# Runaway Inequality and the Crisis of Healthcare in America

DJDI
Debs
Jones
Douglass
Institute

RunawayInequality.org

## About the Debs-Jones-Douglass Institute

Named for labor champions Eugene V. Debs, Mother Jones, and Frederick Douglass, DJDI is a non-profit 501(c)(3) organization founded in 1998. DJDI is working to address the health care crisis in the United States by organizing working people in support of Medicare for All through grassroots organizing and popular education as well as conducting research and policy. DJDI seeks to amplify the need for a robust Just Transition for health insurance and healthcare workers as we move toward Medicare for All.

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# Why We Are Here

American healthcare is in crisis. Our system is unsustainable and must be replaced.

Today we'll take a close look at our system, how it compares to other countries', and who really benefits from it. We'll consider how healthcare costs affect collective bargaining. We'll dig deep to see that our system isn't actually designed to deliver healthcare; it's designed to deliver profits.

We'll see how our healthcare system deepens runaway inequality, and we'll see that we can afford to provide good healthcare for every person in America.

We'll discuss the jobs related to healthcare insurance that would be eliminated under Improved Medicare for All and how the labor movement and progressives can fight for a fair and equitable transition for those workers.

We'll see what lessons the Canadian healthcare system might have for us.

Finally, we'll talk about how we'll win good, affordable healthcare for every American.

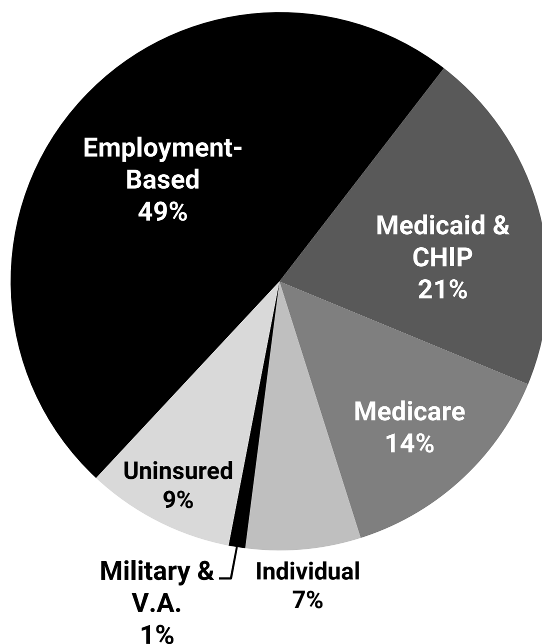
# Introduction

## Task: Current Healthcare Coverage

***How do you currently get healthcare insurance for yourself and your family? (Choose more than one if applicable.)***

______ Employment (including COBRA)
______ Medicare
______ Medicaid or CHIP
______ V.A.
______ ACA (Obamacare)
______ Other
______ No insurance

## SOURCES OF HEALTHCARE COVERAGE IN THE U.S.




**Employment-based**
Private insurance, including those covered through a current or former employer or union, either as policyholder or as dependent.

**Medicare**
Government insurance plan for anyone over 65 and some younger people with disabilities. Administered by the federal government.

**Medicaid & CHIP**
Government insurance plans for those with low incomes or a disability. Administered by states. CHIP, the Children's Health Insurance Program covers children and, in some states, pregnant women.

**Military**
Government insurance for active and retired military & families.

**Veterans Administration (VA)**
Direct health services for all veterans who are honorably discharged.

**Individual**
Private insurance purchased directly from an insurance company. Includes plans bought through ACA (Affordable Care Act) exchanges, both with and without government subsidies.

**Uninsured**
No healthcare insurance.

# Activity 1: Can We Afford Better Healthcare?

## Task 1: The CEO-to-Worker Wage Gap

Discussions about a major overhaul to our healthcare system are often immediately derailed by claims that there's no way to pay for it. To evaluate that claim, we first need to understand how runaway inequality has divided us into haves and have nots.

***How big is the gap between how much CEOs are paid and what average workers are paid?***

| *How big is the wage gap now?* | |
|---|---|
| 1. *How much do you believe a CEO of a large company receives each year in total compensation?* | $____________ |
| 2. *How much do you believe an average worker in a large company receives?* | $____________ |
| 3. *What ratio do you get when you divide the CEO estimate by the worker estimate?* | _______ *to one* |
| ***How big should the wage gap be?*** | |
| 4. *In your opinion, what should a CEO of a large company receive each year in total compensation?* | $____________ |
| 5. *What do you think an average worker should receive per year?* | $____________ |
| 6. *What ratio do you get when you divide the CEO estimate by the worker estimate?* | ________ *to one* |

# Top CEOs Make 842 Times More Than Workers

We've averaged out the CEO-to-worker pay ratio over several years because CEO pay can vary considerably with year to year. From 2010 to 2018, the ratio ranged between 655-to-one and 1313-to-one, with an average of 842-to-one.

**WAGE GAP: TOP 100 CEOS VERSUS AVERAGE WORKERS**

Averaged over 2010-2018

**Average production or nonsupervisory worker, based on weekly wages, multiplied by 52 weeks. The "production or nonsupervisory worker" category covers about 80% of working people.*

**Task 2: The Gap Between Productivity and Wages**

# There's a Huge Gap Between Productivity and Wages

The chart below shows that a gap has developed between **productivity** and **real wages. Productivity** measures how much we produce in a given hour. In general, in a productive economy, we collectively have the knowledge, skill, technology, and organization to produce more each hour. **Real wages** is what we earn after taking inflation into account.

## REAL WAGES VS. PRODUCTIVITY INCREASES

For generations, as productivity (top line) increased, so did real wages (bottom line). As we can see, from WWII until the mid-1970's, productivity and wages were virtually inseparable. Average workers shared in the rewards of higher productivity.

In the mid-1970's, something changed. Productivity kept going, but our wages didn't. Today we produce two-and-a-half times more goods and services per hour of labor than we did in 1947. Yet average wages have stalled since the mid-1970's.

Had we continued to get our fair share of productivity gains, the average American worker's wage would have been $1,377 per week in 2017.* That's almost double the actual average weekly wage of $746.

That gap between productivity and wages is the money that the 1% has taken systematically from working people year after year for the last 40 years. We now live in an age of **runaway inequality:** the ever-increasing gap between the super-rich and the rest of us.

**Average weekly wages for production and non-supervisory workers based on Bureau of Labor Statistics data. Wages measured after inflation in 2017 dollars.*

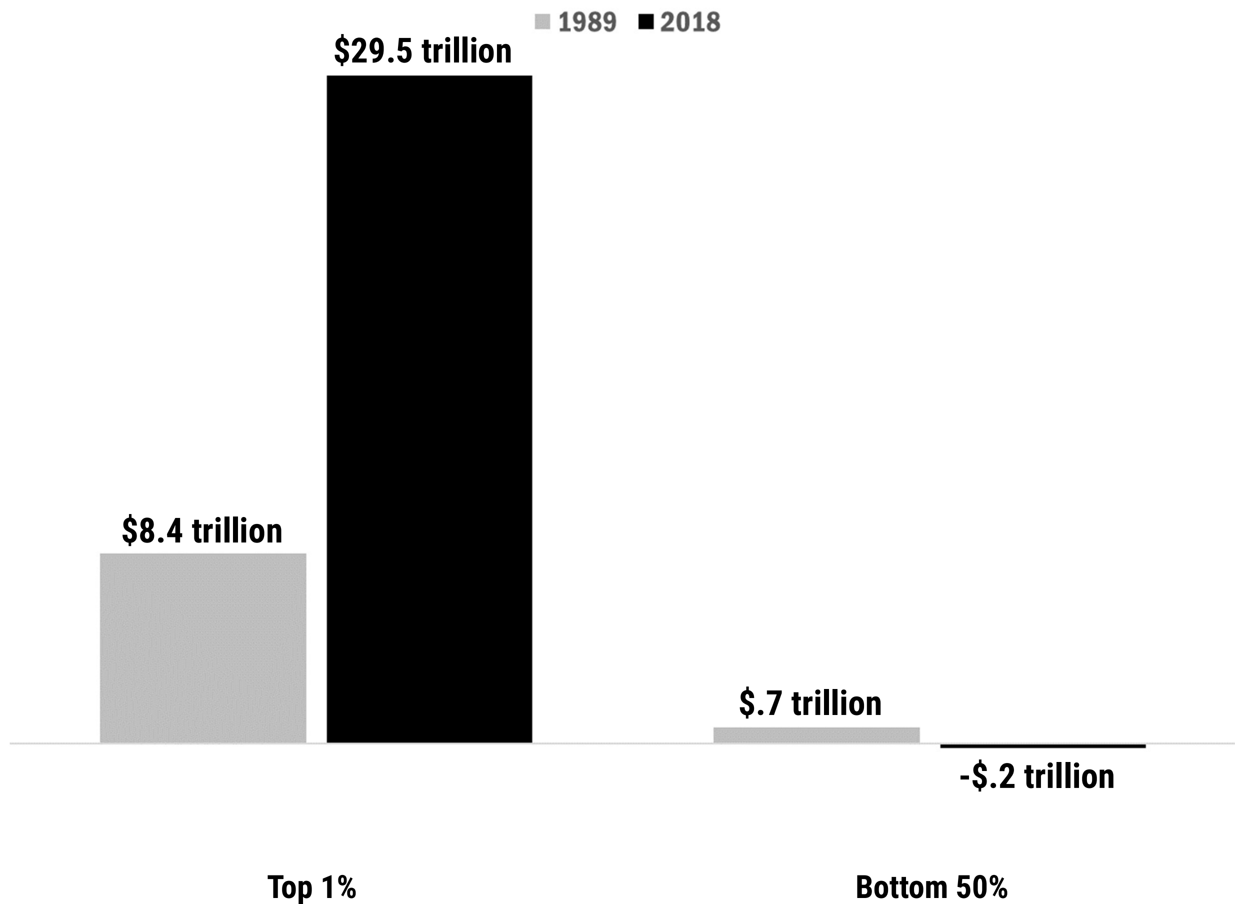
# The Top 1% Have Taken $21 Trillion Since 1989

Since 1989, the total net worth of the top 1 percent has **increased by $21 trillion.**

The total net worth of the bottom 50 percent has **decreased by $900 billion**.

## TOTAL WEALTH OF TOP 1% AND BOTTOM 50%

1989-2018




*Source: Calculated by Matt Bruenig from Federal Reserve data on Distributive Financial Accounts, 6/4/19, www.peoplespolicyproject.org/2019/06/14/top-1-up-21-trillion-bottom-50-down-900-billion*

## Task 3: What Happened?

In your small groups, please make a list of the reasons you think the two lines pulled apart. Please choose one person in your group to be the recorder for this task. Their job is to make sure that everyone can participate in the discussion, record your group's answers, and report back to the entire group.

***Why do you think the two lines pulled apart? In your small groups, please make a list of reasons.***

- 
- 
- 
- 

*Read more about how the gap between productivity and wages got so big in chapter 3 of Runaway Inequality, pp. 39-40.*

## Task 4: How Much Are They Taking?

All together, we will calculate how much of our productivity has been diverted to the super-rich. We'll go through this calculation together, but you may want to write the numbers in your workbook to refer to in the future.

| *First we'll calculate how much each worker is missing every year:* | |
|---|---|
| *1. Average weekly wage today if wage gains kept up with productivity:* | |
| *2. Actual average weekly wage today:* | - |
| *3. Subtract #2 from #1 = Our missing weekly wages* | = |
| *4. Multiply by 52 weeks* | x 52 |
| *4. Our missing annual wages per worker* | = |
| ***Now, how much are we missing collectively?*** | |
| *4. Number of workers (according to the Bureau of Labor Statistics)* | 103,000,000 |
| *5. Our missing annual wages* | x |
| *6. Multiply number of workers by missing annual wages* | = |

## Task 5: Can We Afford Medicare for All?

In your small groups, please review the fact sheets on pages 7-17 and answer the two questions below. Choose a different person in your group to record your answers and also help make sure that your group looks through all the fact sheets.

1. ***How would you respond to someone who says we can't afford Improved Medicare for All?***

2. ***Of the fact sheets on pages 7-17, which ONE do you think would be most important to share with your co-workers or community?***

***Page*** ____

***Title of fact sheet*** ______________________________________________________

***Why did you choose this fact sheet?***

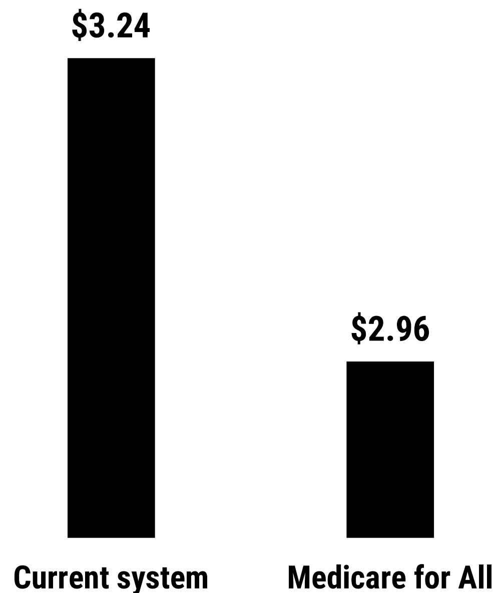
# Improved Medicare for All Costs Less Than Our Current System

The cost for Medicare for All is *less* than we're spending on the current system even though Medicare for All would cover millions more people and expand services for everyone.

- Our entire healthcare system now costs **$3.24 trillion** a year.

  *This includes all payments by individuals, government, and employers: payroll and other taxes, premiums, out-of-pocket costs (like co-pays and deductibles, and out-of-network or uncovered services), Medicare, Medicaid, the V.A., and subsidies for the ACA.*

- Improved Medicare for All would cost **$2.96 trillion** per year.
- How? Medicare for All has much lower administrative costs and takes out the profiteering.




*Source: Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim, and Michael Ash, "Economic Analysis of Medicare for All," University of Massachusetts Amherst, Political Economy Research Institute, November 2018, p. 2.*

# Cost Saving Potential Under Medicare for All

Medicare for All can potentially offer major cost savings compared to what our country spends today. These savings would come from reducing the amount of money that is spent on activities other than delivering healthcare, like administrative billing, profit, and advertising. Additional savings come from negotiating pharmaceutical prices, establishing uniform Medicare rates for hospitals, physicians, and clinics, and eliminating waste.

