were the highest, \$4,618, compared with *clergy spouse* claims of \$2,910.¹⁸
 - While the average age of lay employees in HealthFlex is lower than the average age of clergy, lay employees are not necessarily a statistically less expensive actuarial pool. Lay employees may have access to plans through their spouses. However, if they are not covered elsewhere, they seek coverage through annual conference or local church plans if eligible.
 - Providing a health care plan of last resort for a lay employee spouse creates adverse selection. Conferences and local churches should work out their choices around this issue, by reflecting on their own mission and sense of justice.
- **As a connectional church, there is a need to continue exploring ways to accomplish the following goals, other than through a mandated denominational plan:**
 - improve access to condition support programs,
 - invest in denomination-wide approaches to wellness through initiatives, services and programs,
 - build best practices in health care plan coverage, and
 - leverage the collective purchasing power of the denomination.

Collaborative purchasing and strategic opportunities among annual conferences might reduce costs and share risks. Denomination-wide risk pools (e.g., stop-loss, drug purchasing, condition support programs, etc.) will need to demonstrate cost savings and administrative efficiencies. Evidence exists that denomination-wide risk pools, established for annual conferences or other employer groups, may reduce costs.

¹⁸ *General Board of Pension and Health Benefits HealthFlex Participants 2005 Medical and Rx Claims by Relationship Report, November 2006.*

Health Care Coverage and Sustained Health in Retirement

Many believe that caring for retirees is a part of the Church's promise, and that it is part of the denomination's witness to the world. The Task Force believes that there is no stability in retirement without health care coverage; therefore, the Church needs to do what is necessary to fulfill any of its coverage promises.

- **Organizations are cutting programs and increasing cost-sharing for retiree benefits.**
 - A Kaiser Family Foundation survey, conducted in 2005, found that only one-third of companies with 200 or more employees offered any health care benefits to their retirees—down from 66% in 1988. Small companies, which employ about half of the work force, have never offered very generous retirement health care benefits. The companies that still offer health insurance for retirees have been trimming the plans in many ways.¹⁹
 - The fulfillment of the Church's promise to its employees in retirement is putting financial strain on some annual conferences. The Church needs to ensure that annual conferences have taken adequate measures to fulfill any promises they have made.
- **The Task Force identified issues related to the move from one annual conference to another of clergy or lay employees nearing retirement.**
 - Eligibility requirements change from conference to conference and, therefore, there are potential unexpected benefit losses for individuals who move among conferences.
 - The issue of “portability” and “creditability” of retiree benefits among conferences as clergy and lay employees approach retirement is real, as well as are any associated liabilities.

Impact of the Church Employment Systems and Structures on Clergy and Laity Health

In 2004, the General Board convened more than 50 individuals from across the denomination to discuss clergy health. As a result of that dialogue, a systems map was created depicting complex, interconnected issues in the lives of clergy today.

The Task Force discussed the causes of clergy stress and examined *The Book of Discipline* for aspects of the employment structure and culture of the Church that have a negative impact on clergy and laity health. While these issues are not specified in the initial charge from General Conference, addressing them was essential to support an ethic of proper self-care and to allow for clergy and laity to attend to healthy lifestyle practices in daily life.

The Task Force identified the following stressors in the lives of clergy:

- Traditional itineracy within the Church is being challenged by social and economic pressures. Therefore, the employment offers or packages are shifting; moving is stressful, and freedom from itineracy is often desired. Long-term appointments are often seen as a reward for success.
- Support is lacking within the “call system” for those transitioning into ordained clergy.
- Professional training in seminaries is inadequate.
- The guaranteed appointment system does not support the selection and retention of clergy striving for health and healing. The system fails to support accountability for mental, physical, emotional and spiritual health.

