

The first offering is from a homily from last year, presented on the feast of the Dedication of St. John Lateran. It is a powerful reflection on the importance of faith-based communities and it fits in particularly well with this week's Gospel from John, in which the Eucharist is established on a hillside, with all invited, rather than in the upper room, by invitation only. Grateful to Joe for passing this along.

I have it from "good sources" that there are several people who will be in purgatory until the Parousia. At the top of the list is the first person to have called a building a church.

Today is one of those occasions when the readings we employ in the liturgy tell us not to celebrate the feast the liturgy commemorates.

Our earliest Christian ancestors in the faith had no specific buildings in which they celebrated the Lord's Supper. They simply gathered in their homes for such meals. As a child I was falsely taught they did so because of persecution. Since they feared being arrested and eventually martyred, they avoided meeting in high profile places like churches.

We realize from Paul's letters that they met in homes long before any persecutions began. Besides, rarely were the actual Roman persecutions empire-wide. Most were local and brief.

Christians met in homes for theological, not political reasons. As I mentioned in a previous column, they were convinced Jesus' death and resurrection had once and for all destroyed the distinction between sacred and profane. Everything, every place, every time, and every person could now be sacred. Jesus had torn down the veil which separated the two opposing elements. One's home had become just as sacred as the holiest temple on earth.

It's clear from our I Corinthians pericope that Paul believes the sacredness once reserved for special buildings, like the Jerusalem temple, now resides in Jesus' followers. "You are God's building The temple of God, which you are, is holy." No one has ever said it better.

Though we know the earliest Jerusalem followers of Jesus frequented the temple for prayers, Luke reminds us in Acts that the "breaking of bread" took place in their homes.

Their temple attendance soon ceased for two reasons. First, Christian Jews were eventually prohibited from entering these sacred precincts because of their practice of admitting Gentiles into their number. Without some personal (and embarrassing) inspection, the authorities couldn't be certain all Christians were Jews. Second, after 70 CE there was no temple. The Romans had demolished it.

These factors seem to be behind our gospel passage. Utilizing his well-known "replacement theology" (Anything Jews can do, we Christians can do better!) John teaches that the life-giving benefits people, like Ezekiel, expected to receive from the temple, they can now receive from Jesus. "'Destroy this temple and in three days I will raise it up.' . . . He was speaking about the temple of his body."

Since John doesn't have to worry about a real, physical temple any more - the Romans had taken care of that - he leaves out a statement of Jesus which the other gospel

writers thought was significant: "My house shall be a house of prayer (for all people), but you have turned it into a den of thieves!"

Because of Jesus' dramatic encounter with the merchants at the temple's entrance, it's easy to misinterpret his den of thieves comment. It has nothing to do with how business is being transacted in this sacred place. He's simply quoting his prophetic predecessor, Jeremiah (7:11), who wasn't dealing with buyers and sellers. I often remind my students that the den isn't normally the place where thieves do their thieving. It's where they go for security after they've thieved.

Like Jeremiah, Jesus points out that his fellow Jews have turned this sacred place into a sacred security blanket. It permitted them to go out and sin against their neighbors, then return to the temple, a "hide and seek base" on which they believed not even God could touch them.

Thankfully we never developed such a mentality about sacred places in Christianity.

Barbara passed along the following from the Daily Kos blog. It is a long, but worthwhile, read. You may click on the author's name to link to the blog.

Dear Mr. President

by [Hunter](#)

Jul 25, 2009

Dear Mr. President: I am writing you today because I am outraged at the notion of involving government in healthcare decisions like they do in other countries. I believe healthcare decisions should be between myself and my doctor.

Well, that is not strictly true. I believe healthcare decisions should be between myself, my doctor, and my insurance company, which provides me a list of which doctors I can see, which specialists I can see, and has a strict policy outlining when I can and can't see those specialists, for what symptoms, and what tests my doctors can or cannot perform for a given set of symptoms. That seems fair, because the insurance company needs to make a profit; they're not in the business of just keeping people alive for *free*.

Oh, and also my employer. My employer decides what health insurance company and plans will be available to me in the first place. If I quit that job and find another, my health insurance will be different, and I may or may not be able to see the same doctor as I had been seeing before, or receive the same treatments, or obtain the same medicines. So I believe my healthcare decisions should be between myself, the company I work for, my insurance company, and my doctor. Assuming I'm employed, which is a tough go in the current economy.

Hmm, but that's still a little simplistic. I suppose we should clarify.

I also believe my healthcare should depend on the form I fill out when I apply for that health insurance, which stipulates that any medical problems I ever had previously in my life won't be covered by that insurance, and so I am not allowed to seek further care for them, at least not at my insurance company's expense. That seems fair; otherwise my

insurance company might be cheated by me knowing I needed healthcare for something in advance.

And if I didn't know about an existing condition I had, but I *could* have known about it, had someone discovered it, I suppose it doesn't make much sense for my insurance to cover that either.

But let us assume that all hurdles have been cleared and I am allowed to see my doctor, chosen from a list of available doctors, about a health problem, except health problems I have previously been treated for. After that, I believe my healthcare decisions should be between myself, my insurance company, my insurance plan, my employer, and my doctor.

Oh -- and the doctors at the insurance company, of course.

They will never actually meet me, or even speak to me on the phone, and in fact I couldn't tell you the name of a single one of them, or what state they were in, or whether or not they've just all been outsourced to a computer program somewhere in Asia at this point -- but they're in charge of determining which treatments might be "effective" for me, and which will be a waste of money, er, time. They do this by looking not at my case, which is individualistic and piffling and minor, but at the statistical panoply of treatments on the insurance company spreadsheet and their statistical cost vs. effectiveness. My doctor may think one treatment or another might be effective for me in a particular instance -- but he may be a little too closely involved with my personal case, and unable to make these decisions nearly as well as my less involved, more dispassionate insurance company can.