Here's one estimate of the savings potential:

## PERCENTAGE OF CURRENT HEALTHCARE SPENDING WE COULD SAVE UNDER MEDICARE FOR ALL

| Area of savings | % of current healthcare spending |
|---|---|
| Administration | 9% |
| Pharmaceutical pricing | 5.9% |
| Uniform rates for hopsitals, physicians, and clinics | 2.8% |
| Waste and fraud in providing services | 1.5% |
| **Total cost savings** | **19.2%** |

*Source: Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim, and Michael Ash, "Economic Analysis of Medicare for All," University of Massachusetts Amherst, Political Economy Research Institute, November 2018, p. 2.*

# To Make Big Money, For-Profit Insurers Need to Spend Billions on Wasteful Administration and Lobbying

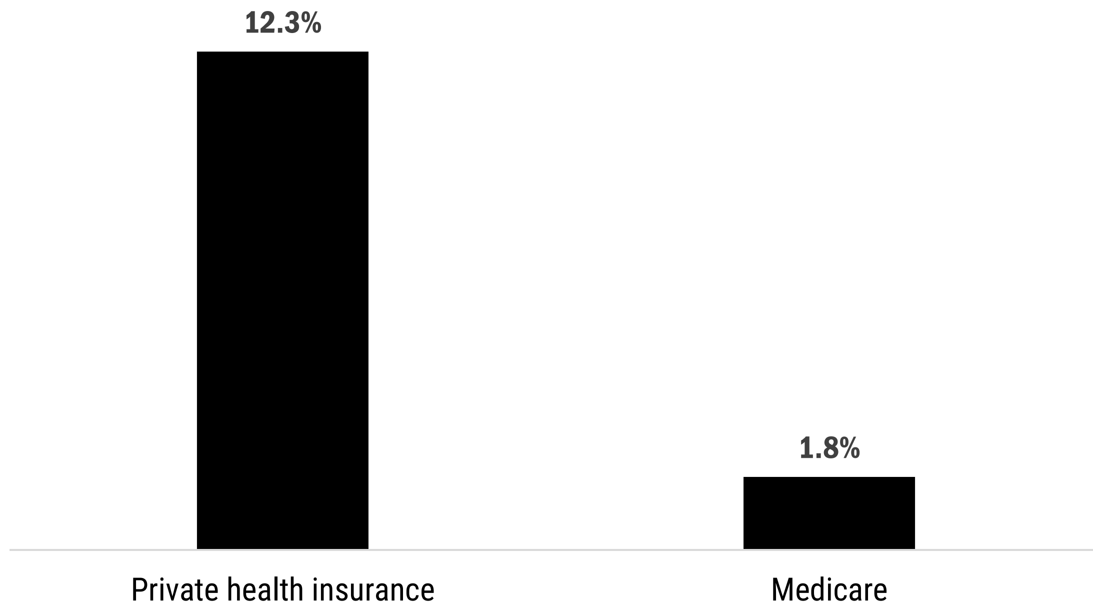
To make for-profit insurance profitable, the companies need to set up an elaborate administrative system to delay and deny claims. They hire armies of lobbyists to make sure that the rules allow them to keep ripping us off. And they spend billions on marketing to sell their products. This costs them a great deal. But they recoup their costs by charging us more in premiums, co-pays, and deductibles.

While this bloated administration is highly profitable for them, it's a colossal waste for society and extremely costly for us.

That's why Medicare costs a lot less to administer than private healthcare insurance. The costs of running Medicare don't have to include profits, excessive executive pay, marketing, and lobbying.

## Overhead Costs as a Share of Total Health Expenditures

2010-2015




*Source: Center for Economic & Policy Research, cepr.net/blogs/cepr-blog/overhead-costs-for-private-health-insurance-keep-rising-even-as-costs-fall-for-other-types-of-insurance, citing Centers for Medicare and Medicaid Services; Medicare Trustees Reports, 2011-16*

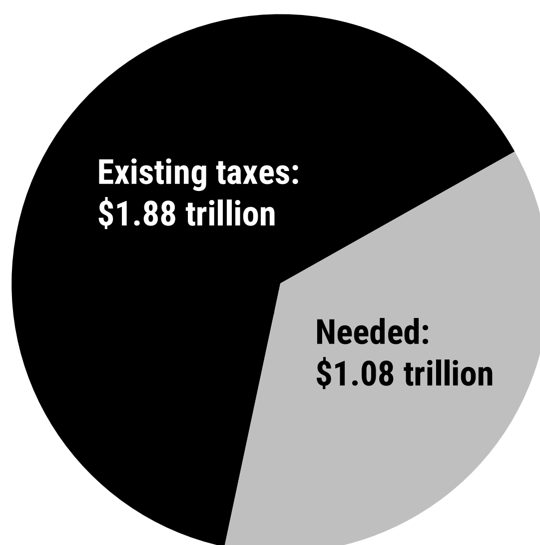
# We Don't Need to Tax Ourselves to Pay for Improved Medicare for All

As we saw on the previous pages, Medicare for All would cost $2.96 trillion per year.

The taxes we pay now cover **$1.88 trillion, or two-thirds of the cost.** So we would need to raise an additional **$1.08 trillion** per year.

That's a lot of money, but we don't need to increase taxes on the middle class. There are many ways to raise that $1.08 trillion, such as making corporations actually pay their taxes or putting a small wealth tax on the super-rich.

## SOURCES OF FUNDING FOR IMPROVED MEDICARE FOR ALL



# 60 Companies Paid No U.S. Income Tax in 2018

Sixty large companies with a combined profit of $79 billion paid no corporate income taxes in 2018. Almost all of them actually claimed a federal tax *rebate*.

## U.S. Corporate Profits and Federal Tax Rebates

2018, in millions

| Company | U.S. Profits | Tax Rebate |
|---|---|---|
| Amazon.com | $10,835 | ($129) |
| Delta Air Lines | $5,073 | ($187) |
| Chevron | $4,547 | ($181) |
| General Motors | $4,320 | ($104) |
| EOG Resources | $4,067 | ($304) |
| Occidental Petroleum | $3,379 | ($23) |
| Duke Energy | $3,029 | ($647) |
| Dominion Resources | $3,021 | ($45) |
| Honeywell | $2,830 | ($21) |
| Deere | $2,152 | ($268) |
| American Electric Power | $1,943 | ($32) |
| Kinder Morgan | $1,784 | ($22) |
| Public Serv. Ent. Group | $1,772 | ($97) |
| Principal Financial | $1,641 | ($49) |
| FirstEnergy | $1,495 | ($16) |
| Prudential Financial | $1,440 | ($346) |
| Xcel Energy | $1,434 | ($34) |
| PulteGroup | $1,340 | ($44) |
| Molson Coors | $1,325 | ($23) |
| Devon Energy | $1,297 | ($14) |
| Pioneer Natural Res. | $1,249 | $0 |
| DTE Energy | $1,215 | ($17) |
| Wisconsin Energy | $1,139 | ($218) |
| PPL | $1,110 | ($19) |
| Halliburton | $1,082 | ($19) |
| Ameren | $1,035 | ($10) |
| Netflix | $856 | ($22) |
| Salesforce.com | $800 | $0 |
| CMS Energy | $774 | ($67) |
| Rockwell Collins | $719 | ($16) |

| Company | U.S. Profits | Tax Rebate |
|---|---|---|
| Whirlpool | $717 | ($70) |
| MGM Resorts Int'l | $648 | ($12) |
| Atmos Energy | $600 | ($10) |
| Eli Lilly | $598 | ($54) |
| Alaska Air | $576 | ($5) |
| Cleveland-Cliffs | $565 | ($1) |
| UGI | $550 | ($3) |
| IBM | $500 | ($342) |
| Celanese | $480 | ($142) |
| Activision Blizzard | $447 | ($228) |
| Goodyear | $440 | ($15) |
| U.S. Steel | $432 | ($40) |
| Owens Corning | $405 | ($10) |
| Penske Automotive | $393 | ($16) |
| Ryder System | $350 | ($23) |
| Arthur Gallagher | $322 | $0 |
| Aramark | $315 | ($48) |
| MDU Resources | $314 | ($16) |
| AECOM Technology | $238 | ($122) |
| JetBlue Airways | $219 | ($60) |
| Tech Data | $203 | ($10) |
| Realogy | $199 | ($13) |
| Performance Food | $192 | ($9) |
| Arrow Electronics | $167 | ($12) |
| Trinity Industries | $138 | ($19) |
| Pitney Bowes | $125 | ($50) |
| Avis Budget Group | $78 | ($7) |
| SPX | $66 | ($5) |
| SpartanNash | $40 | ($2) |
| Gannett | $7 | ($11) |
| Total | $79.0 billion | |

*Source: "Corporate Tax Avoidance Remains Rampant Under New Tax Law," Institute on Taxation and Economic Policy, 4/11/19, itep.org/notadime*

# Can the Super-Rich Afford It?

The top 1% of wealth holders collectively own more than 40% of the nation's total wealth.

It's hard for most of to wrap our minds around just how wealthy the super-rich are. How much is $50 million? $500 million? $1 billion? $100 billion?

One current wealth tax proposal calls for a 2% tax on fortunes of $50 million to $1 billion and a 3% tax on $1 billion or more. Let's look at how that could affect the ultra-rich.

**Mega-millionaire Martha** has a fortune of $50 million. If she paid a 2% wealth tax, she'd have a fortune of … $49 million.

If Martha paid a 2% tax each year—and didn't earn any more money (which seems unlikely!)—after 10 years she'd still have about $42 million.

**Billionaire Brian** has a $1 billion fortune. How much is that? It's enough to spend $20 million per year for the next 50 years.

If Brian paid a 3% tax each year—and didn't earn any more money (again, pretty unlikely!)—after 10 years he'd still have $737 million. That's enough to spend $14.7 million a year for the next 50 years.

**It's enough to spend $40,000 *every single day* for the next 50 years.**

**Amazon CEO Jeff Bezos,** the richest person on the planet, has over $100 billion. How much is that?

It's enough to spend $5.5 million **every day** for the next 50 years.

If he paid a 3% tax each year—and didn't earn any more money—after 10 years he'd still have $73.7 billion, enough to spend $1.5 billion a year for the next 50 years.
**It's enough to spend $4 million *every single day* for the next 50 years.**

*Source: Steve Wamhoff, "The U.S. Needs a Federal Wealth Tax," Institute on Taxation and Economic Policy, 1/23/19, itep.org/the-u-s-needs-a-federal-wealth-tax*

# Takeaways

1. Improved Medicare for All would cost far less than our current healthcare system and would cover everyone.
2. Through our taxes, we're already paying for two-thirds of the cost of Improved Medicare for All.
3. If average wages had kept up with productivity, an average worker's paycheck would be double what it is today.
4. Instead, the super-rich have walked off with trillions that we produced. Improved Medicare for All is one way to take some of that back.
5. The $3 trillion we currently spend on healthcare could be used to pay for a system based on humane principles.

# Activity 2: We Can Afford to Replace Our Healthcare System. Do We Need to?

## Task 1: What Are We Paying for Now?

Our entire healthcare system now costs $3.24 trillion a year. Are we getting what we're paying for? In your groups, please review the information on pages 20-27. Then make a list of your agreements and disagreements with the statement below.

Finally, please choose the ONE fact sheet that you think is most important to share with your co-workers or community. Please choose a different member of your group to take notes and report back.

1. ***What are your agreements and disagreements with the statement below?***

> "America has an outstanding healthcare system. Consumers can choose their own doctors, who are truly the best in the world. Our scientists do cutting-edge research and design the best technology and drugs that produce the best results. And we don't have government bureaucrats stifling innovation and interfering with our healthcare choices. Yes, our system is expensive, but, like everything else, you get what you pay for."

***Agreements:***

***Disagreements:***

2. ***Of the fact sheets on pages 20-27, which ONE do you think would be most important to share with your co-workers or community?***

   ***Page ___***

   ***Title of fact sheet ________________________________________________***

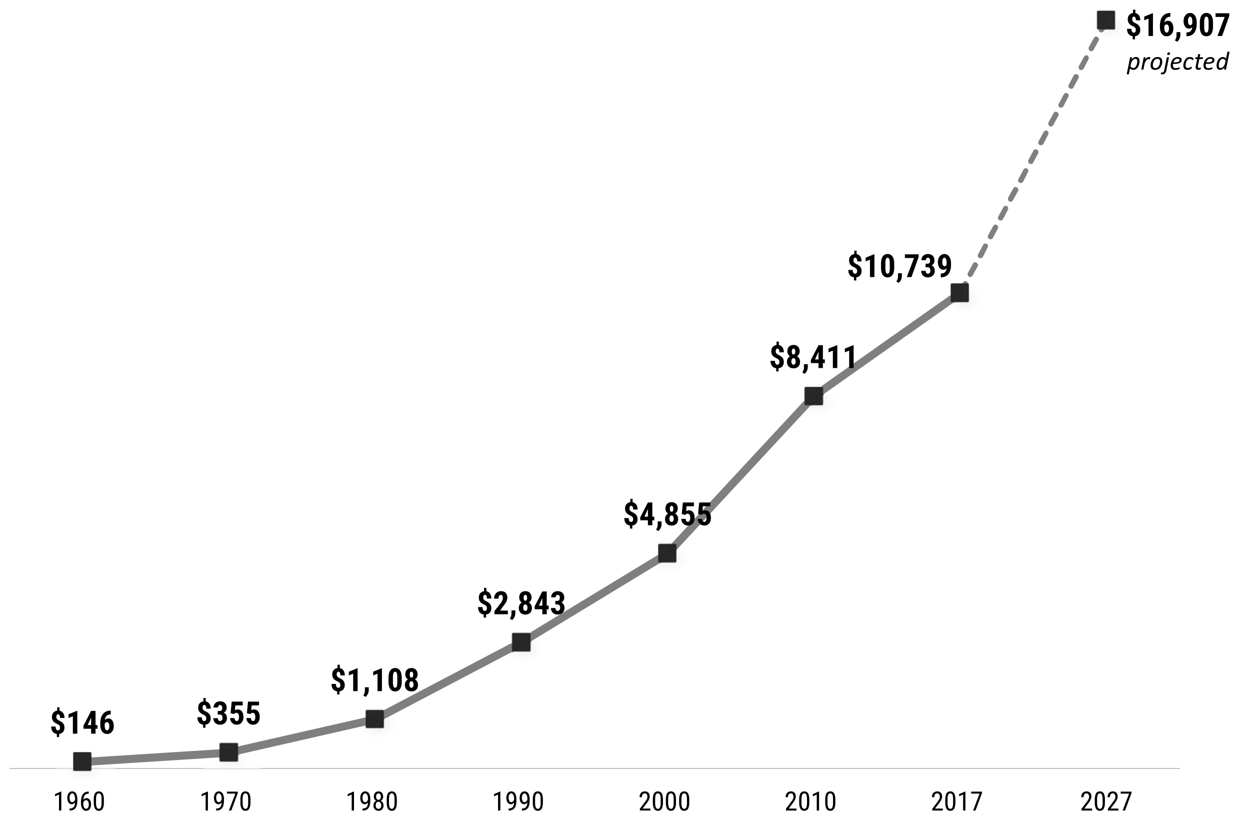
   ***Why did you choose this fact sheet?***

# We Are Spending More and More on Healthcare

Healthcare prices are rising faster than just about everything. The chart below illustrates the increase in healthcare spending in America. We are now spending well over $10,000 per person per year on healthcare. This includes all costs, public and private.

