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 health care workers as we move toward Medicare for All.

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revised 2/21/2021
version 3.2.NUHW

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Why We Are Here

Our healthcare system isn't working. It costs too much, covers too few people, and puts enormous strain on us and our families. More than 27 million people have no health insurance and millions more struggle to afford care even with insurance. Many employers are also staggering under ever-higher healthcare costs and they continue to shift more of the cost onto workers.

There's wide agreement that our current system is unsustainable. As we consider what comes next, it's crucial that workers and unions are a central part of the discussion so whatever comes next will work for us.

Today we'll take a close look at our current system, how we compare to other countries, and who really benefits from it. We'll consider how healthcare affects collective bargaining now and could affect it in the future, how insurance companies behave, and how hospitals would fare under Improved Medicare for All. We'll discuss why healthcare professionals support Medicare for All and how the Canadian healthcare system works.

Finally, we'll look at the jobs that would be eliminated under Medicare for All in the health insurance industry and in health provider administration and how the labor movement can fight for a fair and equitable transition for those workers.

Introduction

Task 1: Current Medicare

About 14% of people in the U.S., including everyone 65 or older,* have Medicare. Many proposals to change our current healthcare system build off Medicare, so let's take a look at how it works.

In your small groups, please **review the fact sheets on pages 4-9** and then answer the questions below. 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.

1. What is your opinion of our current Medicare system?

2. Do you intend to go on Medicare when you turn 65? Would you consider going on Medicare sooner if you were allowed to?

**If they or their spouse have worked for at least a total of 40 quarters (10 years) in jobs that pay into Medicare.*

Medicare Basics

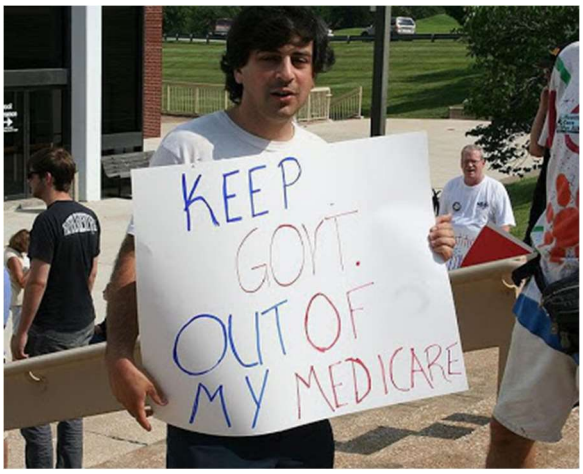
- Medicare is provided by the federal government.
- Medicare is insurance that covers everyone 65 or older* and some people with long-term disabilities, regardless of income or medical history.
- Medicare is paid for by a 1.45% payroll tax paid by employees and employers.
- More than 62 million people are currently enrolled.
- Can go to any doctor, hospital, or provider who is enrolled in Medicare.

Cost to Participants

Medicare is far cheaper than most insurance, but there are costs for participants. (Costs below apply to individuals making less than $87,000/year. Premiums increase with income.)

Hospitalization

Medicare is broken up into parts. For Medicare that covers hospitalization and skilled nursing, there's no premium. The annual deductible, if hospitalized, is $1,440.



Other medical care

For other services, premiums depend on income, location, and options. The average monthly premium ranges from $23 to $176 and the average deductible is less than $600.

Co-pays and/or co-insurance are required for some services.

(Note that the proposed "Improved Medicare for All," which we will discuss later, would be simplified and would cover all services without premiums or out-of-pocket costs.)

Medicare Users Rate It Highly

Public opinion on Medicare has been positive since it began. Here are some recent findings:

	Medicare/ Medicaid	Private insurance
Rate their healthcare coverage as excellent or good *(e.g., services covered, choice of providers)*	**79%**	**70%**
People age 65 and older		
Say Medicare works well		**80%**
Say Medicare is "very important" to me and my family		**90%**

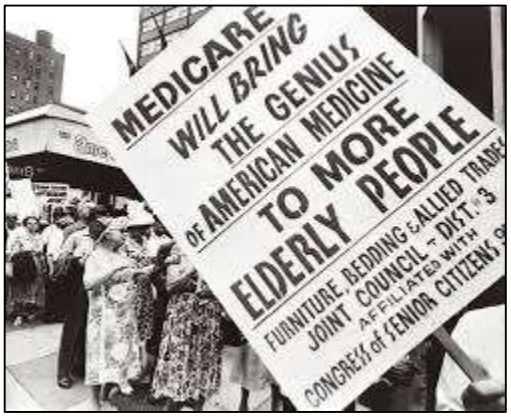
Sources: Kaiser Family Foundation tracking polls; Gallup, news.gallup.com/poll/245195/americans-rate-healthcare-quite-positively.aspx

Medicare Reduced Poverty

Before Medicare was created in 1965, less than half of people 65 or older had health insurance. 35% of those 65 or older lived in poverty. Even with Social Security benefits, most could not afford the rising cost of hospitalization.

Medicare had two purposes: to provide better healthcare to older Americans and to keep them from becoming destitute. It succeeded at both.

"Few programs in the history of the United States have brought as much benefit to society as Medicare. Since its enactment in 1965, Medicare has provided access to quality health care for those Americans least likely to be attractive to private insurers—those over age 65, disabled, or with end stage renal disease. Medicare has also prevented many Americans from slipping into poverty. "



Organized labor strongly supported the creation of Medicare

More financial security for families

"Medicare also provides security across generations: it has given American families assurance that they will not have to bear the full burden of health care costs of their elderly or disabled parents or relatives at the expense of their young families."