And then there's the claims office. When my doctor sends a bill to my insurance company, it must travel through a phalanx of people and departments and procedures in order to determine whether or not it is, in fact, a valid medical complaint to be treated for, done the right way, at the right time, by a doctor on the right list. If the paperwork is not done on time, or not done completely, or not done to the satisfaction of the right people, or if I did not receive the proper prior approval for the medical treatment administered, or if that approval expired, or if the insurance company rescinded the approval months after the fact, my medical care will not be covered. While my doctor has had to sometimes forgo payments because the 30-day window for receiving "all requested documentation" somehow slipped by, I myself have received notes from the insurance company denying coverage for treatments from twelve full months beforehand. It can't be helped: sometimes it takes twelve months for their computers to process the paperwork and determine that I owe them more money. They like to be thorough.

So that's getting a bit more complete. I believe my healthcare decisions should be between me, my insurance company plan, my statement of preexisting conditions, the claims adjusters at my insurance company, my insurance company's doctors, my employer, and myself.

And the separate claims review team that will be looking over my treatment.

My health insurer might have flagged me as someone who needs a lot of healthcare, and who is therefore costing the company money. Needing to use the insurance you paid for is naturally a suspicious activity: that means that a special review team will look over my paperwork, seeing if there is any vaguely plausible reason for the company to be rid of me. They will look for loopholes in my application, irregularities in the paperwork

my doctor filled out or any other situations which, like magic, mean that all the money I have paid for health insurance premiums was in fact irrelevant, null and void, and they don't have to pay a single cent of claims because I defrauded them by neglecting to remember that I had chicken pox in sixth grade, not fifth, or that what I presumed was a bad cold in 1997 was in fact maybe-possibly-bronchitis, and I can't possibly expect to be covered for any lung-related complaints since then. I suppose I cannot complain too much; after all, this is a crack squadron of employees whose pay is determined by how much they can reduce the healthcare costs incurred by the company. It would be irresponsible for them to *not* look for such loopholes.

And then there is the board of directors at the insurance company, of course. My personal healthcare is irrelevant, when considered in the abstract; a health insurance company exists to make a profit, and the pay of every executive in the company and every board member is dependent on squeezing out the maximal amount of profits from every dollar.

This is where "experimental" and/or "preventative" treatments come in. New-fangled treatments, things that have only been around for a decade or two, are usually the most expensive. For example, when I complained of chest pains I could have had an CT scan to determine the state of the arteries around my heart, and it would have shown exactly where the problems, if any, lie. This is what the specialist recommended -- but using a CT scan in this way is considered "preventative" treatment, not "diagnostic" treatment, so it is not covered, and I am not allowed to have one. Instead, less accurate tests were used to get a "feel" for what the arteries might look like; these tests *are* covered. Problem solved; as it turned out, my chest pains were probably a preexisting condition, most likely caused by me having bones. And if it's not, I suppose we'll find out in another ten years or so, when no doubt I am covered by another insurance company and not this one.

These may seem like arbitrary determinations, but they are not. They are based on a rigorous study of how well the treatment works, how much it costs, and how likely it is that the company will have its corporate ass sued off if they do not provide it. This is weighed against the desired profit announcements for the insurance company during that quarter in order to determine how much care must be denied to customers, in aggregate, in order to meet the appropriate financial goals.

Let us not forget the obligations to the stockholders, after all. Of every dollar paid in premiums, currently eighty cents is paid back out for actual medical claims; the rest is administration and profit-taking. Fifteen years ago the number was 95 cents: in other words, the insurance companies themselves have gone from taking five cents of every healthcare dollar to taking twenty cents of every dollar, all since the Clinton presidency.

The stockholders require healthy profits. The executives require personal profits for providing those profits. And since people for some reason aren't getting any healthier, those profits can only come from one place -- reducing what the company pays out when people *do* become sick.

I recently heard a radio interview with a health insurance company whistleblower; he was describing his trips on the company jet. Gourmet meals were served on china, and the forks were gold plated.

I was pondering this, while looking over the letter from my insurance company informing me that they were switching the coverage of my most expensive monthly medication -- those expensive allergy/asthma shots now count as a "procedure", not as "medicine", and so therefore those vials are not covered by my pharmaceutical plan anymore. It must be very difficult to balance all the tasks of an insurance company CEO. If the corporate jet has inferior place settings, imagine the corporate shame. If a new medication or treatment is no longer considered "experimental", or a treatment classified as actually useful, as opposed to "preventative" nonsense, consider how many millions of dollars the company would have to pay out to give people that treatment. It seems reasonable indeed for the president of my insurance company to have personally pocketed a few hundreds of millions here or there -- I cannot imagine the stress of keeping up with proper utensil etiquette during a time when those you insure are doing you the constant insult of actually getting sick.

So, Mr. President, I write to you with this demand: we are not a socialist country, one which believes the health of its citizens should come without the proper profit-loss determinations. I believe that my healthcare decisions should be between me, my insurance company plan, my insurance company's list of approved doctors I am allowed to see and treatments I am allowed to get, my insurance company's claims department, the insurance company doctors who have never met me, spoken to me or even personally looked at my files, my own preexisting conditions, my insurance company's crack cost-review and retroactive cancellation and denial squads, my insurance company's executives and board of directors, my insurance company's profit requirements, the shareholders, my employer, and my doctor.

Anything else would be insulting.

**Your comments and submissions are appreciated. Send them to:
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