## U.S. Health Expenditures Per Person Per Year

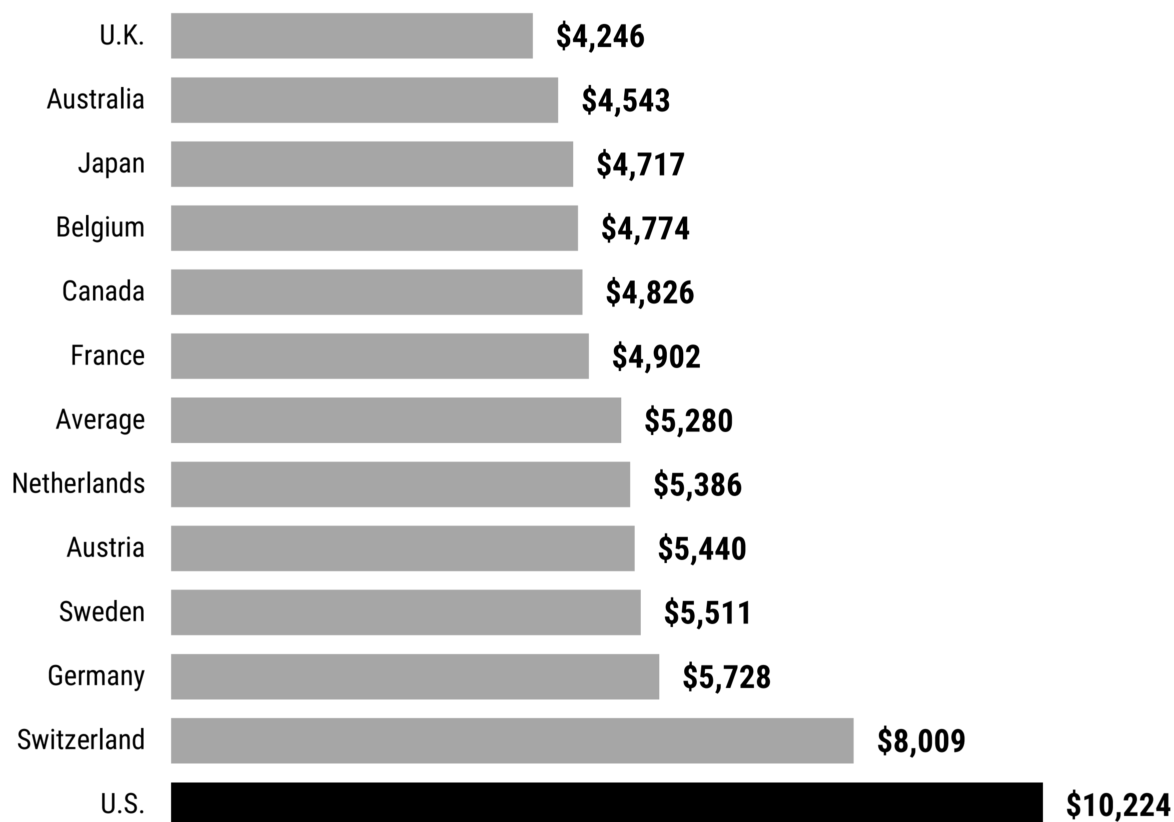
1960-2027 in 2017 dollars




*Source: National Health Expenditures Data, U.S. Centers for Medicare & Medicaid Services, www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata*

# And We Are Spending More Than Other Countries

Other wealthy countries spend far less on healthcare than the U.S. The average is about half as much.




*Source: Bradley Sawyer and Cynthia Cox, "How does health spending in the U.S. compare to other countries?," Kaiser Family Foundation, 12/7/18, www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries*

# Yet People in Other Countries Live Longer

Despite all the money we spend on healthcare, the U.S. ranks #27 in life expectancy. On average, people in the U.S. live to 78.6, while people in Japan live to 84.2.

## AVERAGE LIFE EXPECTANCY

2017

| | Country | Years |
|---|---|---|
| 1 | Japan | 84.2 |
| 2 | Switzerland | 83.6 |
| 3 | Spain | 83.4 |
| 4 | Italy | 83 |
| 5 | Iceland | 82.7 |
| 6 | Rep. of Korea | 82.7 |
| 7 | Norway | 82.7 |
| 8 | Australia | 82.6 |
| 9 | France | 82.6 |
| 10 | Sweden | 82.5 |
| 11 | Ireland | 82.2 |
| 12 | Canada | 82 |
| 13 | New Zealand | 81.9 |
| 14 | Netherlands | 81.8 |
| 15 | Austria | 81.7 |
| 16 | Finland | 81.7 |
| 17 | Belgium | 81.6 |
| 18 | Portugal | 81.5 |
| 19 | Greece | 81.4 |
| 20 | U.K. | 81.3 |
| 21 | Denmark | 81.2 |
| 22 | Germany | 81.1 |
| 23 | Slovenia | 81.1 |
| 24 | Costa Rica | 80.4 |
| 25 | Chile | 80.2 |
| 26 | Czechia | 79.1 |
| 27 | U.S. | 78.6 |

### Even Shorter Lives

Some groups in the U.S. fare even worse. For example, people with higher incomes live longer than those with lower incomes. On average, White people live longer than African-Americans.

*Source: OECD, "Life expectancy at birth," data.oecd.org/healthstat/life-expectancy-at-birth.htm, retrieved 9/7/2019*

# Our Maternal Mortality Rate Is Higher Than Other Countries

The maternal mortality rate measures how many women die during pregnancy or during the 6 following weeks. The U.S. ranks behind 45 other countries.

## MATERNAL MORTALITY RATIO (PER 100,000 LIVE BIRTHS)

2015 (most recent available)

| Rank | Country | Rate |
|---|---|---|
| 1 | Finland | 3 |
| 2 | Greece | 3 |
| 3 | Iceland | 3 |
| 4 | Poland | 3 |
| 5 | Austria | 4 |
| 6 | Belarus | 4 |
| 7 | Czechia | 4 |
| 8 | Italy | 4 |
| 9 | Sweden | 4 |
| 10 | Kuwait | 4 |
| 11 | Israel | 5 |
| 12 | Norway | 5 |
| 13 | Spain | 5 |
| 14 | Switzerland | 5 |
| 15 | Japan | 5 |
| 16 | Denmark | 6 |
| 17 | Germany | 6 |
| 18 | Slovakia | 6 |
| 19 | U.A.E. | 6 |
| 20 | Australia | 6 |
| 21 | Canada | 7 |
| 22 | Belgium | 7 |
| 23 | Cyprus | 7 |

| Rank | Country | Rate |
|---|---|---|
| 24 | Netherlands | 7 |
| 25 | Montenegro | 7 |
| 26 | Croatia | 8 |
| 27 | France | 8 |
| 28 | Ireland | 8 |
| 29 | Rep. of N. Macedonia | 8 |
| 30 | Estonia | 9 |
| 31 | Malta | 9 |
| 32 | Slovenia | 9 |
| 33 | U.K. | 9 |
| 34 | Libya | 9 |
| 35 | Lithuania | 10 |
| 36 | Luxembourg | 10 |
| 37 | Portugal | 10 |
| 38 | Singapore | 10 |
| 39 | Bosnia and Herzegovina | 11 |
| 40 | Bulgaria | 11 |
| 41 | New Zealand | 11 |
| 42 | Rep. of Korea | 11 |
| 43 | Kazakhstan | 12 |
| 44 | Saudi Arabia | 12 |
| 45 | Qatar | 13 |
| **46** | **U.S.** | **14** |

**Even Higher Mortality Rates**

African-American, Native American and Alaska Native women die of pregnancy-related causes at a rate about three times higher than White women.

*Source: World Health Organization, apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=25*

# And So Is Our Child Mortality Rate

The under-five mortality rate is the probability of dying by age 5 per 1000 live births. The U.S. ranks 45th in the world, behind many rich countries, but also relatively poor countries such as Estonia and Belarus.

## UNDER-5 MORTALITY RATE

2017

| Rank | Country | Rate |
|---|---|---|
| 1 | Iceland | 2.1 |
| 2 | Slovenia | 2.1 |
| 3 | San Marino | 2.2 |
| 4 | Finland | 2.3 |
| 5 | Japan | 2.6 |
| 6 | Luxembourg | 2.6 |
| 7 | Norway | 2.6 |
| 8 | Cyprus | 2.7 |
| 9 | Estonia | 2.7 |
| 10 | Singapore | 2.8 |
| 11 | Sweden | 2.8 |
| 12 | Spain | 3.1 |
| 13 | Andorra | 3.3 |
| 14 | Czechia | 3.3 |
| 15 | Monaco | 3.3 |
| 16 | Rep. of Korea | 3.3 |
| 17 | Italy | 3.4 |
| 18 | Australia | 3.5 |
| 19 | Ireland | 3.5 |
| 20 | Montenegro | 3.5 |
| 21 | Austria | 3.6 |
| 22 | Israel | 3.6 |
| 23 | Belarus | 3.7 |
| 24 | Germany | 3.7 |
| 25 | Portugal | 3.7 |
| 26 | Belgium | 3.8 |
| 27 | Netherlands | 3.9 |
| 28 | France | 4.2 |
| 29 | Latvia | 4.2 |
| 30 | Switzerland | 4.2 |
| 31 | Denmark | 4.3 |
| 32 | Lithuania | 4.3 |
| 33 | U.K. | 4.3 |
| 34 | Hungary | 4.5 |
| 35 | Croatia | 4.6 |
| 36 | Poland | 4.7 |
| 37 | Canada | 5.1 |
| 38 | Greece | 5.3 |
| 39 | New Zealand | 5.3 |
| 40 | Cuba | 5.4 |
| 41 | Slovakia | 5.6 |
| 42 | Bosnia & Herzegovina | 5.7 |
| 43 | Serbia | 5.7 |
| 44 | Malta | 6.4 |
| **45** | **U.S.** | **6.6** |

*Source: World Health Organization, apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=7*

# Americans Don't Use More Healthcare Than Other Countries

A common explanation for our higher spending on healthcare is that we use it more than people in other countries, but that's not what the data shows. Americans see doctors less often and have shorter in-patient hospital stays, and we have fewer acute care hospital beds.

We also have fewer doctors and nurses than comparable countries.

## USAGE OF U.S. HEALTHCARE SYSTEM VS. COMPARABLE COUNTRIES

2014 or 2015 (for each, most recent year in which comparable data was available)

| | **Number of doctor consultations** (per capita) | **Average inpatient hospital stay** | **Number of hospital beds** (acute care) | **Practicing nurses** (per 1,000 people) | **Practicing physicians** (per 1,000 people) |
|---|---|---|---|---|---|
| **U.S.** | 3.9 | 6.1 days | 2.5 beds | 7.9 | 2.6 |
| **Average in comparable countries*** | 7.6 | 10.2 days | 3.4 beds | 9.9 | 3.2 |

**Median in OECD countries (Organisation for Economic Co-operation and Development)*

*Source: Health Affairs, www.jhsph.edu/news/news-releases/2019/us-health-care-spending-highest-among-developed-countries.html*

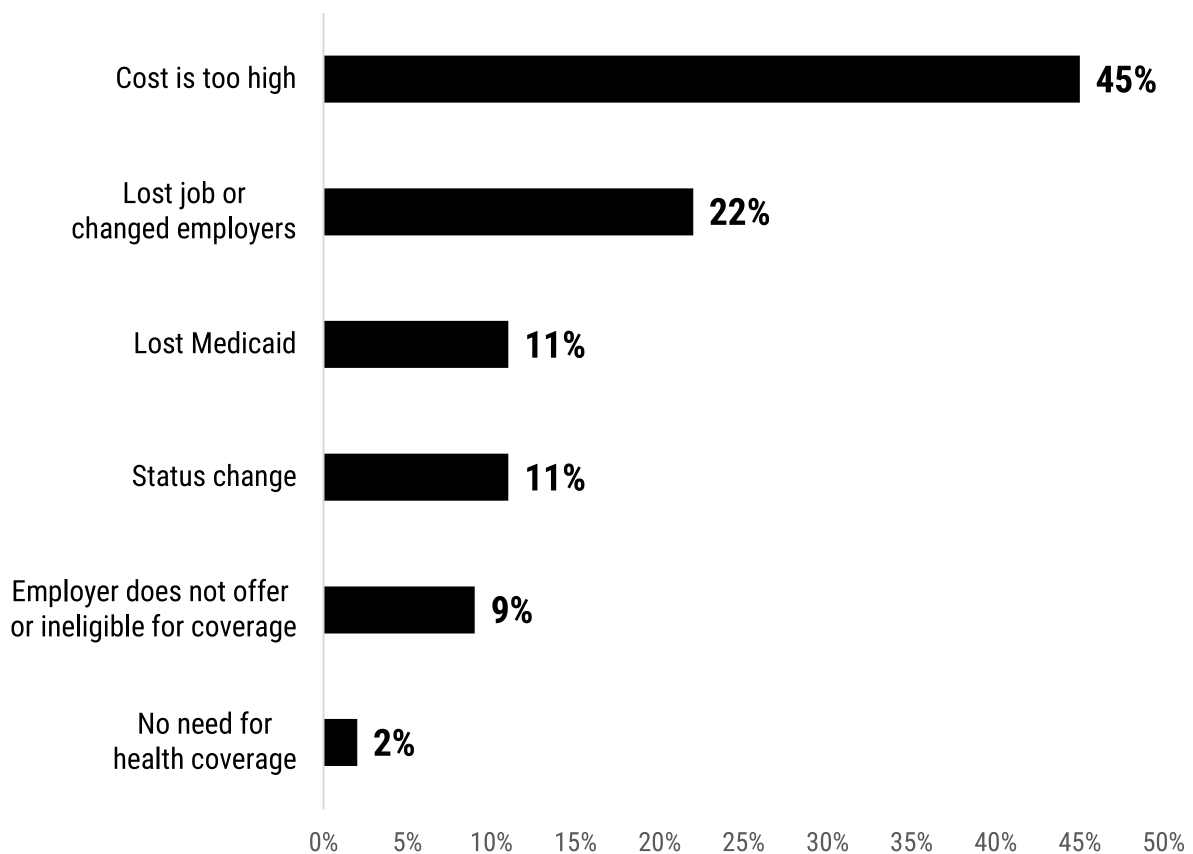
# 27.4 Million People Are Still Uninsured

We spend more, but we still don't cover everyone. Even with the Affordable Care Act in effect, more than 27 million people in the U.S. have no healthcare coverage, because they can't get it or can't afford it.