¹⁹ *Benefits Go the Way of Pensions, The New York Times, February 9, 2006. “A survey of large companies by Kaiser and Hewitt Associates, a consulting firm, found that while only 12 percent of large employers ended all retiree health benefits last year, 71 percent required higher premium contributions from retirees, 34 percent increased co-payments or co-insurance and 24 percent increased deductibles.”*

- Clergy face the expectation of round-the-clock availability.
- The Church does not have a good “exit strategy” from the ministry. Clergy who are not equipped stay in the system; their health deteriorates and their congregation’s health and vitality may also suffer.
- The societal status of clergy has declined and the expectations of churches have changed. Whether the church is large and growing or small and declining, there are many pressures on clergy and many roles that clergy are expected to play (e.g., preacher, CEO, counselor, educator, financial navigator, coach, fundraiser, etc.).
- The Church has not acclimated to the change in clergy status and expectations. Clergy are often set apart within their communities.
- Clergy who are experiencing emotional or physical health problems are reluctant to discuss them with friends or church members because they fear doing so may affect their next appointment. By not addressing problems in an appropriate manner, health issues compound.
- Parsonage housing enhances economic security, but homes are frequently in poor condition and lack privacy. The parsonage setting poses challenges and can be difficult to manage within broader communities.

These are complex issues that require great care in order to address the employment systems and structures of the denomination.

Current Access to Information to Protect and Promote Health

The results of the Financial Information Survey, commissioned by the Task Force and conducted by the General Board, revealed that the current costs, impact and effectiveness of health care plans and programs vary across annual conferences. Significantly, the variations are difficult to compare because annual conferences do not collect comparable data. Currently, there is no shared standard against which health care plans and programs can be measured, and there is no standard for collecting financial and other data.

In the Task Force’s Health and Wellness Initiatives Survey, a number of annual conferences expressed interest in knowing what other conferences are doing, cross-denomination collaboration and sharing positive experiences. Several annual conferences are gathering more information and statistics to determine the best courses of action to address clergy and laity health issues and healthy lifestyles. Many asked for guidance and data in using incentives to encourage participants to take advantage of preventive care and health improvements.

- No comparable data exist across annual conferences to demonstrate an understanding of clergy health as a whole.
- No connectional repository exists for this kind of information. While current health care plans are not identical, the Church needs to find ways to gather comparable data and specific knowledge to assess the state of health across the denomination.
- It is incumbent on the individual annual conferences to adhere to some standard mechanism for reporting, learning and sharing.

The Task Force conducted a Financial Information Survey among annual conferences, in an effort to understand the financial health of the respective health care plans. Of the 63 annual conferences surveyed, 40 responded. Of those that responded, many had missing data or data that were not comparable. As a result, the Task Force was not able to draw conclusions about the financial soundness of the health care plans of many annual conferences.

There were significant variations in the methods used to report health plan financial data. The most significant variations related to a lack of common accounting reporting standards across annual conferences (e.g., accrual basis vs. cash basis, inclusion or non-inclusion of post-retirement benefit obligations, etc.) and determining total liabilities, net assets and adequacy of health plan revenues to cover total plan costs for those conferences that did not provide any data.

As a denomination, we saw a need for the following actions to be taken to improve access to information:

- active conversation about best practices in the health arena (i.e., what is succeeding and what is not),
- annual conferences learning what others are doing by collecting and publishing data that:
 - help annual conferences that are vulnerable and attempting to implement interventions and initiatives on their own, and
 - share best practices to strengthen the collective learning and connectionalism of the denomination.

Recommendations

The Task Force explored approaches across the denomination to support the health of clergy and lay employees; examined the employment systems and culture that affect their health; considered ways to ensure group health plan access for full-time clergy and lay employees; and sought to foster the health and wholeness of retired clergy, lay employees and their spouses.

The Task Force formulated the following four recommendations:

Recommendation 1

Improve the Health of Clergy and Lay Employees to Support the Mission and Ministry of The United Methodist Church.

- The General Board shall support health as wholeness across the denomination with health information and data sharing through a unified effort to:
 - collect and analyze annual conference, Council of Bishops and general agency health data,
 - establish benchmarks,
 - identify best practices, and
 - recommend strategies and guidelines.
- The General Board shall seek to amend the Comprehensive Protection Plan, as necessary, to enact the recommendations.
- Annual conferences, the Council of Bishops and general agencies shall:
 - develop and maintain health and wellness programs; and
 - submit health plan data annually to the General Board.