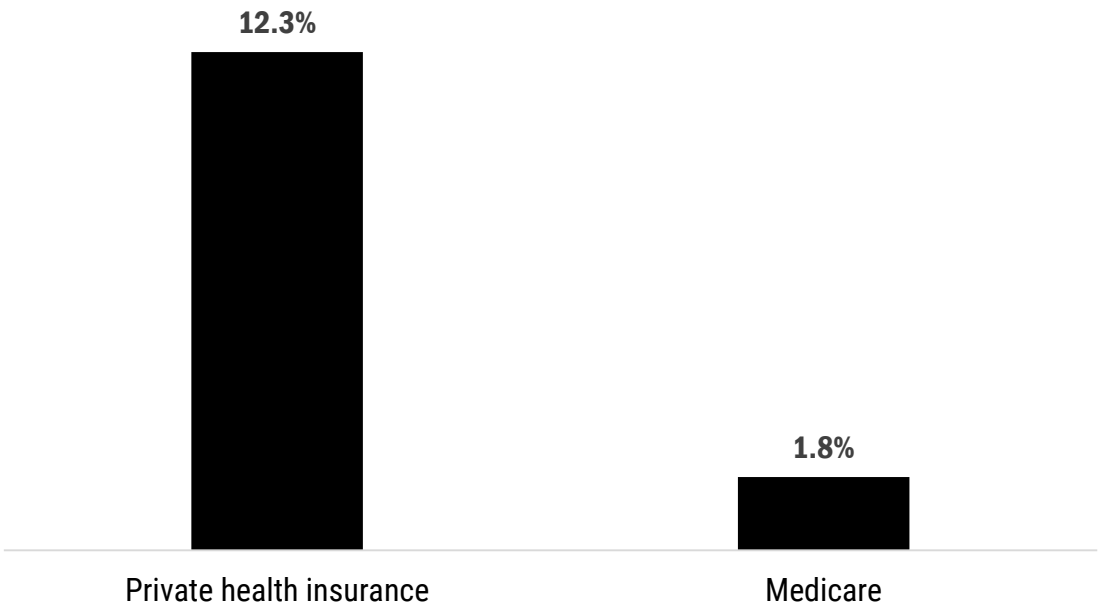
Source: www.medicareadvocacy.org/medicare-info/medicare-and-health-care-reform

Medicare Is More Cost-Efficient Than Private Insurance

Medicare's overhead and administrative costs are a fraction of costs at private insurance companies.

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

Some Opposed Medicare as "Socialized Medicine"

The American Medical Association (AMA) and the insurance industry fought against Medicare, calling it "un-American" and "socialized medicine."

"Operation Coffeecup"

The A.M.A. tried to create a grassroots campaign against Medicare through "Operation Coffeecup." They sent out a recording called "Ronald Reagan Speaks Out Against Socialized Medicine," to the A.M.A.'s ladies auxiliary. The "ladies" were instructed to "put on the coffeepot," play the record for their friends and other physicians' wives, and then write letters to their members of Congress.

Reagan warns that "one of the traditional methods of imposing statism or socialism on a people has been by way of medicine."

At the end of the recording, Reagan tells listeners that if they don't prevent the passage of Medicare, "one of these days you and I are going to spend our sunset years telling our children and our children's children what it once was like in America when men were free."

Sources: Julian Zelizer, "How Medicare Was Made," New Yorker, 2/15/2015, https://www.newyorker.com/news/news-desk/medicare-made; "Ronald Reagan Speaks Out Against Socialized Medicine" (recording), https://youtu.be/AYrlDlrLDSQ

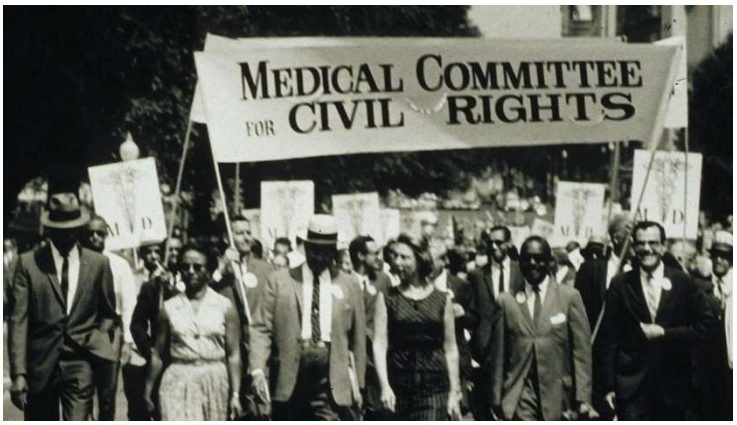
Medicare Desegregated America's Hospitals

Medicare was responsible for desegregating America's hospitals. Before Medicare:

- Hospitals across the South were rigidly segregated. Many were reserved for whites only; others had separate entrances, waiting rooms, and wings for Black patients.
- Hospitals in the North weren't officially segregated, but Black doctors couldn't get privileges to practice at hospitals dominated by whites, and white doctors were pressured to send Black patients elsewhere.
- White hospitals routinely denied emergency care to Black patients even when there was no Black hospital in the area.
- White hospitals generally had better funding and facilities.

But when Medicare became law in 1965, any hospital that wanted to accept Medicare was required to desegregate. As a result, more than 1,000 hospitals integrated staff and patients in just four months.

> "They desegregated the entire system, not just by race but by income as well. Today, as a consequence, hospitals are the most racially and economically integrated of any private institutions in the country. . . . The fundamental moral imperative — that those needing medical care should receive it — began for the first time to reflect actual use of services."



The Medical Committee for Civil Rights at the 1963 March on Washington. MCCR fought to desegregate health care.

Sources: David Barton Smith, The Power to Heal: Civil Rights, Medicare, and the Struggle to Transform America's Health Care System; Michelle Andrews, "1965: The Year That Brought Civil Rights To The Nation's Hospitals," Kaiser Health News, 8/9/2016, https://khn.org/news/1965-the-year-that-brought-civil-rights-to-the-nations-hospital

Task 2: Positives and Negatives of Your Healthcare Benefits

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

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

Positives	Negatives

Task 3: What Is "Improved Medicare for All"?

"Improved Medicare for All" is just what it sounds like: starting with the current Medicare system and improving it by including everyone in the country and expanding the medical services that it covers.

In your small groups, please review the description of Improved Medicare for All on the next page and answer the question below. Select a different member of your group to take notes and report back to the larger group.

How would a system like Improved Medicare for All compare with your existing healthcare insurance? What might be better? What might be worse?

Might Be Better	Might Be Worse

What Is "Medicare for All"?

1. "Medicare for All" (also called "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 expanded and greatly enhanced so that **everyone is covered from birth for all medical care.**

3. **Comprehensive coverage,** including:
    - Primary
    - Preventive
    - Vision, dental and hearing
    - Mental health
    - Hospital care
    - Prescriptions
    - Reproductive and maternity
    - Long-term care

4. **No cost barriers.** No premiums, deductibles, or co-pays.

5. **Fair financing.** Takes the burden of health care costs off the backs of working people. 95% of U.S. households will pay less for healthcare than they do now. Paid for through:
    - new taxes on the wealthy,
    - employer payments, and
    - Medicare payroll tax.

6. **Takes health insurance off the bargaining table.** Employment-based health insurance would no longer be necessary. Other employer-provided insurance (like life and disability) would not be impacted.

7. **Increased equity** for underserved populations and geographic areas.