Another 41 million people are "**under**insured": they have some kind of health insurance but can't afford to use it.

## REASONS FOR BEING UNINSURED

2017, among adults under 65




*Note: Includes individuals ages 18 to 64. Respondents can select multiple reasons. Status change includes marital status change, death of spouse or parent, or ineligible due to age or leaving school.*

*Sources: "Key Facts About the Uninsured Population," Kaiser Family Foundation,12/7/2018, www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population; "How Well Does Insurance Coverage Protect Consumers from Health Care Costs?", Commonwealth Fund, Oct. 2017, www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_oct_collins_underinsured_biennial_ib.pdf*

# Pharmaceutical Companies Charge Far Higher Prices in the U.S.

The same prescription drugs are vastly more expensive in the U.S. than in other countries.

## LIST PRICE OF PRESCRIPTION DRUGS (ONE-MONTH SUPPLY)

| | Humira | Crestor | Lantus | Advair | Januvia |
|---|---|---|---|---|---|
| **Main use** | Rheumatoid arthritis | Cholesterol | Insulin | Asthma | Diabetes |
| **U.S.** | **$3,431** | **$216** | **$373** | **$310** | **$331** |
| **Germany** | $1,749 | $41 | $61 | $38 | $39 |
| **Australia** | $1,243 | $9 | $54 | $29 | $34 |
| **Canada** | $1,164 | $32 | $67 | $74 | $68 |
| **UK** | $1,158 | $26 | $64 | $47 | $48 |
| **France** | $982 | $20 | $47 | $35 | $35 |
| **Norway** | $918 | $20 | $45 | $24 | $34 |

## Importing Medicine from Abroad

Clearly, many Americans are acutely aware of these price differences. 19 million American adults say they import medication to save money. (The real number is probably higher since importing prescription drugs is against the law.)

*Sources: Commonwealth Fund, "Paying for Prescription Drugs Around the World: Why Is the U.S. an Outlier?", 10/5/2017, www.commonwealthfund.org/publications/issue-briefs/2017/oct/paying-prescription-drugs-around-world-why-us-outlier; files.kff.org/attachment/Kaiser-Health-Tracking-Poll-November-2016-Topline*

## Task 2: Healthcare and Runaway Inequality

In your small groups, please review the information on pages 29-35 and answer the two questions below. Please choose a different member of your group to take notes and report back.

1. ***Runaway inequality is the ever-increasing gap in income and wealth between the super-rich and the rest of us. Are runaway inequality and our healthcare system connected?***

   ***If yes, how?***

2. ***Of the fact sheets on pages 29-35, which ONE do you think would be most important to share with your co-workers or community?***

   ***Page ___***

   ***Title of fact sheet ________________________________________________***

   ***Why did you choose this fact sheet?***

# Low-Income Americans Face High Barriers to Medical Care

According to an analysis by Health Affairs, compared to higher-income Americans, low-income people face greater barriers to accessing medical care, including:

- They are less likely to have health insurance,
- Less likely to receive new drugs and technologies
- Less likely to have ready access to primary and specialty care.
- May have to travel further and wait longer for care.
- May have difficulty paying for transportation and childcare required to get care.
- More likely to work for employers that don't offer health benefits. Less than one-third of low-income workers get health insurance through their employer, compared to nearly 60 percent of higher-income workers.
- Those without health insurance are more likely to forgo care because of cost.
- Uninsured people are less likely to receive preventive care and are more likely to be hospitalized for conditions that could have been prevented.

*Source: Dhruv Khullar and Dave A. Chokshi, "Health, Income, & Poverty: Where We Are & What Could Help," Health Affairs, 10/4/18, www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/*

# Poor Health and Expensive Healthcare Keep People in Poverty

## The "Poverty-Health Trap"

- If you're poor in the U.S., it's hard to afford healthcare you need.
- If you don't get healthcare that you need, you're more likely to stay poor.

## Those with Low Incomes Are More Likely to Have Severe Health Problems

- Low-income adults are more than 3 times as likely to have limitations with routine activities (like eating, bathing, and dressing) due to chronic illness, compared with more affluent individuals.
- Lower-income adults are more likely to have heart disease. The prevalence of heart disease is nearly 50 percent higher among poor adults than among adults in the highest-income group.
- Diabetes is twice as common among poor adults as among those in the highest-income group
- Children living in poverty are more likely to have risk factors such as obesity and elevated blood lead levels, affecting their future health prospects.

## Health Problems Affect Household Income

- Poor health makes people more likely to miss work, of course, and people in low income jobs are less likely to have paid sick leave. That means they have to choose between going to work sick (or sending their kids to school sick) and losing wages.

*Sources: Dhruv Khullar and Dave A. Chokshi, "Health, Income, & Poverty: Where We Are & What Could Help," Health Affairs, 10/4/18, www.healthaffairs.org/do/10.1377/hpb20180817.901935/full; Samuel L Dickman et al., "Inequality and the health-care system in the USA," The Lancet, 4/8/2017, doi.org/10.1016/S0140-6736(17)30398-7; Dave A. Chokshi, MD, "Income, Poverty, and Health Inequality," 4/3/2018, jamanetwork.com/journals/jama/fullarticle/2677433*

# Medical Costs Deepen Runaway Inequality

- Paying for premiums, co-payments and deductibles pushed more than 7 million Americans into poverty in 2014, according to a study in the American Journal of Public Health.
- These families paid a third or more of their income in medical expenses.
- Of those 7 million, 4 million were pushed into extreme poverty, with their income reduced to below 50 percent of the poverty line. They spent about two-thirds of their total income on healthcare.
- After taking account of households' medical payments, the incomes of the poorest 10% of the population fell by 47.6 percent.
- In addition, the burden of healthcare spending fell steadily as income rose. Such spending cut the incomes of households at the median income by about 8 percent, while it reduced the income of the wealthiest 1 percent by only 1.3 percent.

*Sources: Andrea Christopher, M.D., M.P.H., et al., "The Effects of Household Medical Expenditures on Income Inequality in the United States," American Journal of Public Health, 3/1/2018, doi.org/10.2105/AJPH.2017.304213; Vann R. Newkirk, "The American Health-Care System Increases Income Inequality," The Atlantic, 1/19/2018, www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997*

# The Lower Your Income, the Shorter Your Life

In general, we expect that over time people will be able to live longer as there are improvements in medicine, nutrition, and other factors. In the U.S., that's been true—but only for people in the top 20% of income.

People in the top 20% live more than 12 years longer than those in the bottom 20%.

**LIFE EXPECTANCY BY INCOME LEVEL IN THE U.S.**
2010, once people have reached age 60

| | Women | Men |
|---|---|---|
| INCOME LEVEL | | |
| **Bottom 20%** | 78.3 | 76.1 |
| **Top 20%** | 91.9 | 88.6 |
| **Gap** | 13.6 years | 12.5 years |

It's actually gotten worse over time. Both women and men in the bottom 20% actually live ***shorter*** lives than they did in 1980, while those in the top 20% live considerably longer.

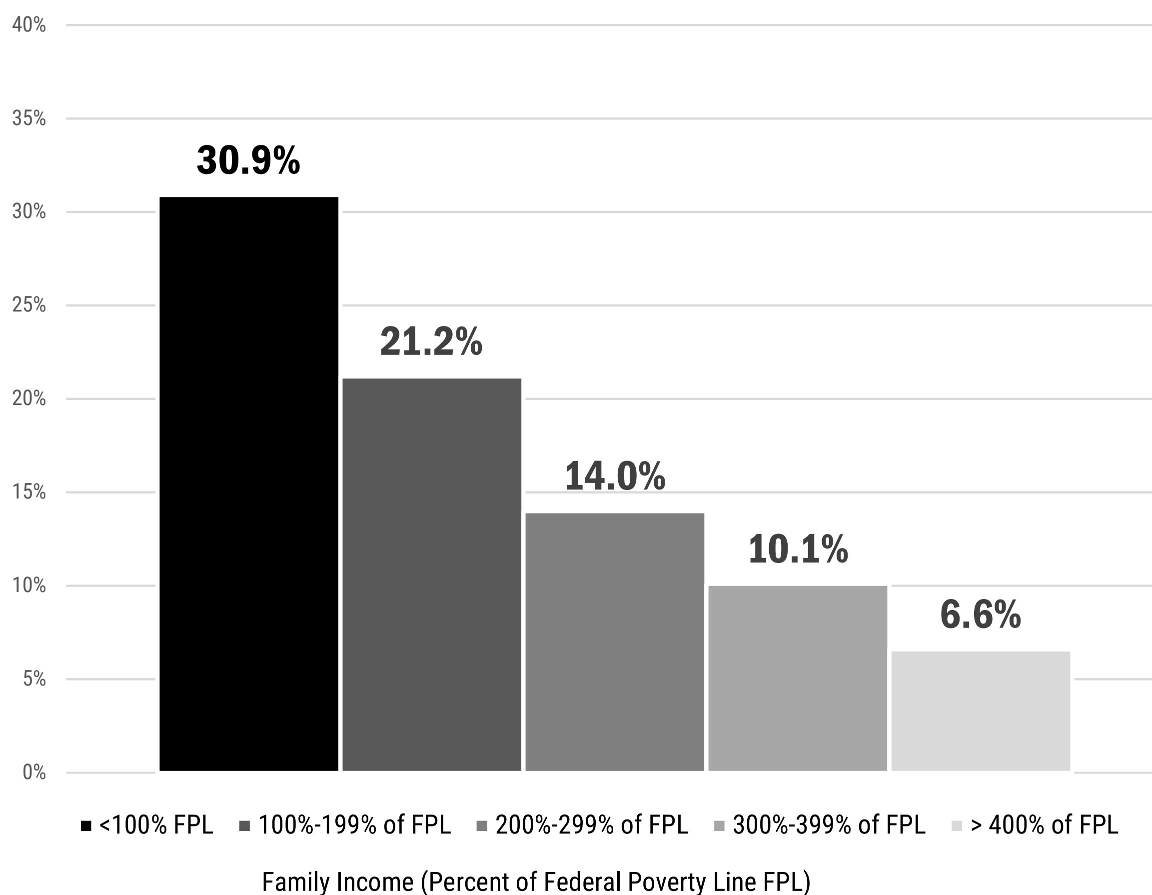
*Source: Diane Whitmore Schanzenbach et al., The Hamilton Project, "The Changing Landscape of American Life Expectancy," June 2016, www.hamiltonproject.org/assets/files/changing_landscape_american_life_expectancy.pdf, based on data from Chetty, Raj, et al., "The Association between Income and Life Expectancy in the United States, 2001–2014," Journal of the American Medical Association, 4/26/2016, jamanetwork.com/journals/jama/article-abstract/2513561*

# Lower Income, Worse Health

Compared with adults in the highest-income group, poor adults are nearly five times as likely to be in poor or fair health.

## PERCENT OF ADULTS WITH POOR/FAIR HEALTH, BY FAMILY INCOME

Adults 25 & older



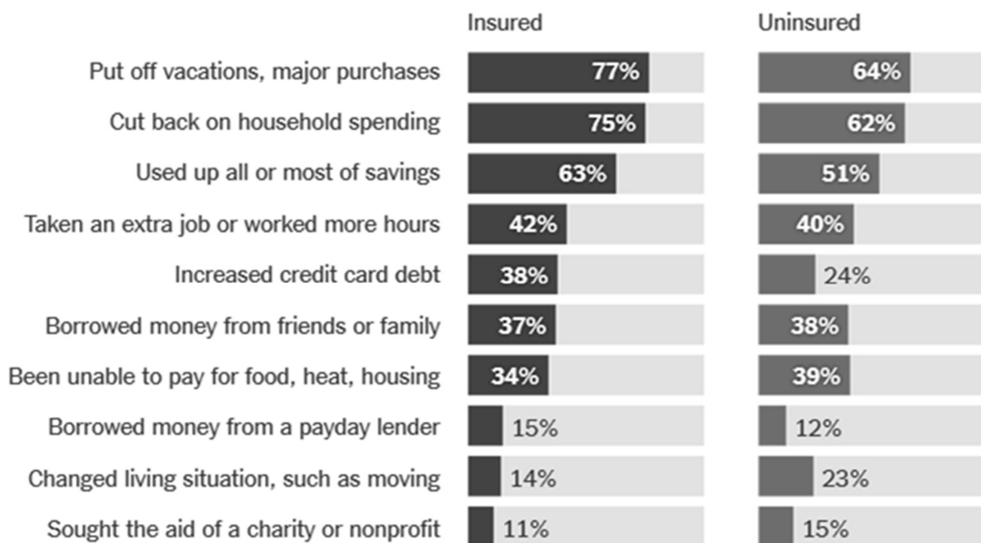

*Source: Robert Wood Johnson Foundation, "Overcoming Obstacles to Health," Feb. 2008, p.17, www.commissiononhealth.org/PDF/ObstaclesToHealth-Report.pdf*

# Medical Bills Cause Financial Sacrifices

In a 2016 survey, people who had trouble paying their bills reported that someone in their household made financial sacrifices, like the ones listed below.

## HOUSEHOLD SACRIFICES IN LAST 12 MONTHS TO PAY MEDICAL BILLS

Among people who had trouble paying medical bills




**What other significant changes did you make in your way of life in order to pay these medical bills?**

- *"Apartment instead of house. Not getting groceries some weeks to get by."*
- *"Cold showers, can't fix plumbing. Other needed repairs have been patched as best as possible but not fixed."*
- *"Medical Insurance / bills was the deciding factor in a job change. I gave up other benefits to choose a job that had the best medical coverage."*
- *"Sold everything we could spare."*
- *"Can't take the kids anywhere. Wish I could do more for my kids!"*
- *"I need physical therapy after shoulder repair but I couldn't afford to finish it. I wish I could have."*
- *"I am losing my house."*
- *"I've cut back on just about everything for my family and the way we live."*

*Source: Kaiser Family Foundation/New York Times Medical Bills Survey, Jan. 2016, www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey*

# High Medical Bills Lead to Borrowing, Bankruptcy, and Debt

People have come up with strategies to avoid healthcare expenses, like taking the risk of going without insurance and skipping needed care or medication. When those costs just can't be avoided, we end up in debt or worse.