Elaboration by the Task Force

The denomination needs a standard for collecting and sharing information about our health as a community, within our broad definition of what constitutes health. By shining the light on the demonstrated best practices across the denomination, we can learn from those within our connection. The General Board will be the focal point for collection, analysis and dissemination of information regarding the health of the employees of the Church.

- The annual reporting process will include:
 - a report format determined by the General Board in conjunction with advisory group(s),
 - raw data available electronically (e.g., indicative data by conference: average age, average salary, etc.) as determined by the General Board and the advisory group(s),
 - data available at the annual conference, the Council of Bishops and general agency level, and
 - a database developed by the General Board in conjunction with the advisory group(s).
- Advisory group(s), reflecting racial/ethnic constituencies, will work with the General Board. UMC, medical, health benefits, public health and financial interests will be represented among the advisory group(s). Responsibilities will include:
 - guiding database development,
 - analyzing data and identifying trends,
 - determining denominational and industry benchmarks,
 - identifying healthy lifestyle initiatives, and
 - ensuring compliance.

- The work of the General Board will include:
 - evaluation of existing and development of enhanced programs and initiatives to improve the health of the employees of the Church,
 - establishment of appropriate denominational benchmarks related to health,
 - identification of denominational and industry best practices associated with healthy lifestyles and health care cost management,
 - collaboration with other general agencies to coordinate a church-wide, grassroots network dedicated to health and wholeness, and
 - consultation with annual conferences, the Council of Bishops and other general agencies on health care plan designs, coverage, costs, financial viability and sustainability and health and wellness initiatives, aligned with health care plans and with conference and church activities.
- The Task Force determined that assets from the Comprehensive Protection Plan would be used to fund the associated administrative costs. Over time, these efforts should result in reductions in long-term medical diagnoses and disabilities.
- The responsibilities of annual conferences, the Council of Bishops and general agencies will include:
 - developing or modifying health and wellness program initiatives in consultation with the General Board to leverage best practices information,
 - providing specifications on health care plan data and health and wellness initiatives to the General Board, and
 - sharing reporting results and trends annually.

Recommendation 2

Identify and Assess Opportunities for Improvements in the Employment Systems and Culture Affecting the Health of Church Employees.

- Establish a joint General Board of Pension and Health Benefits and General Board of Higher Education and Ministry Task Force with jurisdictional representation from the Council of Bishops to:
 - examine itineracy and the appointment-making systems and recommend improvements that support clergy health,
 - examine and recommend improvements to the supervisory systems,
 - address processes for entering and exiting ordained and licensed ministry, and
 - provide guidelines for sustaining a healthy work/life balance.

Elaboration by the Task Force

The examination of the supervisory systems includes the roles and training required to support the health of clergy and laity. We recommend that the General Board of Pension and Health Benefits and the General Board of Higher Education and Ministry form a joint Task Force with jurisdictional representation from the Council of Bishops to examine itineracy, appointment-making and supervisory systems; address processes for entering and exiting ordained and licensed ministry; and provide guidelines for sustaining a healthy work/life balance. These systems are at the heart of health considerations.

- The assessment would include:
 - relationships between the guaranteed appointment system and the system of itineracy,
 - ramifications of clergy transfers between conferences,
 - processes for vocational transitions out of ordained ministry, including expanded employee assistance through identification, support and retraining, and
 - transitioning clergy into ministry (acclimation process).
- The General Board of Pension and Health Benefits and the General Board of Higher Education and Ministry will be responsible for convening the joint Task Force.

- The Task Force will report to the Connectional Table, Council of Bishops and General Secretaries and present findings/recommendations by 2011.
- The Task Force will develop recommendations for submission to the 2012 General Conference.

Recommendation 3

Sponsor or Participate in a Group Health Care Plan to Ensure Access

- Each annual conference, the Council of Bishops and each general agency shall sponsor or participate in a group health care plan,²⁰ ensuring access for their full-time clergy and full-time lay employees in the U.S.²¹
- Additional participant eligibility may be determined locally.