8. Medicare for All replaces Medicaid, CHIP, Medicare for seniors, and subsidies for the Affordable Care Act.* Seniors would no longer have to purchase private "add on" insurance like Medicare Advantage or MediGap.

9. **Doctors continue to work in private or public practice,** as they choose.

10. We can **choose our own providers.** There are no "networks" that limit our choices.

11. Protection, known as a **"just transition,"** for displaced healthcare and administrative workers.

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

Takeaways

1. The existing Medicare program covers most people 65 and older as well as some younger people with disabilities.
2. Medicare lowered poverty among the elderly and helped desegregate our healthcare system.
3. "Improved Medicare for All" would build on existing Medicare, expanding it to cover everyone in the U.S., and covering all medically necessary services.

Activity 1: Healthcare Benefits and Collective Bargaining

Task 1: Your Experience with Employer-Based Healthcare Insurance

Please answer the following questions for yourself in the online poll.

In bargaining, have any of the following happened with your current or a previous employer?

	Yes	No	Not sure
1. Do you think your union bargaining committee has been forced to make trade-offs between wage increases and healthcare costs?			
2. Did you get wage increases but also have to pay more for healthcare?			
3. Have the premiums you have to pay increased?			
4. Have your co-pays, deductibles, or other out-of-pocket costs increased?			
5. Has your employer refused to bargain over retiree healthcare?			
6. Has your employer made changes (like switching to a different insurance company or changing who is in-network) that forced you to change providers?			
7. Have you taken or stayed in a job because of the healthcare benefits?			
8. Have you been concerned that employers can cut off healthcare insurance during a prolonged strike (or lockout)?			

Task 2: Healthcare Insurance and Collective Bargaining

Please review the fact sheets on pages 17-23 and answer the questions below. Select a different member of your group to take notes and report back to the large group.

1. Based on the fact sheets and your own experience, how does healthcare affect collective bargaining?

2. Of the fact sheets on pages 17-23, which ONE do you think would be most important to share with your co-workers?

Page _____

Title of fact sheet _____

Why did you choose this fact sheet?

3. If healthcare costs were "off the table"—if our employers weren't spending money on healthcare benefits—how would we want them to spend that money?

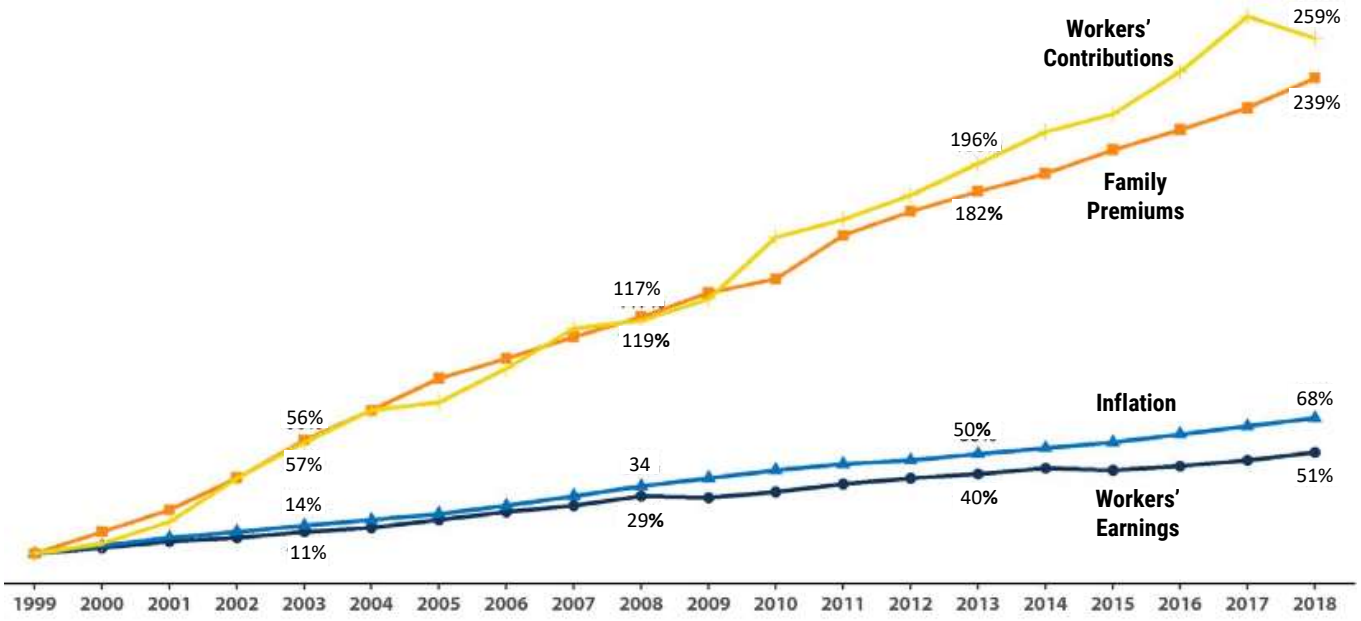
Healthcare Costs Rise Much Faster than Wages

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 ($9.43/hour for a full-time worker).

CUMULATIVE INCREASES IN FAMILY PREMIUMS, WORKER CONTRIBUTIONS TO FAMILY PREMIUMS, INFLATION, AND WORKERS' EARNINGS

1999-2018



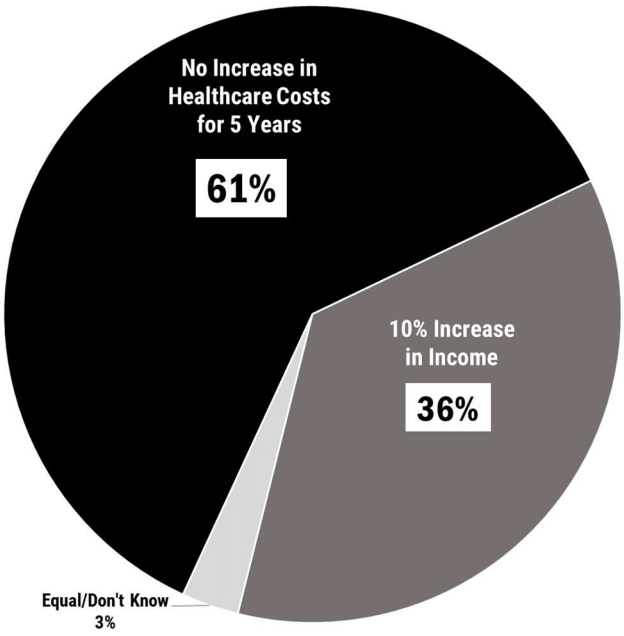
Source: Kaiser Family Foundation Employer Health Benefits Survey, 2018, 10/3/18, www.kff.org/slideshow/2018-employer-health-benefits-chart-pack (slides 3 and 6).