## Borrowing

Collectively, Americans borrowed about $88 billion last year to pay for healthcare. Millions of people borrowed large sums:

- 1.4 million people borrowed between $5,000 and $10,000
- 2.7 million people borrowed more than $10,000

## Bankruptcy

- 45% of all Americans say that they're concerned or extremely concerned that a major health event in their family bankrupt hem. Even among people with household incomes of over $180,000, 32% of them are worried.
- The concern is well-founded. 75% of the 1 million American families experiencing medical bankruptcy every year have coverage when they fall sick.

## Debt

- Medical bills can quickly become medical debt. According to the Consumer Financial Protection Bureau, at least 43 million Americans have overdue medical bills on their credit reports.
- 59% of people contacted by a debt collector say it was over medical bills,.
- Unlike other types of debt, people with medical debt were prevalent across a range of income levels, credit scores, and ages.

*Sources: West Health-Gallup U.S. Healthcare Cost Crisis Report, 4/2/19, news.gallup.com/poll/248081/westhealth-gallup-us-healthcare-cost-crisis.aspx; PNHP, "Frequently Asked Questions about single-payer national health insurance," pnhp.org/system/assets/drupal/single_payer_resources/FAQ_2016.pdf; Michelle Andrews, "Mired In Medical Debt? Federal Rule Changes Proposed For Bill Collectors," 5/29/2019, NPR, www.npr.org/sections/health-shots/2019/05/29/727596397/mired-in-medical-debt-federal-rule-changes-proposed-for-bill-collectors; NPR, "Medical Debt Is Top Reason Consumers Hear From Collection Agencies," 1/24/2017, www.npr.org/sections/health-shots/2017/01/24/511269991/medical-debt-is-top-reason-consumers-hear-from-collection-agencies*

# Takeaways

1. We spend more and get poorer results that all other developed nations.
2. 27 million people are uninsured.
3. Another 41 million are underinsured (meaning they can't afford to pay for needed care even with insurance).
4. To pay medical bills, millions of people cut expenses to the bone, borrow thousands of dollars, or go bankrupt. Many more live in fear of the same things.
5. The high cost of healthcare insurance has created the "poverty-health trap." People with lower incomes can't afford the care they need; not getting the care they need makes it harder to earn more.
6. Americans with lower incomes have a shorter life expectancy than richer Americans and are more likely to have a number of chronic health problems.
7. Medical costs make runaway inequality even worse.

# Activity 3: Can We Fix Our Employment-Based System?

## Task 1: Positives and Negatives of Your Healthcare Insurance

In your small groups, please answer the question below. Choose a different person in your group to be the facilitator and recorder who will make sure that everyone participates in the discussion, record your answers, and report back to the entire group.

***What are the positives and negatives of your current healthcare benefits?***

| Positives | Negatives |
| --- | --- |
| | |

## Task 2: Healthcare and Collective Bargaining

### Employer-based system

No other country in the world bases its healthcare insurance system on whether and where someone is employed. In the U.S., 57% of people under 65 get healthcare insurance through a job. For workers at union employers, healthcare insurance is negotiated during collective bargaining. For non-union workers, employers set the terms.

While not everyone in this room is in a union, union members are central to any solution to our healthcare crisis. The labor movement is the biggest institution in the country with the power to help move this issue. And presidential candidates and others use union members to defend their opposition to Medicare for All. So it's important that everyone understands how healthcare affects collective bargaining.

### Collective bargaining

Since not all of us have been through the process of collective bargaining, here's a thumbnail sketch: When a union bargaining committee negotiates with an employer, they negotiate an entire package. They have to weigh a long list of priorities and make trade-offs between wage increases, healthcare insurance, retirement benefits, job security, and many other issues. The committee reaches the best agreement it can, and then union members vote to accept the agreement or send the committee back to the bargaining table.

If healthcare benefits weren't part of contract negotiations, that would take healthcare "off the table."

---

In your small groups, please discuss the question below. Choose a different member of your group to take notes and report back to the larger group.

***Based on your experience, how does healthcare affect collective bargaining?***

## Task 3: The Future of Collective Bargaining

Please review the fact sheets on pages 40-47 and answer the two questions below. Select a different member of your group to take notes and report back to the large group.

1. ***What do you think your employer's bargaining demands on healthcare coverage will be in your next round of bargaining?***

2. ***If healthcare costs were "off the table"—if your employer weren't spending money on healthcare benefits—how would you want them to spend that money?***

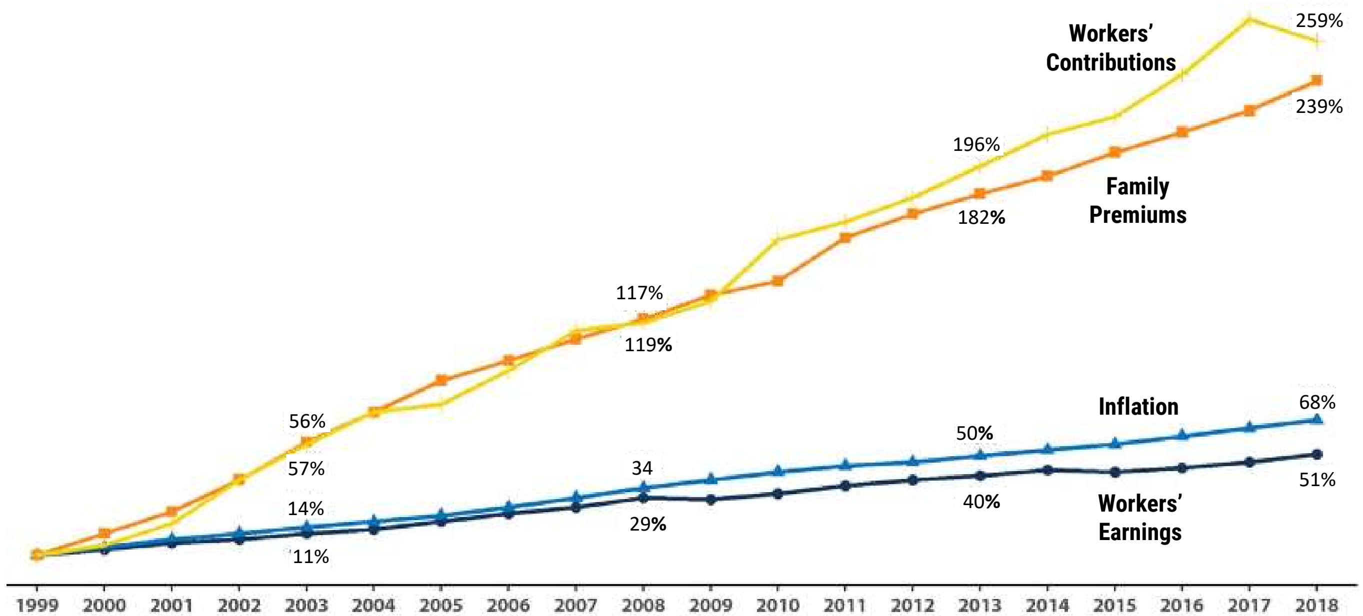
# Healthcare Costs Rise Much Faster than Wages

Healthcare premiums, and worker contributions to premiums, have been rising faster than inflation and wages for decades, as the graph below shows.

Today, the average premium for employer-based health insurance for a family of 4 is $19,616. (That works out to $9.43 per hour for a full-time worker.)

## Cumulative Increases in Family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings

1999-2018



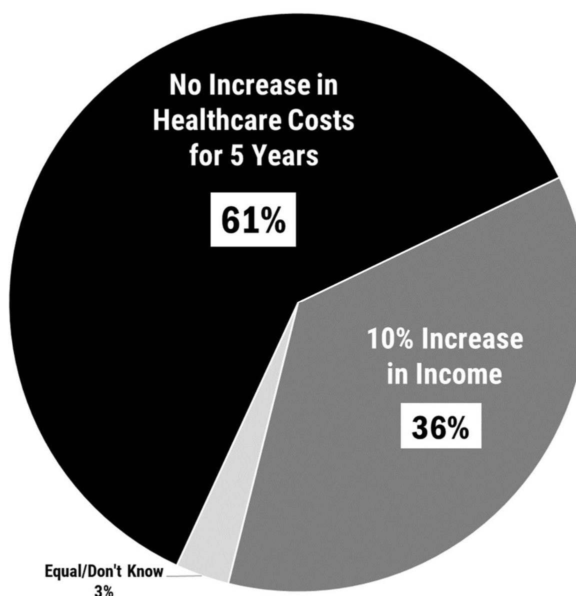

*Source: Kaiser Family Foundation Employer Health Benefits Survey, 2018, 10/3/18, www.kff.org/slideshow/2018-employer-health-benefits-chart-pack (slides 3 and 6).*

# Healthcare Costs Outweigh Wage Increases

A 2019 Gallup poll asked:

> Which of the following scenarios would you prefer: A 10% increase in your household income or a guarantee that your household's cost of healthcare and medicine will not increase in the next five years?

The poll found that 61% of Americans would **give up a 10% pay raise** to guarantee their healthcare costs wouldn't go up.




Even people with high incomes would choose to freeze their healthcare costs rather than getting a pay raise:

**PREFERS NO CHANGE IN HEALTHCARE COSTS:**

| ANNUAL HOUSEHOLD INCOME | |
|---|---|
| <$24,000 | 67% |
| $24,000-<$90,000 | 62% |
| $90,000-<$180,000 | 56% |
| $180,000+ | 53% |

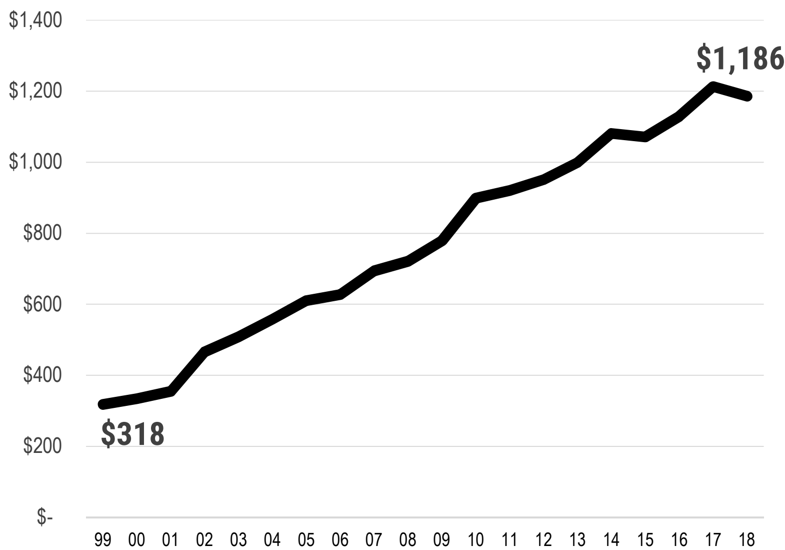
*Source: West Health-Gallup U.S. Healthcare Cost Crisis Report, 4/2/19, news.gallup.com/poll/248081/westhealth-gallup-us-healthcare-cost-crisis.aspx*

# Premiums Paid by Workers Keep Going Up

The charts below show only the share of the premiums paid by employees.

## AVERAGE PREMIUMS PAID BY EMPLOYEES – SINGLE COVERAGE

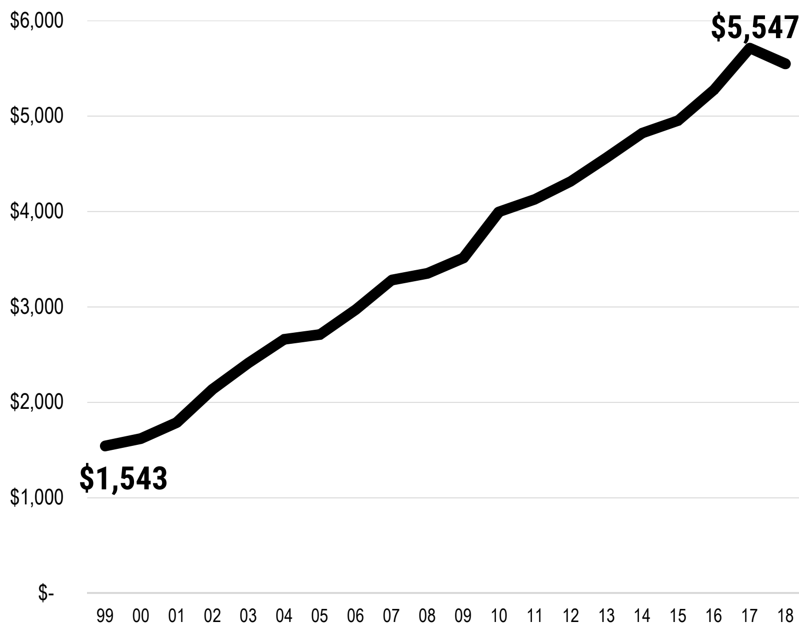
1999-2018




**For single coverage, premiums paid by workers have increased by 273% since 1999.**

## AVERAGE PREMIUMS PAID BY EMPLOYEES – FAMILY COVERAGE

1999-2018




**For family coverage, premiums paid by workers have increased by 259% since 1999.**

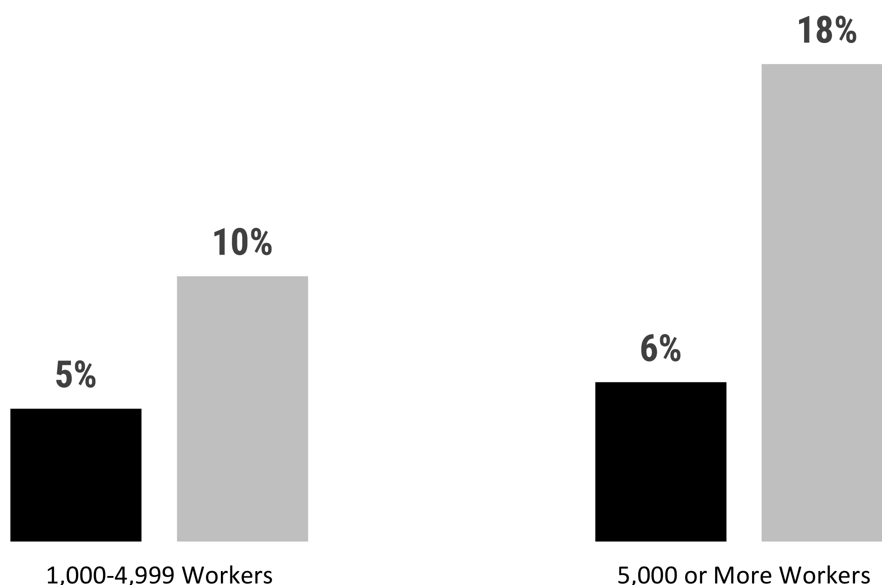
*Source: KFF, www.kff.org/interactive/premiums-and-worker-contributions-among-workers-covered-by-employer-sponsored-coverage-1999-2018*

# Employers Are Giving Workers Fewer Choices

In order to cut costs, employers will switch insurance carriers or eliminate hospitals or other providers from coverage. Employers are also offering “narrow network” plans, which generally only include 10-25% of providers in a local area. (Plans with broad networks are likely to have 70% or more of local providers participating.)