Elaboration by the Task Force

We recommend proposing legislation to amend The Book of Discipline that requires each annual conference, the Council of Bishops and general agencies (the “Affected Entities”) to sponsor and maintain a group health care plan (as defined) and ensure access to a group health care plan for full-time clergy and full-time lay employees of annual conferences, the Council of Bishops and general agencies.

- The Affected Entities will report annually to the General Board:
 - evidence of a group health care plan (by written summary of the plan, plan document, Summary Plan Document or certificate of insurance), and
 - eligibility rules.
- An optimal list of model health program components (e.g., Employee Assistance Programs, Health Risk Assessments, etc.), beyond those in a traditional group health care plan, will be provided by the General Board for use by Affected Entities for comparative purposes.
- The General Board will continue to investigate and develop purchasing coalitions for group health care plan components to help Affected Entities attain optimal design of their group health care plans.
- The Task Force believes that all employers within the Church should strive to facilitate access to group health care plans for all employees.
- We affirm *The Book of Discipline*, which states that each local church committee on pastor-parish relations or staff-parish relations “shall further recommend to the church council a provision for adequate health and life insurance and severance pay for all lay employees.”

²⁰ *Group health care plan, for this purpose, shall mean a group health plan as described in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), meaning a plan covering major medical and hospitalization expenses and not limited scope benefit plans such as stand-alone vision or dental plans (though it does not preclude such plans in addition to the group health care plan). A group health care plan in this context is typically an employee welfare benefit plan as defined in §3(1) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended that, in most case for Church organization will be a church plan as defined in §3(33) of ERISA.*

²¹ *Annual conference employment does not include clergy appointed to extension ministries (except those serving in positions for which the annual conference is responsible), nor lay employees who are not employees of the annual conference, such as lay employees of local churches and lay employees of district and jurisdictional offices.*

- We affirm the current Book of Resolutions, which states that “We seek a national health-care plan that will provide comprehensive benefits to everyone, including preventive services, health promotion, primary and acute care, mental-health care, and extended care.” (Universal Access to Health Care)

Recommendation 4

Respect the Health and Wholeness of Retired Clergy, Lay Employees and Their Spouses

- Each annual conference, the Council of Bishops and each general agency shall respect the health and wholeness of its retired clergy, lay employees and their spouses by:
 - facilitating access to Medicare supplement and prescription drug plans,
 - submitting a biannual Statement of Financial Accounting Standard No. 106 (FAS), as amended, of its projected medical liabilities for its covered population to the General Board starting in 2009,
 - creating a plan by 2011 to address the funding requirements of future retiree medical liabilities, and
 - documenting its policy in writing by 2009 regarding the portability of retiree health care benefits and communicating the policy to its clergy and lay employees.

Elaboration by the Task Force

We request that the General Board facilitate a conversation with the conference benefit officers to determine if there is a mutually agreed-upon resolution to the portability issue for retirees. We also propose legislation to:

- Amend *The Book of Discipline* to require that every Affected Entity ensure access to Medicare supplement and prescription drug plans to Medicare-eligible retired clergy and retired lay employees.
- Amend *The Book of Discipline* to require that every Affected Entity undertake a biannual actuarial valuation [Statement of FAS No. 106, as amended, part of generally accepted accounting principles (GAAP)], beginning in 2009 of the liabilities associated with post-retirement benefits and submit such valuation to the General Board. The General Board will:
 - report the information in aggregate to the denomination and to General Conference, and
 - publish the information and provide it to interested parties.
- Amend *The Book of Discipline* to require that every Affected Entity create a plan to address the funding requirements of future retiree medical liabilities and submit such plan to the General Board by 2011. Such plan must contain a timeline for remedying the unfunded liabilities.
- Each Affected Entity shall document and communicate existing portability of retiree health care benefits policies and practices to its clergy and lay employees and incoming clergy and lay employees from other annual conferences or other general agencies.
- Each Affected Entity shall submit a written document of its retiree health care benefits policies and practices to the General Board, as well as publish it in its conference journal and/or on its conference Web site.
- The General Board will publish the information and provide it to interested parties.

Summary

The four Task Force recommendations support The United Methodist Church's mission and vital ministry in the world and respond to the denomination's health challenge—a new, unified effort to foster better health for the employees of the Church. These recommendations, individually and collectively, seek to improve health across the denomination.