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, as this chart shows:

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%

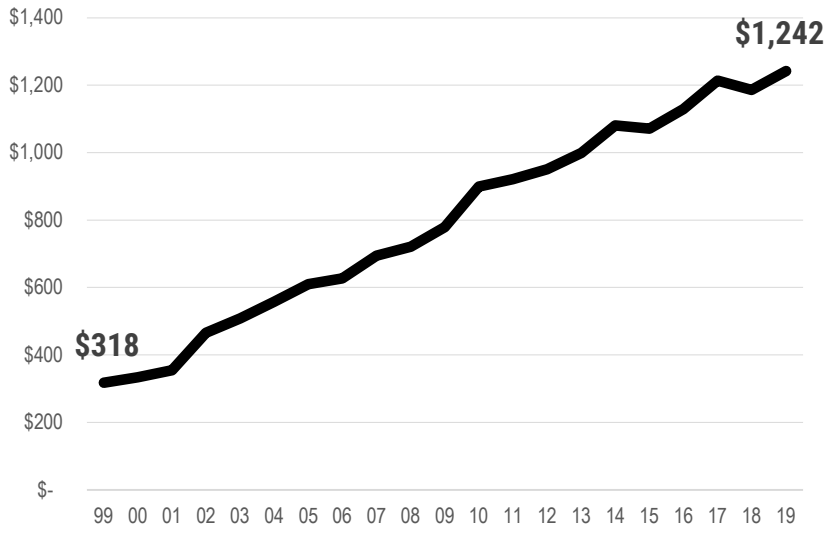
Source: West Health-Gallup U.S. Healthcare Cost Crisis Report, 4/2/19, news.gallup.com/poll/248081/westhealth-gallup-us-healthcare-cost-crisis.aspx

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

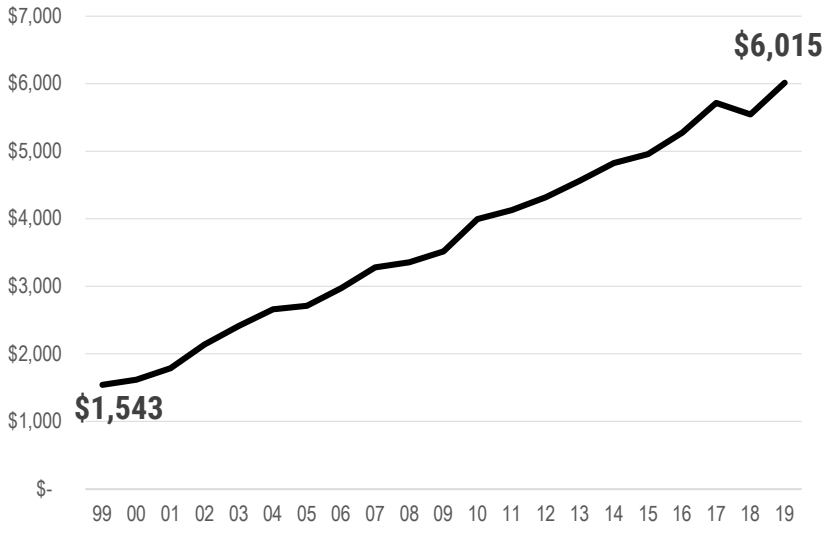
1999-2019



For single coverage, premiums paid by workers have increased by 291% since 1999.

AVERAGE PREMIUMS PAID BY EMPLOYEES – FAMILY COVERAGE

1999-2019



For family coverage, premiums paid by workers have increased by 290% since 1999.

Source: KFF, www.kff.org/interactive/premiums-and-worker-contributions-among-workers-covered-by-employer-sponsored-coverage-1999-2019

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

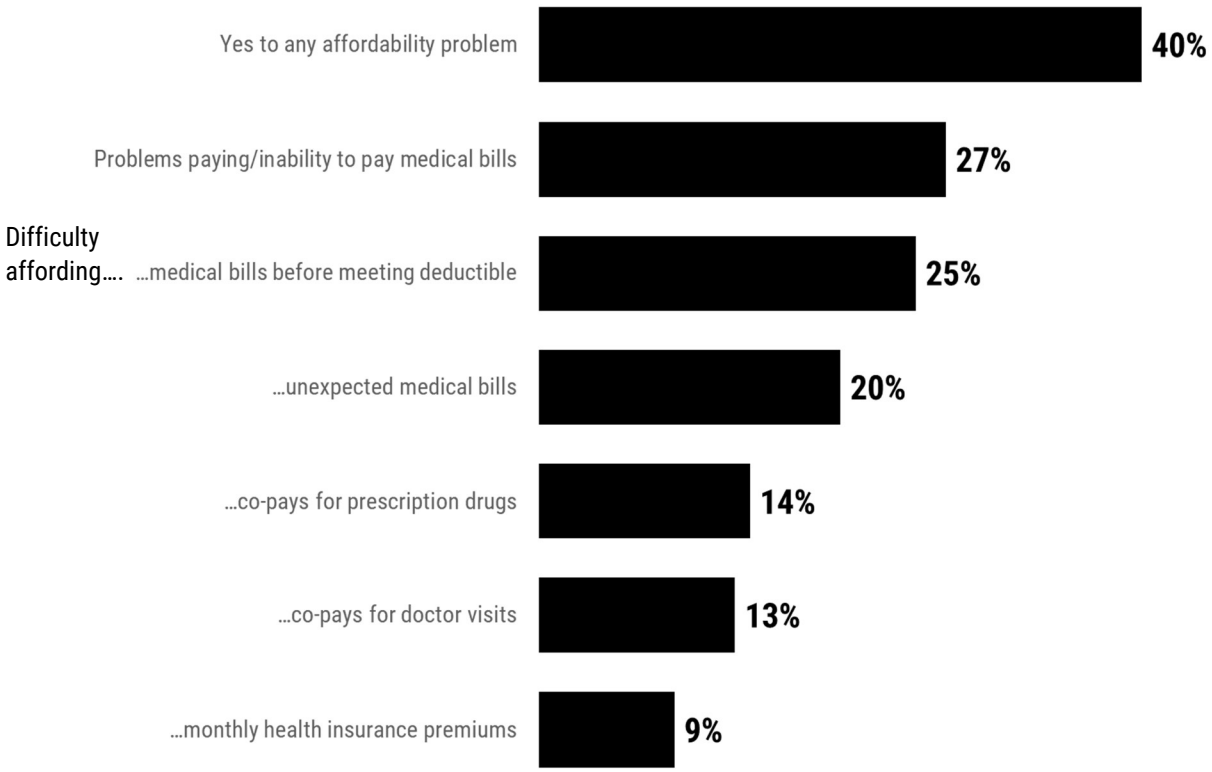
Millions of people are "underinsured." They have insurance but can't afford to use it.