## Firms that Eliminated Hospitals from their Network in the Past Year to Reduce Cost or Offer a “Narrow Network” Plan

2018, by size of firm




*Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.*

*Source: Kaiser Family Foundation Employer Health Benefits Survey, 2018, 10/3/18, www.kff.org/slideshow/2018-employer-health-benefits-chart-pack, slide 21.*

# Having Health Insurance Doesn't Mean Being Able to Afford Healthcare

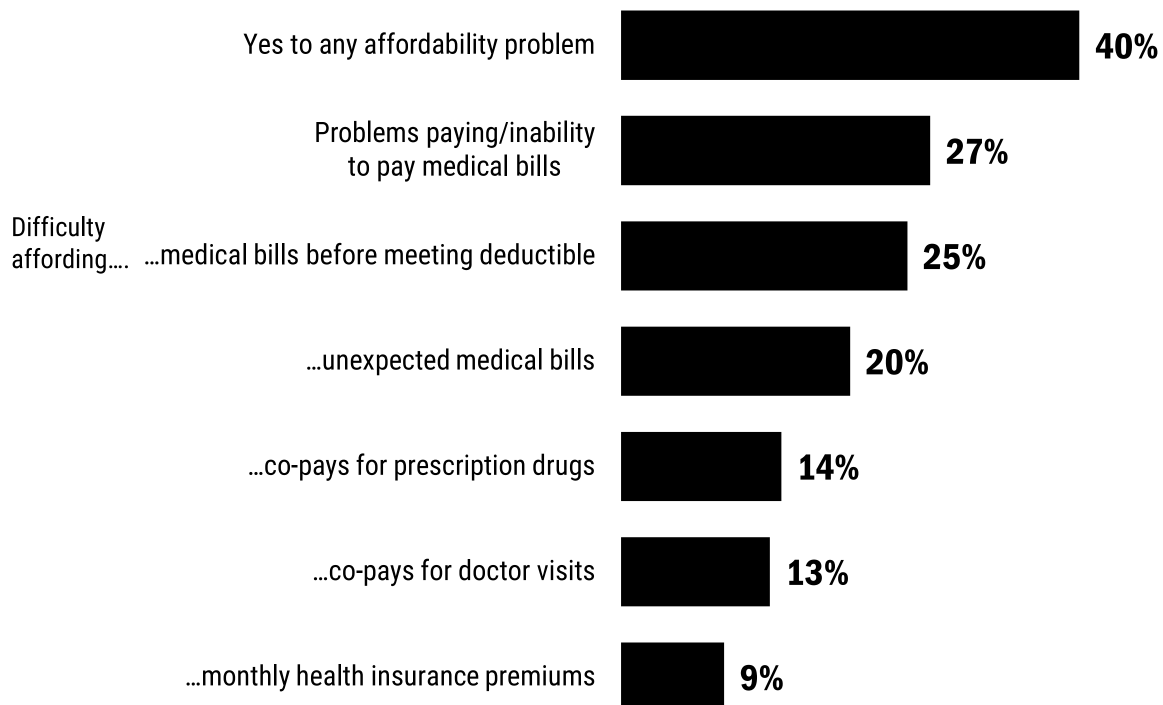
Millions of people are "underinsured." They have insurance but can't afford to use it.

According to a 2018 survey by the Commonwealth Fund, the percentage of people who are underinsured keeps growing and the **largest growth is among people with employer-based health plans.**

Overall, 40% of those with employer coverage reported problems paying medical bills or difficulty affording their premiums, deductibles, cost sharing, or an unexpected bill in the past year.

## Percent Who Say They or a Family Member Experienced Each of the Following in the Past 12 Months

2018, among people with employer-provided insurance

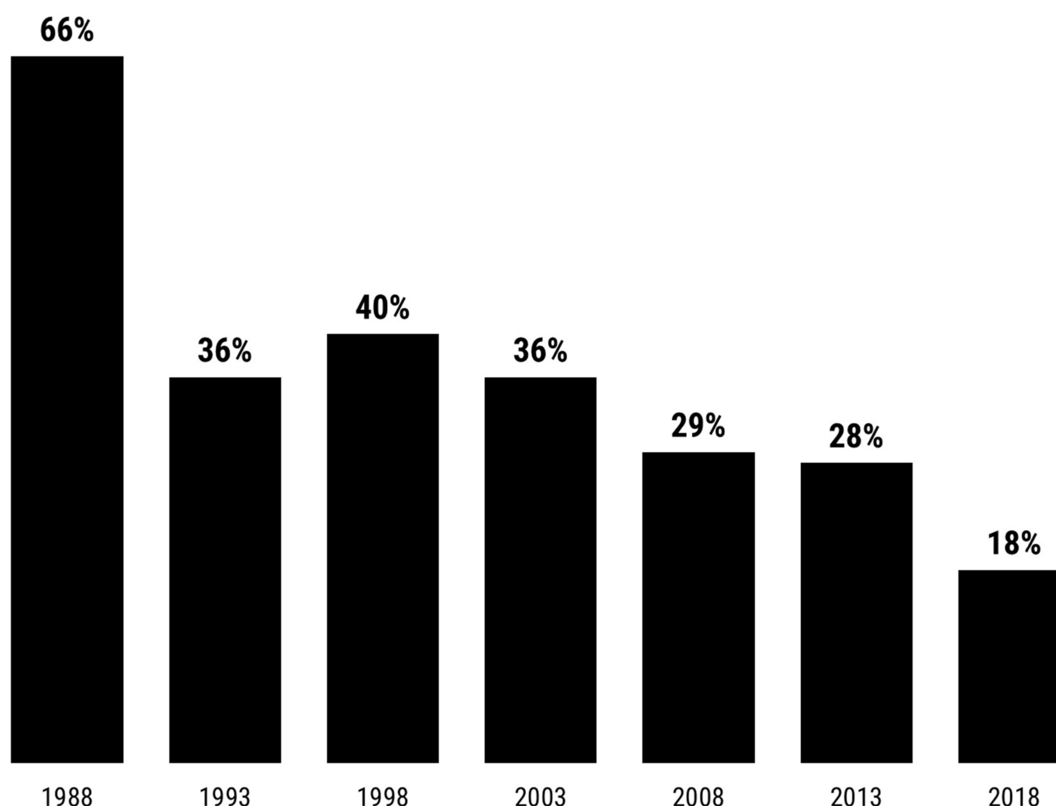



*Sources: "Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance," published 5/2/19, www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance; www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greatest-growth-among-people-employer-health*

# Retiree Benefits Are Vanishing Rapidly

Healthcare for retirees is an expensive part of corporate healthcare costs, so corporations are trying to get rid of these plans as fast as possible. As the chart below shows, large companies are eliminating retiree healthcare plans.

**PERCENTAGE OF FIRMS OFFERING RETIREE HEALTH BENEFITS (AMONG LARGE FIRMS THAT OFFER HEALTH BENEFITS TO ACTIVE WORKERS)**
1988-2018




*Large firms have 200 or more workers. Large firms are far more likely than smaller employers to offer any retiree healthcare benefits.*

*Source: Kaiser Family Foundation, www.kff.org/report-section/2018-employer-health-benefits-survey-section-11-retiree-health-benefits/attachment/figure-11-1*

# 8 Ways to Lose Your Employer-Sponsored Insurance

No matter how good your employer-based healthcare insurance may be, it ends* when you—or your spouse or parent—leave that employer. Or when you turn 26. Or when you get divorced.

There are a lot of ways Americans can and do lose their health insurance plan in the current system.

## Reasons People Lose Employer-Sponsored Healthcare Insurance

| Reason | People potentially affected each year |
|---|---|
| **Quit your job** | 40.1 million people |
| **Lose your job** | 21.9 million people |
| **Separate from your job for some other reason** | 4.1 million people |
| **Employer changes insurance carrier** | 15% of firms |
| **Turn 26 years old** | 4.5 million people |
| **Turn 65 years old** | 3.7 million people |
| **Get a divorce** | 1.5 million people |
| **Spouse or parent whose plan you are on dies** | Not available |

**Employer-sponsored insurance can be extended for a limited time through COBRA if the participant pays the entire premium plus a 2% administrative fee. Not many people can afford this.*

*Source: Matt Bruenig, "Health Insurance Churn in the US Is a Nightmare," People's Policy Project, 7/29/2019, www.peoplespolicyproject.org/2019/07/29/health-insurance-churn-in-the-us-is-a-nightmare-2*

# Employers Can Cut Off Healthcare Benefits During a Strike

When our employers provide healthcare insurance, they can take it away.

## GM Cuts Off Strikers' Healthcare

On September 16, 2019, the United Automobile Workers (UAW) went on strike at GM. One of the key issues is healthcare costs.

Almost immediately, and with no warning, GM cut off strikers' healthcare benefits.

This is perfectly legal. Employers can cut off healthcare benefits at any point during a strike or lockout, though it's rare that it happens so quickly or without warning.

After 10 days of public outrage and bad press, GM backed down and restored benefits, but could cut them off again if they choose.

BUSINESS NEWS SEPTEMBER 17, 2019 / 10:20 AM / 25 DAYS AGO
GM stops paying for health insurance for striking union workers; talks continue

AUTO · Published 24 days ago
UAW blasts GM for using worker health insurance as 'leverage'

Published on Wednesday, September 18, 2019 by Common Dreams
'Heartless and Unconscionable': Outrage as General Motors Cuts Off Healthcare for 50,000 Striking Workers

## Healthcare Used as Leverage

Even the threat that they could lose health insurance may make workers less willing to strike. It might also drive them to end a strike early and accept an inferior agreement.

# Takeaways

1. No other country in the world bases its healthcare system on employer-sponsored insurance.
2. The way we bargain for healthcare benefits is unsustainable. More and more of our bargaining power goes just to keeping our healthcare benefits.
3. Healthcare insurance costs keep going up and our employers keep shifting more costs onto us.
4. Retiree healthcare benefits are becoming a thing of the past.
5. Relying on our employers for healthcare also weakens our ability to strike—or even to threaten to strike.
6. If our employers weren't spending money on healthcare, that money would be on the bargaining table for wages and other improvements we want.

# Activity 4: How Do Insurance Companies Make Money?

## Task: What Would You Do as a Typical Healthcare Insurance CEO?

Now we'll look at the other defining feature of the U.S. healthcare system: for-profit insurance.

In your small groups, please review the information on pages 50-54 and answer the two questions below. Please choose a different member of your group to take notes and report back.

1. ***Imagine that you are a typical CEO of a health insurance company. What things would you do to maximize your profits?***

2. ***Of the fact sheets on pages 50-54, which ONE do you think would be most important to share with your co-workers or community?***

   ***Page ___***

   ***Title of fact sheet ______________________________________________***

   ***Why did you choose this fact sheet?***

# How Medical Reviewers Save Money for Insurance Companies

Insurance companies hire doctors to decide if a particular test or treatment is medically necessary—for patients that they've never seen.

When Dr. Linda Peeno was a medical reviewer for Humana, her job was to pay out as little as possible by denying claims. Her denial rate was compared with other doctors. The doctor with the highest rate of denials was paid a bonus.

In 1996, Dr. Peeno testified before Congress:

**"When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment."**

"I wish to begin by making a public confession: In the spring of 1987, as a physician, I caused the death of a man.

"Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was 'rewarded' for this. It bought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could indeed do what was expected of me, I exemplified the 'good' company doctor: I saved a half million dollars!

"Since that day, I have lived with this act, and many others, eating into my heart and soul. For me, a physician is a professional charged with the care, or healing, of his or her fellow human beings. The primary ethical norm is: do no harm. I did worse: I caused a death.... The man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. … When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment.'

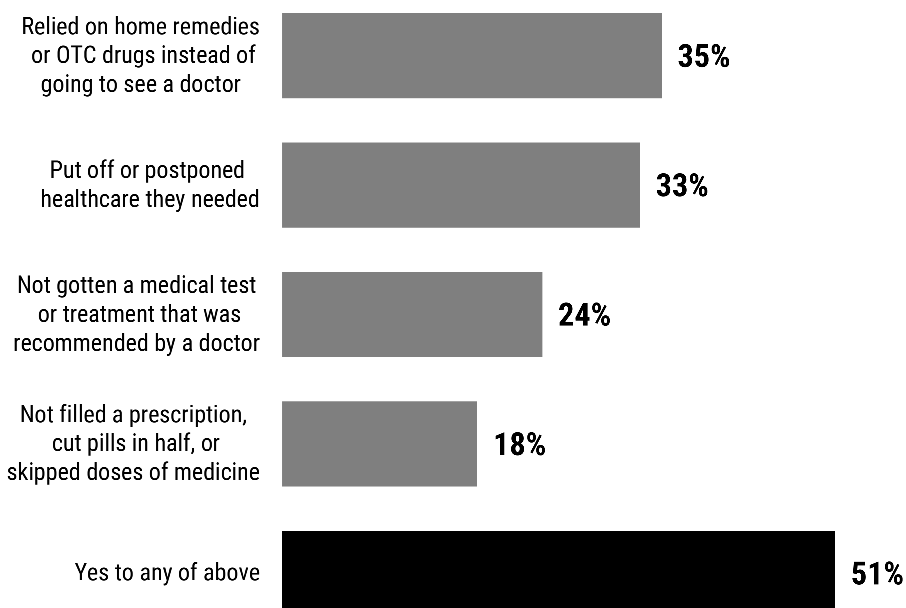
"Whether it was non-profit or for-profit, whether it was a health plan or hospital, I had a common task: using my medical expertise for the financial benefit of the organization, often at great harm and potentially death, to some patients."

*Sources: Linda Peeno, M.D., testimony before the U.S. House Subcommittee on Health and Environment, 5/30/1996, www.hospicepatients.org/drpeenotestimony.html#c3; Interview in "Sicko," 2007*

# High Deductibles and Co-Pays Keep People from Using Their Healthcare Insurance

High deductibles and co-pays keep people from getting healthcare when they need it. Half of people with insurance from their employers delay or go without care because of the cost.