Wesley's holistic approach to health is essential to the articulation of the recommendations. Wesleyan values underpin the Task Force's definition of health: *whatever is necessary for the individual to be in mission (i.e., engaged with our whole selves in carrying out a life of purpose in relationship with and as directed by God and in community and service to others).*

Denominational health improvements must incorporate mental, physical, emotional, spiritual and communal health. The challenge for the denomination is to act now, act connectionally, act with compassion and act with accountability to strengthen health in all its dimensions, so that in community we participate in God's saving grace.

Thoughts

The Denominational Health Task Force invites your reflections on our work and on this *Summary Report*.

E-mail your comments to: **DHTF@gbophb.org**.

Appendix

General Conference 2004 Petition

Submitted Petition Text:

The Virginia Annual Conference of the United Methodist Church petitions the General Conference of the United Methodist Church to direct the General Board of Pensions to conduct a study of the feasibility of health care coverage serving active and retired clergy and full and part-time lay employees, effectively uniting all the conferences of the United Methodist Church located in the United States into one single plan, with recommendations as to what coverage could be available, the cost of the coverage with recommendations on how it could be divided between an annual conference and the clergy, the source(s) of payment for the coverage, and a plan for the timely implementation of such health care coverage, and to report to the annual conferences by February 1, 2006.

Committee Majority Text:

Replace the text of the petition with the following:

2004 General Conference of The United Methodist Church directs the General Board of Pensions and Health Benefits to conduct a study of the feasibility of health care coverage serving eligible active and retired clergy or lay employees, effectively uniting all the conferences of The United Methodist Church located in the United States into one single plan. If the results demonstrate feasibility for all of these employees or any of the group(s) of these employees the General Board of Pensions will report to the Annual Conference Boards of Pensions by January 1, 2007, the results of this study with sufficient detail that the annual conferences can evaluate the recommendation. The General Board of Pensions will work with the Annual Conference Board of Pensions to produce the most acceptable plan for submission to the 2008 General Conference. Exhibit 1 on Page 767 of the DCA and included as a part of Petition #41329-FA will become a foundational document for this study except for the final paragraph on Page 770 titled "Process & Timetable".

Task Force Participants

Annual Conference Members

Boyd Brown, Tax Attorney	Virginia	Lay
Deborah Dangerfield, Benefits Manager ¹	Northern Illinois	Lay
Arturo Fernandez, Retired	Oregon Idaho	Clergy
Marvin Guier, Treasurer and CBO	North Texas	Clergy
David Hawkins, Treasurer and CBO	Tennessee	Clergy
Debbie Maltbie, Treasurer and CBO	Kansas West	Lay
Verna McKinney, CBO	Kentucky/Red Bird	Lay
Tracy Merrick, Chairperson	Western Pennsylvania	Lay
Dan O'Neill, Treasurer and CBO ¹	Rocky Mountain	Lay
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Elijah Stansell, Treasurer	Texas	Clergy
Sharon Strother, Treasurer and CBO	North Carolina	Lay
R. Stanley Sutton, Treasurer and CBO	West Ohio	Clergy
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 Richard Day, PhD, Richard Day Research
 Randy Maddox, PhD, Professor, Duke Divinity School

¹ Indicates a member or previous member of the General Board of Pension and Health Benefits Board of Directors.

Values and Elaboration

The Task Force pursued its work in accordance with the following overarching values grounded in Wesleyan theology:

- define health as wholeness through and for God's mission,
- steward health,
- act connectionally,
- balance compassion and accountability, and
- offer prophetic witness.

Define Health as Wholeness Through and for God's Mission

Health is necessary for individuals to be most effective in mission and to be engaged with their whole selves in participating in God's plan to restore wholeness to creation. We seek health to participate more fully in God's mission, and through participating in God's mission we find greater health.

Our culture tends to define health as individual fulfillment, an individual quest for beauty, strength and capability. We define health as communal; good health is as much determined by the interplay of individuals in communities as by individuals experiencing the absence of disease. It is in community that we participate in God's saving grace; it is as the Church that we live out God's mission.