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 job-based health plans.**

Overall, 40% of those with employer coverage report 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



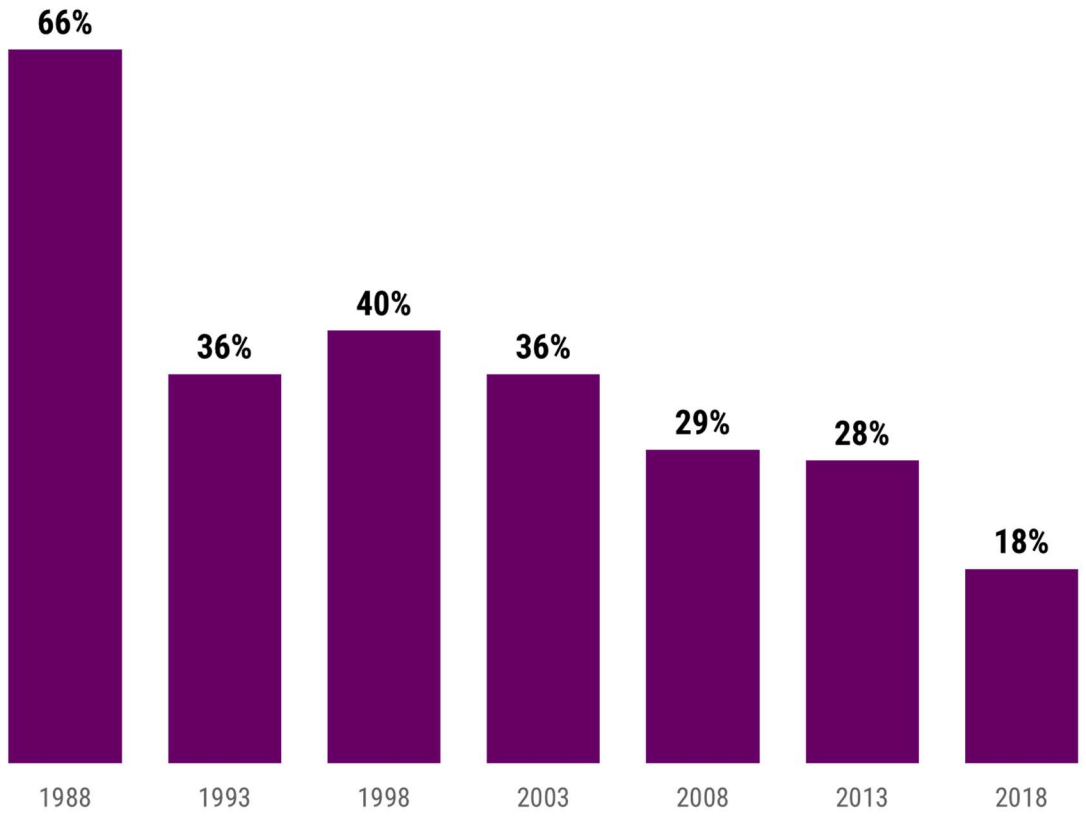
Sources: "Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance," published 5/2/19, www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance; www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greate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

Retiree Benefits Are Vanishing Rapidly

Health care for retirees is an expensive part of corporate health care costs. As a result, corporations are trying to get rid of these plans as fast as possible. As the charts below show, large companies (200 or more employees) are eliminating retiree health 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

COVID-19 Update:

As of December 2020, as many as 7 million people may have lost their employer-sponsored health insurance because of COVID-19 job losses.

Source: Commonwealth Fund, "Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?"' 1/11/2021, www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic

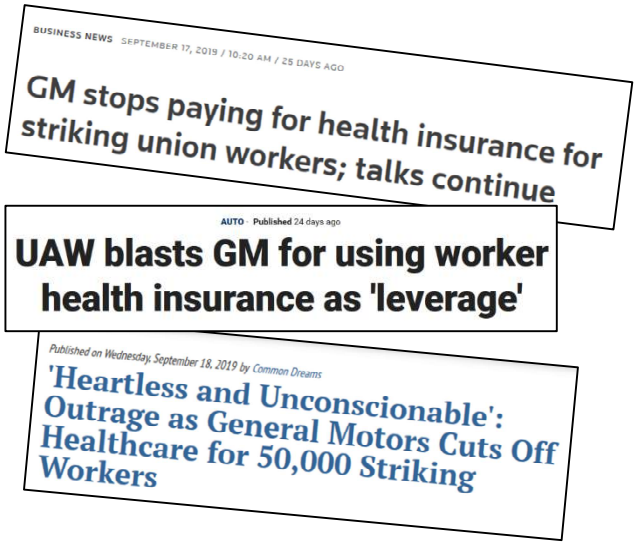
**Employer-sponsored insurance can be extended for a limited time through COBRA if the participant pays the entire premium plus a 2% administrative fee. Not many people can afford this.*

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 had the power to cut them off again if they chose.

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. Relying on our employers for healthcare also weakens our ability to strike—or even to threaten to strike.
5. 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 2: Can We Afford Better Healthcare?

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 26-33. 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. Please select 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. 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 26-33, which ONE do you think would be most important to share with your co-workers?