**SOMEONE IN FAMILY SKIPPED OR POSTPONED NEEDED CARE BECAUSE OF THE COST**
2018, among people with employer-sponsored insurance

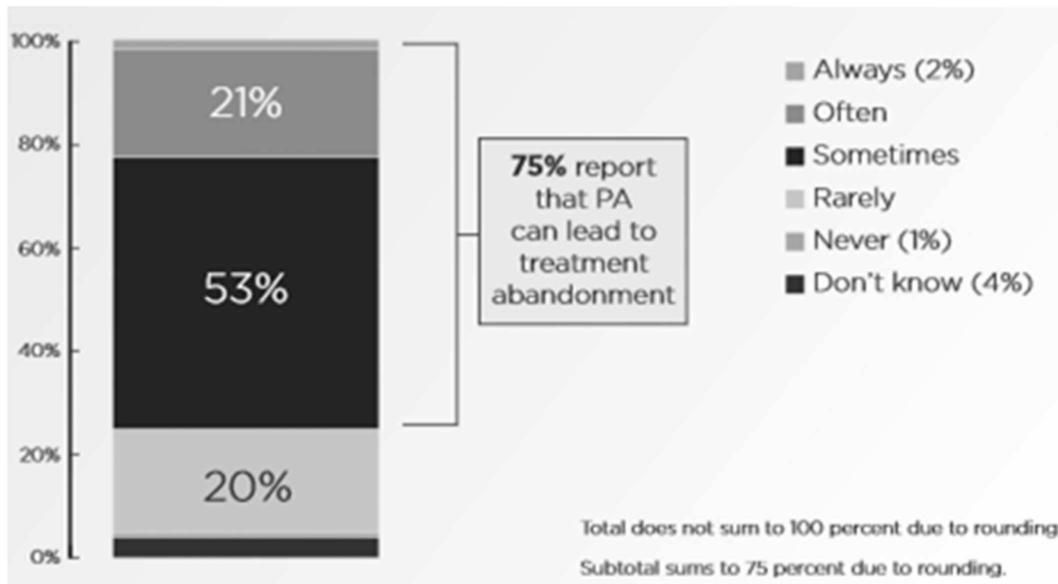



*Source: Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance, 5/2/2019, www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance*

# "Pre-Authorizations" Protect Insurance Company Profits

"Pre-authorizations" are designed to protect insurance companies' profits. Long delays, endless phone calls, and piles of paperwork discourage doctors from ordering lab tests, prescribing drugs, or referring to specialists. Sometimes patients just give up, so the insurance company never has to pay a claim.

## PERCENTAGE OF PHYSICIANS WHO REPORT THAT PRE-AUTHORIZATION PROCESS LEADS PATIENTS TO ABANDON TREATMENT




*Sources: American Medical Association, "2018 AMA Prior Authorization Physician Survey," www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf*

# Through Prescription Co-Pays, Insurers Overcharge Us to Create Big Profits for Themselves

Prescription drugs are expensive, so we're lucky if we have insurance to help cover the cost, right? Not always.

## Patients overpaid 23% of the time

Researchers looked at a sample of prescriptions and found that 23% of the time, the patient's co-pay was at least $2.00 ***more*** than what the insurance company* paid for the prescription. That extra $2.00 goes right to the insurance company's bottom line.

- The average overpayment was $7.69 per prescription.
- The total overpayment for that sample was $135 million.

## A drop in the bucket

- Those researchers looked at 9.5 million prescriptions.
- The number of prescriptions filled in the U.S. every year is over ***4 billion.***
- We don't have the data on all 4 billion prescriptions, but imagine if a quarter of them were overcharged by even $1.00. That's $1 billion every year, straight from our pockets to their profits.
- In reality, overpayments can run to a few cents to hundreds of dollars.

**Some insurance companies outsource prescription coverage to a middleman known as a "pharmacy benefit manager" (PBM), like ExpressScripts or OptumRx. Depending on their arrangement, the overpayment might go to the PBM or to the insurance company.*

*Sources: Karen Van Nuys, et al., Overpaying for Prescription Drugs, USC Schaeffer, March 2018, healthpolicy.usc.edu/wp-content/uploads/2018/03/2018.03_Overpaying20for20Prescription20Drugs_White20Paper_v.1-2.pdf; PBS, "Why a patient paid a $285 copay for a $40 drug," 8/19/2018, www.pbs.org/newshour/health/why-a-patient-paid-a-285-copay-for-a-40-drug*

# If They Could, Insurance Companies Would Never Insure the People Who Need Insurance

Before the Affordable Care Act, insurance companies routinely refused to cover "pre-existing conditions." This is the way to mint money for insurance companies. If you insure only people who aren't sick, you get to keep most of the premiums because you pay out very little. If you insure sick people, it will eat into your profits. So the name of the game until the ACA was to weed out the sick and insure only the fit.

## Definition of "pre-existing condition"

A disease or injury that …

… you were born with
… you had been diagnosed with
… you had ever had symptoms of
… you had ever received medical advice about
… you had ever been treated for
… you had been tested for
… ran in your family
… the insurance company thought you should have gotten treatment for

"Conditions" weren't limited to diseases or injuries; they included pregnancy and intellectual disabilities.

## Ways insurance companies protected their profits

Insurance companies had lots of ways to weed out people with "pre-existing conditions":

- Refuse to sell you any policy
- Charge 150% of the standard premium
- Exclude treatment for the pre-existing condition
- Exclude the "body part or system" affected by the condition
- Increase the deductible or apply a separate deductible for the condition
- Limit the benefits (*e.g.,* exclude prescription drug coverage)

## The Affordable Care Act protects "pre-existing conditions"

The Affordable Care Act forbids insurance companies from denying insurance to anyone who applies or from charging premiums based on health status.

# Takeaways

1. The purpose of private healthcare insurance isn't to provide healthcare. Its purpose is to maximize profits for insurance companies.
2. Insurance companies exist to take in premiums and pay out as little as possible.
3. They use high deductibles and co-pays, pre-authorizations, and medical reviewers to keep people from using their insurance benefits.
4. Before the Affordable Care Act, private insurance companies simply refused to cover millions of people who needed healthcare.
5. Medicare costs a lot less to administer than private healthcare insurance because it doesn't have to include profits, excessive executive pay, marketing, and lobbying.

# Activity 5: What's the Alternative to Employer-Based, For-Profit Health Insurance?

## Task 1: Debunking the Myths

What's the alternative to employer-based, for-profit health insurance? Canada offers one example. Proposals for Improved Medicare for All in the U.S. are a lot like the healthcare system in Canada (which is also called Medicare) which puts everyone, not just the elderly, into their Medicare program.

We'll now watch a 9-minute video on myths and reality of the Canadian Medicare system.

Wendell Potter, a former PR executive in the healthcare industry, has described how he and other insurance executives systematically lied about Canada's healthcare system in order to protect their profits.

*"Debunking the Myths About Canadian Healthcare," wendellpotter.com/2018/12/lied-to-about-canada-health-care*

## Task 2: Could "Improved Medicare for All" Work in America?

In your small groups, please review the description of Medicare for All on the next page and answer the two questions below.

1. ***Based on the description on page 59, do you think Improved Medicare for All could work in the U.S.?***

   ***Why or why not?***

2. ***Would you support Medicare for All even if it eliminates private health insurance that employers now provide? Why or why not?"***

# The Basics of Improved Medicare for All

What do we mean by "Improved Medicare for All"?

1. "Improved Medicare for All" is a shorthand description for a system of public insurance and privately delivered healthcare.
2. The current Medicare program for seniors would be greatly enhanced so that everyone is covered from birth for all medical care, including doctors' visits, tests, drugs, hospital care, mental healthcare, substance abuse treatment, comprehensive reproductive, maternity and newborn care, long-term care, vision, dental, and hearing.
3. No premiums, deductibles, or co-pays for individuals.
4. This system would replace existing public programs, including Medicaid, CHIP, Medicare for seniors, and subsidies for the Affordable Care Act.* Seniors would no longer have to purchase private "add on" insurance or Medicare Advantage.
5. The current Medicare administration would be expanded to handle all payments for the system. It becomes the "single payer" for healthcare in the U.S.
6. Doctors can continue to work in private or public practice, as they choose.
7. We can choose our own providers. There are no "networks" that limit our choices.
8. Protection for displaced healthcare and administrative workers (known as a "just transition" to a new job).
9. Employment-based health insurance would no longer be necessary. Other employer-provided insurance (like life and disability) would not be impacted by Improved Medicare for All.

*The V.A. and Indian Health Services would continue to operate because they provide unique services for unique constituencies.

# Takeaways

1. Insurance companies have engaged in a deliberate campaign of spreading fear about the Canadian universal healthcare system.
2. Canadians love their Medicare system and get good healthcare.
3. America has a healthcare program like Canada's—if you're over 65.
4. Improved Medicare for All would be similar to our current Medicare system but would greatly expand services and cover everyone in the U.S.

# Activity 6: How Would Improved Medicare for All Affect Workers?

## Task 1: Just Transition for Dislocated Workers

It's estimated that about 1.8 million health insurance-related workers might lose their jobs under Medicare for All. This will affect not only individual workers but also the economic health of their communities. It's up to the labor movement and progressives to make sure these workers are protected by defining a "just transition" and fighting for it.

What kind of protections and benefits should displaced workers receive? In your small groups, please review the fact sheets on pages 62-65 and answer the question below.

### *Your group is a committee assigned to come up with a proposal to answer the following question:*

*Implementing Medicare for All would create a massive change in our economy, would affect certain communities more than others, and would dislocate up to 1.8 million workers. What would your committee propose?*

*(The items listed under "sample proposal" are taken from various proposals for dislocated workers in different industries. You can use them as a point of reference if you choose.)*

| | No special benefits | Sample proposal | Does your committee support this? | Why or why not? |
|---|---|---|---|---|
| **Salary replacement** | Regular unemployment insurance | Wage replacement until you find a comparable job | Yes / No | |
| **Job training** | $0 | Up to 4 years | Yes / No | |
| **College education** | $0 | Up to 4 years | Yes / No | |
| **Relocation assistance for school or job** | $0 | $10,000 | Yes / No | |

# An Estimated 1.8 Million Workers Would Be Displaced

Two groups of workers would be displaced: those who work for insurance companies and those who deal with insurance billing on behalf of healthcare providers.

## Healthcare insurance industry

- 800,000 workers affected
- 50% are in sales and office and administrative support. The other half includes accounting, management, and IT.

## Healthcare services

- 1 million workers affected
- Administrative support staff for health services providers in hospitals, clinics, doctors' and dentists' offices, nursing homes, etc.
- Includes secretaries, administrative assistants, and billing clerks.

## Characteristics of affected workers

| | |
|---|---|
| Percentage of female workers | 75% |
| Percentage of non-white workers | 32% |

| Percentage of workers with… | |
|---|---|
| High school diploma or less | 23% |
| Some college or an associate's degree | 41% |
| Bachelor's degree or higher | 36% |

| | |
|---|---|
| Age 60 and older | 15% |

## Some new jobs will be created

Improved Medicare for All will create new jobs delivering healthcare and administering Medicare, but they won't necessarily be jobs that displaced people will want.

# Current Unemployment Insurance for Displaced Workers

- The maximum benefit varies widely by state.
- The average weekly benefit across the U.S. is $363/week.
- The maximum duration in most states is 26 weeks (6½ months).

**MAXIMUM LENGTH AND AMOUNT* OF UNEMPLOYMENT BENEFITS, BY STATE**

| State | Length | Amount | State | Length | Amount |
|---|---|---|---|---|---|
| **Alabama** | 26 weeks | $ 265 | **Montana** | 28 weeks | $ 487 |
| **Alaska** | 26 weeks | $ 370 | **Nebraska** | 26 weeks | $ 426 |
| **Arizona** | 26 weeks | $ 240 | **Nevada** | 26 weeks | $ 407 |
| **Arkansas** | 20 weeks | $ 451 | **New Hampshire** | 26 weeks | $ 427 |
| **California** | 26 weeks | $ 450 | **New Jersey** | 26 weeks | $ 696 |
| **Colorado** | 26 weeks | $ 597 | **New Mexico** | 26 weeks | $ 442 |
| **Connecticut** | 26 weeks | $ 631 | **New York** | 26 weeks | $ 435 |
| **D.C.** | 26 weeks | $ 425 | **N. Carolina** | 12 weeks | $ 350 |
| **Delaware** | 26 weeks | $ 330 | **North Dakota** | 26 weeks | $ 595 |
| **Florida** | 12 weeks | $ 275 | **Ohio** | 26 weeks | $ 598 |
| **Georgia** | 14 weeks | $ 330 | **Oklahoma** | 26 weeks | $ 520 |
| **Hawaii** | 26 weeks | $ 630 | **Oregon** | 26 weeks | $ 538 |
| **Idaho** | 21 weeks | $ 405 | **Pennsylvania** | 26 weeks | $ 561 |
| **Illinois** | 26 weeks | $ 648 | **Rhode Island** | 26 weeks | $ 566 |
| **Indiana** | 26 weeks | $ 390 | **S. Carolina** | 20 weeks | $ 326 |
| **Iowa** | 26 weeks | $ 573 | **South Dakota** | 26 weeks | $ 352 |
| **Kansas** | 16 weeks | $ 474 | **Tennessee** | 26 weeks | $ 275 |
| **Kentucky** | 26 weeks | $ 502 | **Texas** | 26 weeks | $ 507 |
| **Louisiana** | 26 weeks | $ 247 | **Utah** | 26 weeks | $ 543 |
| **Maine** | 26 weeks | $ 646 | **Vermont** | 26 weeks | $ 466 |
| **Maryland** | 26 weeks | $ 430 | **Virginia** | 26 weeks | $ 387 |
| **Massachusetts** | 30 weeks | $ 795 | **Washington** | 26 weeks | $ 749 |
| **Michigan** | 20 weeks | $ 362 | **West Virginia** | 26 weeks | $ 424 |
| **Minnesota** | 26 weeks | $ 717 | **Wisconsin** | 26 weeks | $ 363 |
| **Mississippi** | 26 weeks | $ 235 | **Wyoming** | 26 weeks | $ 489 |
| **Missouri** | 13 weeks | $ 320 | | | |

**A handful of states provide an additional weekly allowance for dependents.*

*Sources: U.S. Dept. of Labor, average for 12 months ending 7/31/19, oui.doleta.gov/unemploy/DataDashboard.asp; Center on Budget and Policy Priorities, www.cbpp.org/research/economy/policy-basics-how-many-weeks-of-unemployment-compensation-are-available; fileunemployment.org/unemployment-benefits/unemployment-benefits-comparison-by-state*

# The G.I. Bill of Rights

## Education benefits

The G.I. Bill of Rights of 1944 provided government funds for education to 7.8 million veterans. The educational costs included tuition, books, supplies, health insurance, and a stipend for living expenses.

As World War II neared its end, Congress recognized that 16 million soldiers would be returning to civilian life, which posed two important problems: Many soldiers lacked education and skills needed for civilian jobs and the U.S. economy couldn't absorb all those people flooding the job market.