Steward Health

Individuals and communities have the responsibility to steward their own health.

We recognize the particular importance of the health of clergy and health as a ministry in making disciples for Christ. "Within the church community, there are persons affirmed by the community by offering themselves in leadership as God's ministry. Clergy are set apart but not separate in ministry from the whole people of God" (2004 *Book of Discipline*, ¶301 and ¶302).

Clergy are offering up their lives to full-time service in the Church, and in that context they need to carefully steward their health. They live with all other ordained ministers in mutual trust and concern and seek along with them the sanctification of the fellowship. Individual health becomes part of the covenant commitment. This covenant community should support an ethic of proper clergy self-care and attend to health practices in daily life.

Act Connectionally

To be in connection is to share resources, burdens and information. Through connection with God and each other, we do together what we cannot do alone. We need the witness of struggling and suffering individuals within the connection so that we can share their burdens and live out our accountability as one people of God in mission in the world.

Practices of the Church should work to improve the health of the whole connection as well as the health of the individuals who serve within it. Although the ideals of connectionalism remain the same, we live out those ideals at specific points in time, and our institutions need to respond to changing contexts.

Balance Compassion and Accountability

We should not legislate conformity, but we should inspire others to seek and follow God's peace. Wesley understood the way to move a person toward spiritual renewal was not through lectures on behavior, but through stories. Wesley's emphasis on health also included compassionate care for the sick. These concerns for health and sickness found practical expression in communal life as people gathered to provide support and discipline for Christian living and prayed for each other's healing.

We cannot allow either physical or mental illness to be a cause for exclusion and need to carefully consider their impact on ordination and appointments. We need to create an environment that embraces and supports clergy in times of transition, but that also holds individuals and institutions accountable for stewardship of their health. The covenant demands it.

Offer Prophetic Witness

As the Church, we lay claim to a passionate and prophetic voice. We live out this public witness by making a commitment to provide adequate health care to the people working for the Church, by equitably including the marginalized, even when it does not serve our financial interests and by teaching and modeling for others our faith and our care for our whole health and the health of our communities.

Although our culture promotes a dualism of body and spirit, the Church needs to teach the value of caring for both the body and the spirit. Prayer life, devotional life and physical life are all spiritual disciplines that individuals pursue in the context of community. As Wesley's example teaches us, clergy have an important responsibility to model and teach good health practices and to serve as living reminders to others.

The Church is called by God to the holistic ministry of healing: spiritual, mental, emotional and physical. United Methodists are called to work toward a healthy society of whole persons. Part of our task is to enable people to care for themselves and to take responsibility for their own health. Another part of our task is to ensure that people who are ill, whether from illness of spirit, mind or body, are not turned aside or ignored, but are given care that allows them to live a full life (*Book of Resolutions*, p. 308).

Listening Sessions

The Task Force shared recommendations with the following groups to gather feedback:

- Several Conference Boards of Pensions (CBOP)
- All five U.S. Colleges of Bishops
- Inter-Agency Health as Wholeness Task Force
- General Board of Higher Education and Ministry/Board of Ordained Ministries (GBHEM/BOM)
- Association of United Methodist Conference Pension Benefit Officers (AUMCPBO)
- Committee on the Study of Episcopacy
- The Connectional Table
- General Board of Pension and Health Benefits—Board of Directors
- District Superintendents Benefits Event Attendees
- HealthFlex Plan Sponsors
- Conference Benefits Officers Forum Attendees
- General Council on Finance and Administration (GCFA)—Board of Directors