Page _____

Title of fact sheet _____

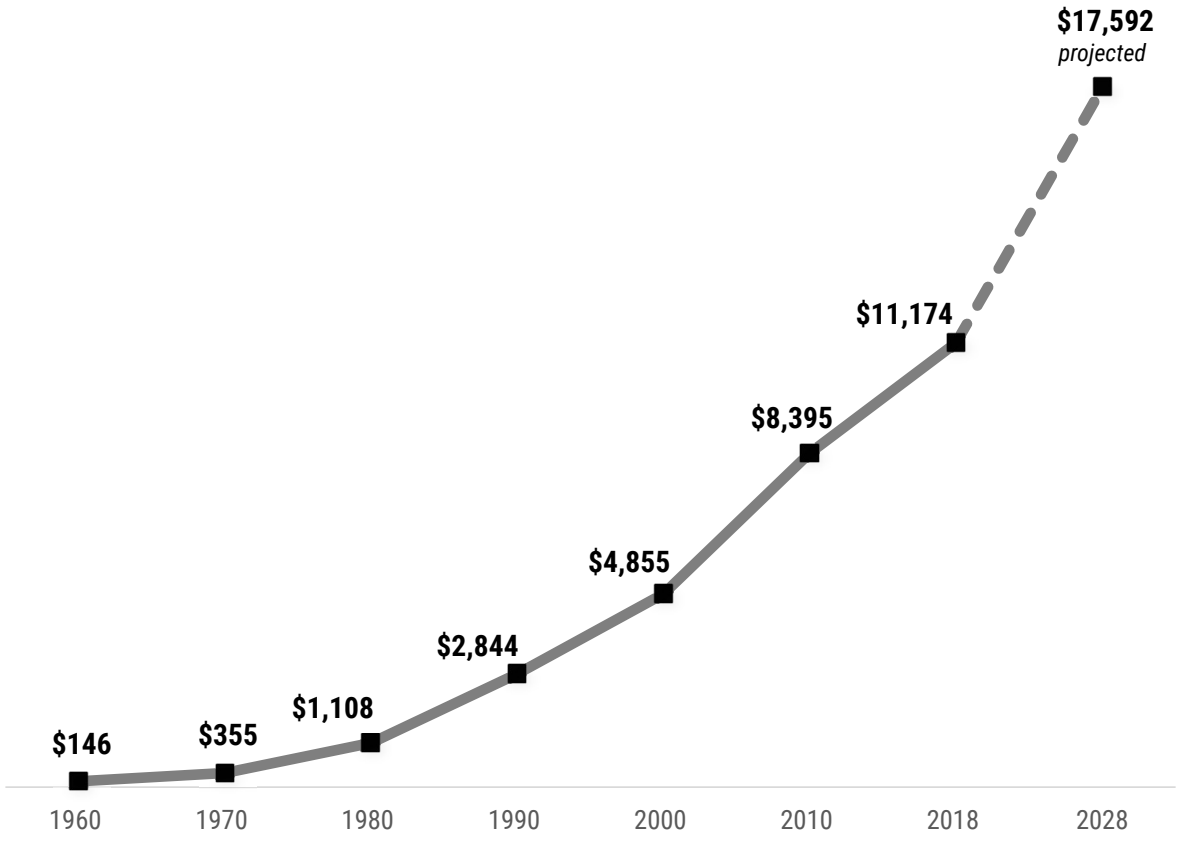
Why did you choose this fact sheet?

We Are Spending More and More on Health Care

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

U.S. Health Expenditures Per Person Per Year

1960-2028 in 2020 dollars



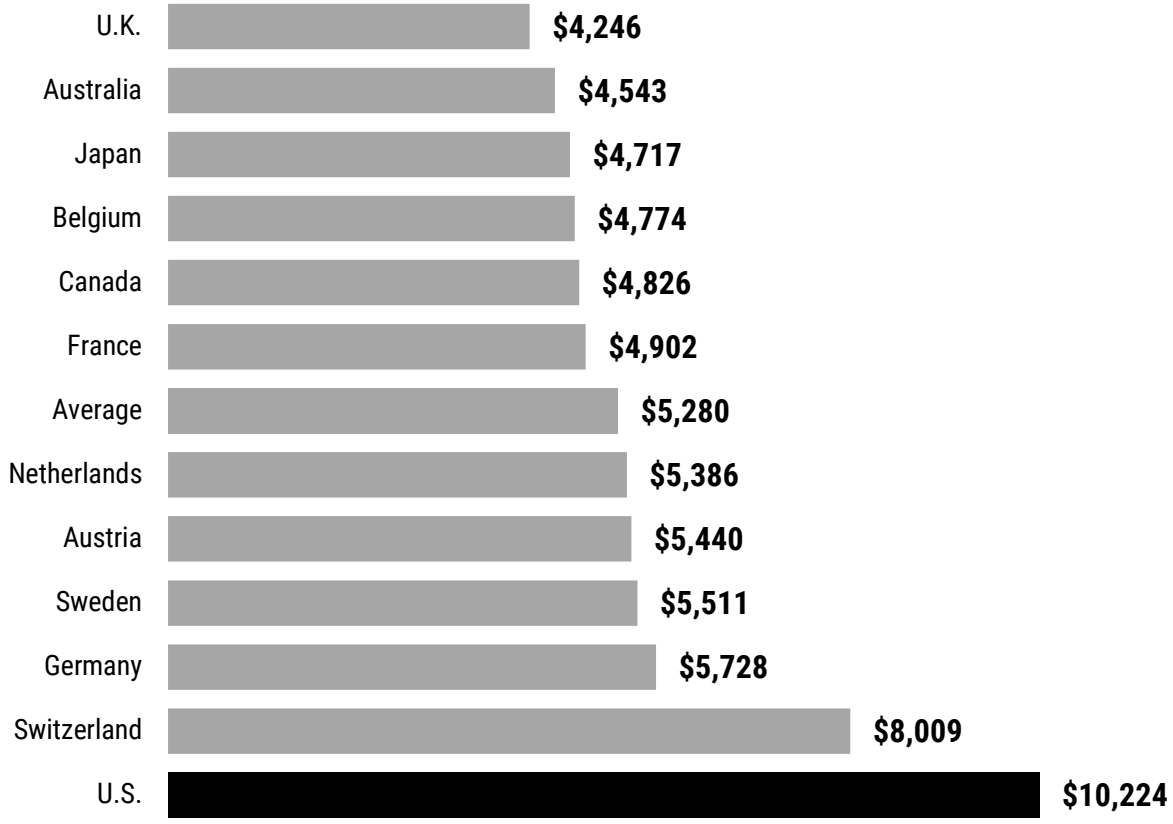
Source: National Health Expenditures Data, U.S. Centers for Medicare & Medicaid Services, www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata

And We Are Spending More Than Other Countries

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

HEALTHCARE SPENDING PER PERSON

2017 in U.S. dollars



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
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 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 hospital beds (per capita; 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