## A boon to the U.S. economy

The program benefited both individual veterans and the country as a whole. A study by the Congressional Joint Economic Committee found that providing education to all those people increased the output of the U.S. economy by billions and created billions more in higher tax revenues when ex-soldiers were able to get better jobs.

For every dollar spent on higher education for GIs, the government and economy received at least $6.90.

The study concluded that, "altogether, the extraordinarily high ratio of benefits to costs … for the G.I. Bill program suggests that post-secondary education has been, and probably remains, a highly productive form of government investment for the nation."

## Opportunities for African-American veterans

Some members of Congress refused to vote for the GI Bill because it gave African-American veterans the same benefits as White veterans. The bill passed without them, and about 70,000 African-American veterans attended college as a result.

# Do No Harm? The Health Effects of Unemployment

If we don't adequately provide for displaced workers, many will suffer increased medical problems, according to a large number of medical studies (two of which are cited below). It would be sadly ironic if the shift to a new and better healthcare system created negative health effects for these workers. But as the second study below concludes, a robust unemployment plan could counter those adverse effects.

## 2013 Study: "How Does Employment, or Unemployment, Affect Health?"

"Laid-off workers are far more likely than those continuously employed to have fair or poor health, and to develop a stress-related condition, such as **stroke, heart attack, heart disease, or arthritis**. With respect to mental health, a 2010 Gallup Poll found that unemployed Americans were far more likely than employed Americans to be diagnosed with **depression** and report feelings of sadness and worry."

## 1993 Study: "Unemployment and health"

- The unemployed and their families have increased mortality experience, particularly from suicide and lung cancer.
- The unemployed also have a reduction in psychological well-being with a greater incidence of attempted suicide, depression, and anxiety.
- The unemployed are more likely to use general practitioner and hospital services and receive more prescribed medicines.
- Smoking and alcohol consumption are often increased after the onset of unemployment.
- Families are put at greater risk of physical illness, psychological stress, and family breakdown.

The study concluded: "Maintaining financial security, providing proactive health care and retraining for re-employment can all reduce the impact of unemployment on health."

*Sources: "How Does Employment, or Unemployment, Affect Health?", Robert Wood Johnson Foundation, 3/12/2013, www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health-.html; "Unemployment and health: A review," Public Health, Volume 107, Issue 3, May 1993, www.sciencedirect.com/science/article/abs/pii/S0033350605804366*

## Task 2: Whose Responsibility Is a Just Transition?

In your small groups, please answer the question below.

***In your opinion, should the labor movement and progressive activists fight for a just transition for dislocated workers?***

***Why or why not?***

# Takeaways

1. Improved Medicare for All might displace 1.8 million workers. It's up to the labor movement and progressives to make sure these workers are protected by defining a "just transition" and fighting for it.
2. Opponents of Medicare for All will try to use these workers as a wedge. We need to be ready.

# Activity 7: Spreading the Word

## Task 1: What's Important to Share about Improved Medicare for All?

What would you say to your co-workers and community to make them seriously consider Improved Medicare for All as a solution to our healthcare crisis? In your small groups, make a list of 5 key points. Then continue on to Task 2.

***Key points:***

**1.**

**2.**

**3.**

**4.**

**5.**

**Now continue to task 2.**

## Task 2: Make a Flyer

Now your small group should make a flyer that would help your co-workers and community seriously consider Improved Medicare for All. Your trainers will give each group a sheet of easel paper and markers for your flyer. Once groups have finished, each group will bring its flyer to the front of the room.

# Activity 8: Objections and Responses to Improved Medicare for All

## Task 1: What About the "Public Option"?

Improved Medicare for All isn't the only healthcare solution people are discussing. There are plans that sound similar, like "Medicare for America" or "Medicare Extra." Some even call themselves "Medicare for All."

These plans would keep the for-profit insurance industry but add a "public option" plan that some people would be allowed to buy into.

In your small groups, please read the fact sheets on pages 72-75, then answer the question below. Choose a different member of the group to take notes and report back.

***Do you think adding a "public option" would solve our healthcare crisis?***

***Why or why not?***

# A Public Option Wouldn't Solve the Cost Problems

## Not Enough Overall Savings

While a public plan itself would be more efficient than private plans, just adding a public plan wouldn't create the same overall savings. Billions in healthcare spending would continue to go to insurance company profits and overhead.

## Doesn't Solve the Cost Problem for Patients

Because it wouldn't generate enough savings, a public option plan would require premiums and out-of-pocket costs, though they would be lower than private plans.

Some people who are uninsured now might be able to afford the public option, but it would still be out of reach for some people who will be left without insurance, miss out on needed care, and rely on emergency rooms.

Adding a "public option" wouldn't help those who now have insurance, who would continue to have high premiums, deductibles, and out-of-pocket costs.

## Doesn't Solve the Cost Problem for Providers

Doctors are fed up with dealing with the complexity of hundreds of different health plans, which costs them money and wastes their time and their staff's time. The public option doesn't solve the complexity; it just adds one more plan.

# The Public Option Would Likely Become a "High-Risk Pool"

- The people most likely to pay for the public option will be the people who need it most, like those with chronic illnesses or other conditions that require ongoing care.
- "Only the sickest of today's uninsured would join, driving public-option prices up higher and becoming a 'high-risk pool.' Insurance depends on a mostly healthy pool of patients to balance the sickest. Whenever you turn that on its head, it goes down in flames." *(Dr. Ed Weisbart, chair of PNHP-Missouri)*
- A Congressional Budget Office analysis of a 2009 public option plan predicted that the plan would attract a "less healthy pool of enrollees."
- "The way insurance works is that you have a very large pool and the healthy people subsidize the sick people. Well, if you have a really large pool, like the entire country, you can do that so much more efficiently." *(Dr. Elizabeth Rosenthal, editor-in-chief of Kaiser Health News)*

*Sources: Interview with Dr. Elizabeth Rosenthal, www.medscape.com/viewarticle/896952#vp_5; Ed Weisbart, M.D., "Think Twice when you hear the words 'public option' health insurance," St. Louis Post Dispatch, 7/5/2019, www.stltoday.com/opinion/columnists/ed-weisbart-think-twice-when-you-hear-the-words-public/article_43106335-d4f1-546e-8ea9-24a8067bdf91.html; Letter to Hon. Charles B. Rangel, Congressional Budget Office, 10/29/2009, p. 6, www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/hr3962rangel0.pdf*

# Employers Would Continue to Control our Healthcare Benefits

With Improved Medicare for All, our employers would no longer have a say in our healthcare.

With a public option, most of us would still depend on our employers for our healthcare insurance.

## Union Workplaces

A public plan doesn't take healthcare off the bargaining table. Our employers would continue to have wide latitude about which insurance companies to use and what range of plans to offer. Unions would continue to expend bargaining power trying to keep costs down for workers.

Employers could continue to threaten to cut off healthcare benefits in a prolonged strike or lockout.

## Non-Union Workplaces

Employers would continue to control what benefits are offered at what price, which insurance company runs the plan, and which doctors and hospitals are covered.

# Key Differences Between Improved Medicare for All and a "Public Option"

| Improved Medicare for All | Public Option |
|---|---|
| Eliminates premiums and out-of-pocket costs. | **No.** Public option would have to charge premiums and co-pays, because it wouldn't provide the same savings as Medicare for All. (Premiums and out-of-pocket costs would probably be lower than many private plans.) |
| Guarantees healthcare for everyone. | **No.** Some people still wouldn't be able to afford insurance. |
| Covers all medically necessary care, including mental health, dental, vision, drugs, home healthcare, and long-term care. | **No.** Some proposed plans would cover only the benefits now legally required; some plans would add a few benefits. |
| Removes corporate middlemen from the equation. | **No.** Most people would still be dealing with for-profit insurance companies. |
| Streamlines billing and administration. | **No.** Keeps existing complexity of dealing with hundreds of insurance plans. |
| Allows patients to see the doctor of their choice. | **No.** Some doctors would accept the public option; some would not. |
| Takes healthcare off the bargaining table | **No.** Union members would continue to make trade-offs between healthcare benefits and wages, other benefits, and working conditions. |
| Takes healthcare decisions away from employers. | **No.** In non-union workplaces, employers would continue to set all the rules. |
| Ends "job lock" | **No.** People would still have to make employment decisions based on healthcare benefits. |
| Allows government to negotiate for better drug prices. | **Yes.** |

*For more: "Compare Medicare-for-all and Public Plan Proposals," Kaiser Family Foundation, 5/15/2019, www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals*

## Task 2: Objections

Together in the large group, we'll brainstorm a list of the biggest objections we expect to hear about Improved Medicare for All.

***What do you think are the biggest objections you'll hear about Improved Medicare for All?***

## Task 3: Our Responses

Your trainers will break you into pairs and assign you and your partner one of the objections. Using any of the fact sheets we've looked at today and your own knowledge and experience, please come up with the best responses to the objection.

***Your assigned objection:*** ______________________________________________

***Your best responses:***

# Takeaways

1. Opponents of Medicare for All will offer objection after objection. We need to be prepared to respond.
2. A public option can't solve the fundamental failures of the private, for-profit insurance industry.

# Activity 9: Winning Improved Medicare for All

## Task: Next Steps

What will it take to pass a federal law creating Improved Medicare for All? And what's our role in getting that law passed?

Key elements:

- Get more Members of Congress to sign onto Improved Medicare for All bills and then hold their feet to the fire to make sure they follow through
- Get more media attention.
- Show broad public support.
- Show support from elected officials at all levels.
- Educate.
- Build a movement powerful enough to win.

In your small groups, please answer the two questions below. Select one member of your group to take notes and report back to the larger group.

### *1. What are your organizations doing now in this fight?*

### *2. What ideas do you have for the future?*

# Final Takeaways

1. The $3.24 trillion we currently spend on healthcare could be used to pay for a system based on humane principles.
2. Healthcare costs are deepening runaway inequality.
3. Improved Medicare for All would take healthcare off the bargaining table, allowing us to use our bargaining power to improve wages, pensions, and working conditions.
4. In the last 40 years, the ultra-rich have robbed us of trillions of dollars of wealth that we created. Improved Medicare for All is one way to take some of that back and give us a pay raise.
5. If we're going to make such a massive change in our healthcare system, we need to ensure that workers in healthcare, healthcare administration, and the insurance industry are protected.
6. The defining features of the American healthcare system are that it's employer-based and run by for-profit insurance companies. Both are incompatible with providing good healthcare to everyone in the U.S.
7. Does Improved Medicare for All sound too good to be true? That's why they'll spend tens of millions to attack the bill.

# Appendix

## Principles of a Fair Healthcare System

- **Everybody in, nobody out.** Healthcare is a human right.
- **Lifetime coverage.** Guaranteed lifetime coverage for all. Healthcare is no longer tied to employment (or any other condition).
- **Comprehensive coverage.** Full coverage including dental, vision, hearing, mental health and addiction services, long term care, and reproductive health services.
- **Affordable.** No financial barriers to care.
- **Less expensive.** At least 95% of all Americans will pay less than what they are currently paying.
- **Quality.** A single standard of care for all.
- **Flexibility.** Freedom to choose providers.
- **Protection for industry workers.** Protection for displaced healthcare and administrative workers (known as a "just transition" to a new job).

# Unions That Have Endorsed Medicare for All

Nineteen unions representing nearly 10 million workers have stepped up to endorse HR 1384 The Medicare for All of 2019. This means that **a majority of union members are now represented by unions that support Medicare for All.**

## HR 1384 Endorsers

- Amalgamated Transit Union
- American Federation of Teachers
- American Federation of Government Employees
- American Postal Workers Union
- Association of Flight Attendants
- Brotherhood of Maintenance of Way Employees/IBT
- California School Employees Association
- International Alliance of Theatrical Stage Employees
- International Association of Machinists
- International Federation of Professional and Technical Engineers
- International Longshore and Warehouse Union
- National Education Association
- National Nurses United
- National Union of Healthcare Workers
- New York State Nurses Association
- Pennsylvania Association of Staff Nurses and Allied Professionals
- Service Employees International Union
- United Automobile Workers
- United Electrical Workers
- United Mine Workers of America
- Utility Workers Union of America

# Why Healthcare Professionals Support Medicare for All

*"Do you know what we see in our hospitals? Healthcare delayed. Why? Because patients with insurance cannot afford care. They stay home and stay sick. Some get very sick. So when they arrive at our hospitals we treat patients with high acuities – unnecessarily severe illnesses."*

—**Marva Wade, R.N, Vice President of NYSNA and Member of the Board of Directors**

*Single-payer "will save lives by guaranteeing millions of Americans receive mental health treatment that is too often denied by their private insurers or too expensive for them to access."*

— NUHW, representing private-sector psychologists, therapists and social workers

*"Americans spend trillions on health care, and what do we have to show for it? Subpar health outcomes, physician burnout, and millions of medical bankruptcies. Single payer would do away with private insurance overhead. This would allow doctors to ditch the paperwork and focus on what they do best: caring for patients."*

— Physicians for a National Health Program

*"We as current and future health care providers support [a single-payer system] because it will get us back to the relationship between a physician and the patient, without insurance bureaucrats in between.*

— Dr. Sunny Aslam and medical students Robertha Barnes, Sydney Russell Leed, Kunfeng Sun, Mike Vidal, Azwade Rahman, Ella Cappello

*"As nurses, we see the devastating effects [of the private insurance system] on our patients every day."*

—Bonnie Castillo, R.N., Executive Dir. of National Nurses United

*"I am not asking for much. All I want is to practice medicine in a world where I no longer have to watch a patient walk out of the ER without medical care that could save their life because they are worried about going bankrupt."*

— Dr. Farzon Nahvi, emergency medicine

*Sources: www.nysna.org/single-payer-must; www.nationalnursesunited.org/press/statement-national-nurses-united-executive-director-bonnie-castillo-rn-budget-committee; nuhw.org/press-release-senate-2019-medicare-for-all-act; student.pnhp.org/private-health-insurance-harmful-health; https://docs.house.gov/meetings/RU/RU00/20190430/109356/HHRG-116-RU00-Wstate-NahviF-20190430.pdf*

# Where to Learn More About Improved Medicare for All and Our Current Healthcare Crisis

- California Health Care Foundation, www.chcf.org
- Commonwealth Fund, commonwealthfund.org
- Health Care-NOW!, healthcare-now.org
- Kaiser Family Foundation, kff.org
- National Nurses United, nationalnursesunited.org
- Physicians for a National Health Program, pnhp.org
- Labor Campaign for Single Payer, www.laborforsinglepayer.org
- UCLA Center for Health Policy Research, healthpolicy.ucla.edu
- UC Berkeley Labor Center, laborcenter.berkeley.edu