Surveys and Reports Commissioned; Reference Materials Used

- Survey information commissioned by the Task Force and collected by the General Board from annual conferences during the second half of 2005:
 - **Financial Information Survey Results**—Based on 40 annual conference responses; excludes two annual conferences that responded too late to be included.
 - **Health and Wellness Initiatives Survey Responses**—Based on 41 out of 63 annual conference responses; excludes one annual conference that responded too late to be included.
 - **Health Insurance Information Survey Results**—Based on 49 out of 63 annual conference responses; excludes one annual conference that responded too late to be included.
- Cross-denominational clergy and laity survey of *Health, Well-Being, Spirituality and Job Characteristics*, Duke University, preliminary data collected in 2006, final report due in June 2007
- Articles/Studies:
 - *2006 Medical Cost Reference Guide: Facts and Trends to Support Knowledge-Driven Solutions*, BlueCross and BlueShield Association
 - *Staying Healthy*, FaithLink, January 22, 2006
 - *Benefits Go the Way of Pensions*, The New York Times, February 9, 2006
 - *Celebrating the Whole Wesley: A Legacy for Contemporary Wesleyans*, Randy L. Maddox, Ph.D., *Methodist History*, 43.2, 2005, pp. 74-89
 - *Managing Health Care Costs in a New Era*, 10th Annual National Business Group on Health/Watson Wyatt Survey Report, 2005
 - *Employer Health Benefits, 2005 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust
 - *The Next Retirement Time Bomb*, The New York Times, December 5, 2005
 - *Ministries of Health: Our Tradition and Our Challenge*, Interpreter, December 2005
 - *The Health Report to the American People*, Citizens' Health Care Working Group, October 14, 2005
 - *The Rising Prevalence of Treated Disease: Effects on Private Insurance Spending*, Health Affairs Web Site, June 27, 2005
 - *Worldwide Wellness*, HR Executive, June 16, 2005
 - *Health Care Opinion Leaders Survey*, The Commonwealth Fund, April 2005
 - *Older Americans 2004: Key Indicators of Well-Being*, Federal Interagency Forum on Aging-Related Statistics, 2004
 - *Boundary Leaders: Leadership Skills for People of Faith*, Gary Gunderson (Fortress Press, 2004)
 - *This Day: A Wesleyan Way of Prayer*, Laurence Hull Stookey (Abington Press, 2004)
 - *Reclaiming Holistic Salvation*, Randy L. Maddox, Ph.D., *Circuit Rider*, May/June 2003, pp. 14-15
 - *Ministerial Health and Wellness, Evangelical Lutheran Church in America*, Gwen Wagstrom Halaas, M.D., MBA, Project Director, February 2002
 - *Religious Involvement and Mortality: A Meta-Analytic Review*, *Health Psychology*, Vol. 19, No. 3, 2002, pp. 211-222
 - *Happiness, Leisure and Wealth*, *American Demographics*, April 1998
 - *Deeply Woven Roots: Improving the Quality of Life in Your Community*, Gary Gunderson (Fortress Press, 1997)
 - *A Heritage Reclaimed: John Wesley on Holistic Health and Healing*, essay by Randy L. Maddox, Ph.D.
- Other materials/presentations:
- *General Board of Pension and Health Benefits HealthFlex Participants 2005 Medical and Rx Claims by Relationship Report*, February 2006, examination of costs of the population of HealthFlex participants

- *An Analysis of Internal and External Data Sources Addressing Issues of Health Care Costs for General Board of Pension and Health Benefits of The United Methodist Church*, Richard Day Research, December 2005
- Presentation to the Task Force, Judy Johnston, M.D., R.D., L.D., December 2005; presentation covered:
 - Major health concerns in U.S. and associated economic costs
 - Obesity/metabolic syndrome and costs
 - Health care insurance issues
 - Options
 - Health Congregations in Action in Kansas
- *High-Level Analysis of Various Demographics*, General Board of Pension and Health Benefits of The United Methodist Church, September 2005
- *Evaluation of Plan Performance and Trend 2003 and 2004*, for HealthFlex, Ingenix, June 30, 2005 and September 30, 2005
- *Asset Mapping*, Task Force work, April 2005; assets categorized by:
 - National/international organizations, including faith-based
 - Body of The United Methodist Church
 - Local church
 - Local community
 - Conference/regional/local
 - Individuals/categories of people
 - Values and other intangible assets
- *Health As Wholeness in Mission: Faith, Community and Health in The United Methodist Church*; General Board of Pension and Health Benefits of The United Methodist Church, December 9, 2004
- *Complex Systems Map*, General Board of Pension and Health Benefits of The United Methodist Church, created 2003-2004

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