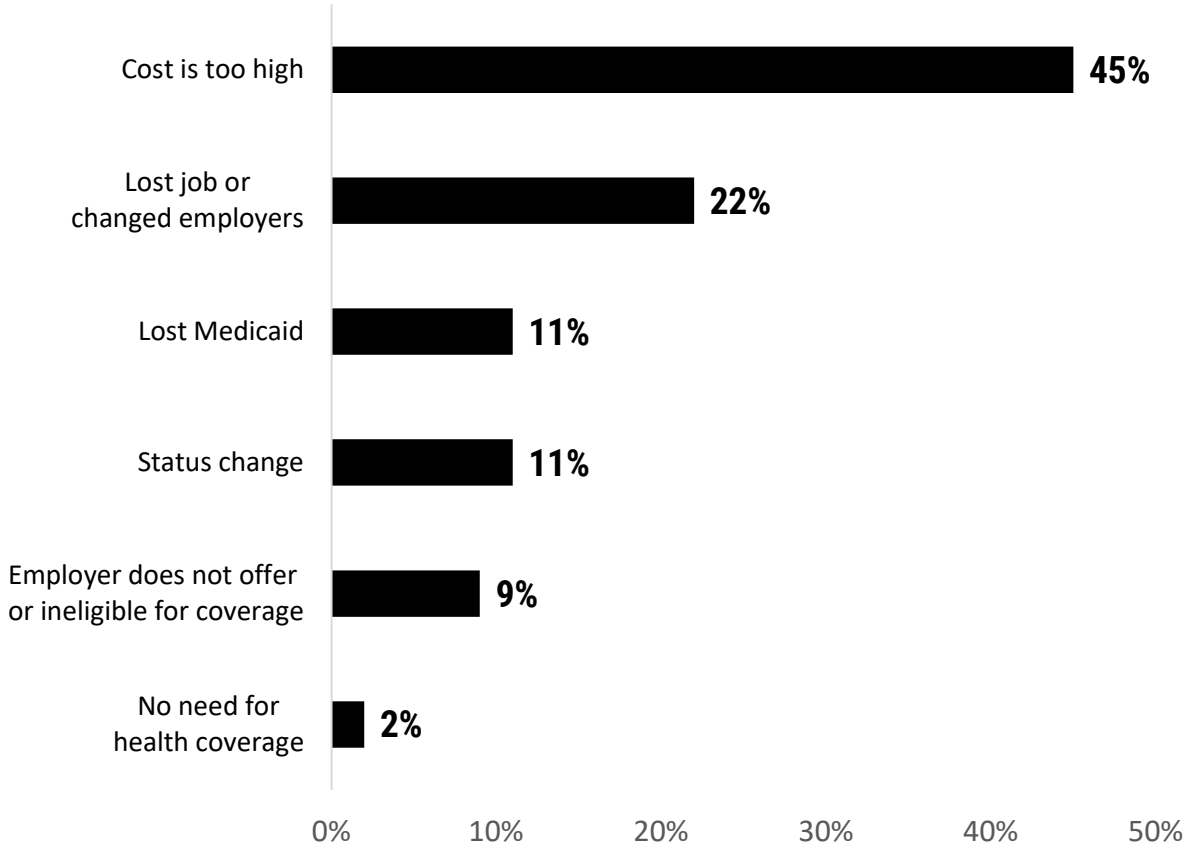
27.4 Million People Are Still Uninsured

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. (Note that this figure is from the end of 2019 and doesn't take into account the people who lost insurance in 2020 due to pandemic job losses.)

Another 41 million people are "underinsured": 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.

Source: Kaiser Family Foundation analysis of the 2017 National Health Interview Survey

Drug 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: The CEO-to-Worker Wage Gap

Discussions about Medicare for All 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. Please continue to the next page.

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 <u>should</u> the wage gap be?	
4. In your opinion, what <u>should</u> a CEO of a large company receive each year in total compensation?	**$_____**
5. What do you think an average worker <u>should</u> receive per year?	**$_____**
6. What ratio do you get when you divide the CEO estimate by the worker estimate?	***_____ to one***

Top CEOs Make 802 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 2011 to 2019, the ratio ranged between 413-to-one and 1313-to-one, with an average of 802-to-one.

WAGE GAP: TOP 100 CEOS VERSUS AVERAGE WORKERS

Averaged over 2011-2019

**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.*

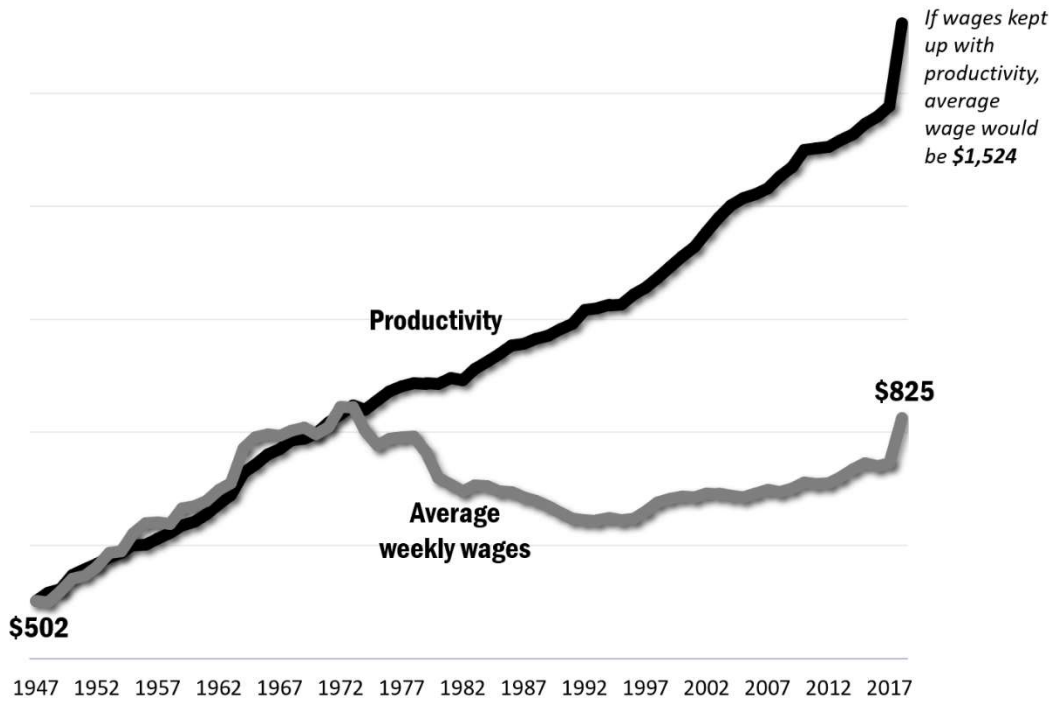
Sources: "CEO Compensation Survey," Forbes, April or May issues, 1971-2014 and Equilar/New York Times, "The New York Times/Equilar 200 Highest-paid CEO Rankings," 2015-2019 and Equilar/AP CEO Rankings, 2020; Bureau of Labor Statistics, "Employment, Hours and Earnings from the Current Employment Statistics Survey (National)," https://data.bls.gov

Task 3: The Productivity-Wage Gap

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 $1,524 per week in 2018.* That's almost double the actual average weekly wage of $825.

That gap between productivity and wages is the money that has been taken systematically from working people year after year for the last 40 years.

**Average weekly wages for production and non-supervisory workers based on Bureau of Labor Statistics data. Wages measured after inflation in 2018 dollars*

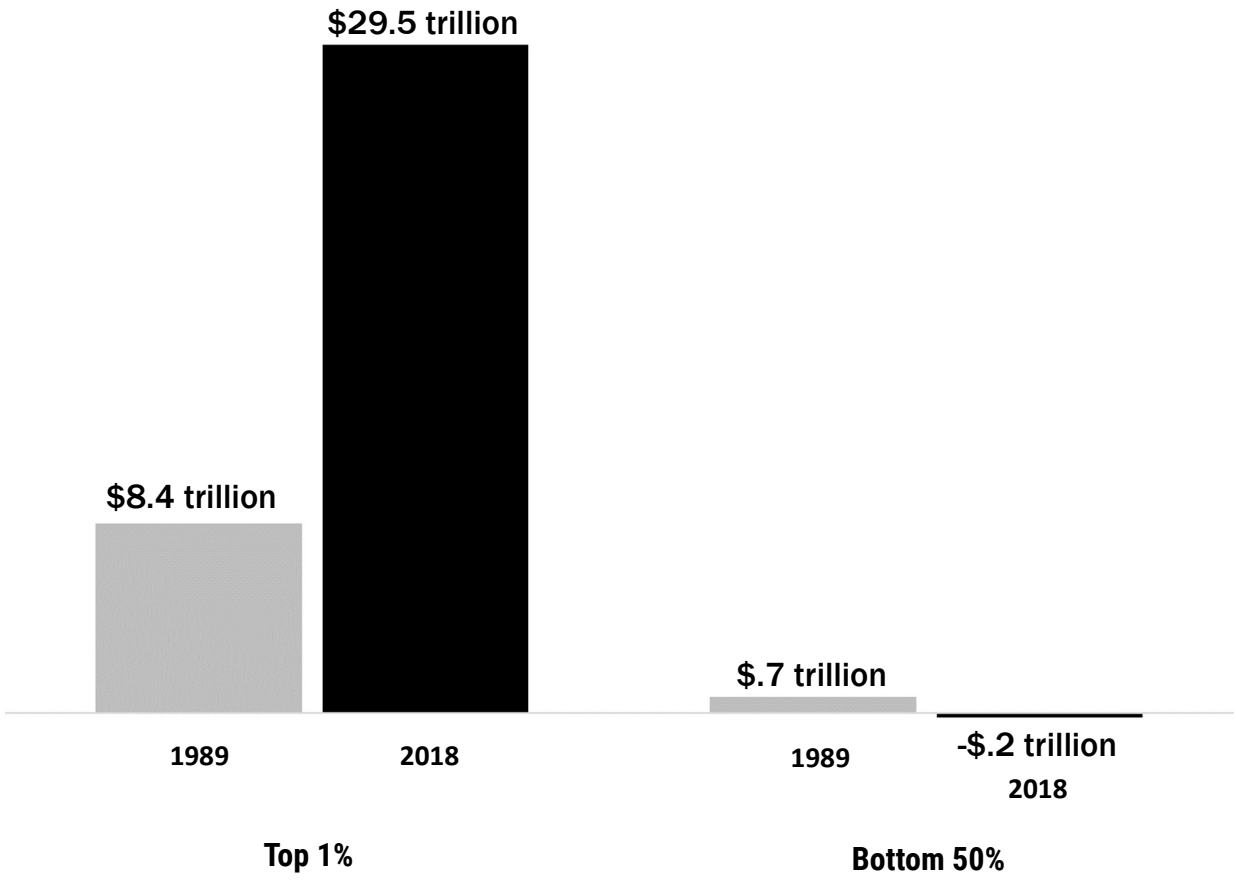
The Top 1% Have Taken $21 Trillion Since 1989

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

Billionaries Have Raked in a Trillion Dollars During the Pandemic

While tens of millions of Americans have lost their jobs, up to 7 million have lost their health insurance, 29 million do not have enough food to eat, and 40 million face eviction, 661 U.S. billionaires saw their wealth increase by 38.6%, or over $1.1 trillion.

WEALTH OF U.S. BILLIONAIRES DURING THE PANDEMIC

Top 5 billionaires are listed first

	Net worth on March 18, 2020	Wealth added	Net worth on Jan. 18, 2021	% growth
in billions				
Jeff Bezos	$ 113.0	$ 68.5	$ 181.5	60.6%
Elon Musk	$ 24.6	$ 154.6	$ 179.2	628.5%
Bill Gates	$ 98.0	$ 22.2	$ 120.2	22.7%
Mark Zuckerberg	$ 54.7	$ 37.4	$ 92.1	68.3%
Warren Buffett	$ 67.5	$ 20.6	$ 88.1	30.6%
All other billionaires	$ 2,589.7	$ 834.2	$ 3,423.9	32.2%
Total	**$ 2,947.5**	**$ 1,137.5**	**$ 4,085.0**	**38.6%**

Source: Americans for Tax Fairness and the Institute for Policy Studies – Program on Inequality, 6/18/2020, americansfortaxfairness.org/3-months-covid-19-pandemic-billionaires-boom-middle-class-implodes/

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 if wage gains kept up with productivity (page 37):*		
2. *Actual average weekly wage (page 37):*	-	
3. *Subtract #2 from #1 = Our missing weekly wages*	=	
4. *Multiply by 52 weeks*	x	52
5. *Our missing annual wages per worker*	=	
Now, how much are we missing collectively?		
6. *Number of workers* *(according to the Bureau of Labor Statistics)*		103,000,000
7. *Our missing annual wages*	x	
8. *Multiply number of workers by missing annual wages*	=	

The money we need for Improved Medicare for All is less than one-third of that.

Task 5: Can We Afford Improved Medicare for All?

In your small groups, please review the fact sheets on pages 42-46 and answer the question below. You may also want to look back at pages 37-39. Choose a different member of your group to take notes and report back.

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

2. Of the fact sheets on pages 37-39 and 42-46, which ONE do you think would be most important to share with your co-workers?

Page ___

Title of fact sheet _____

Why did you choose this fact sheet?

Improved Medicare for All Is Cheaper 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.

- We now spend **$3.24 trillion** a year on healthcare. We could spend less and get more.

  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.

ANNUAL COST OF CURRENT U.S. HEALTHCARE SYSTEM VS. IMPROVED MEDICARE FOR ALL
in trillions

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.

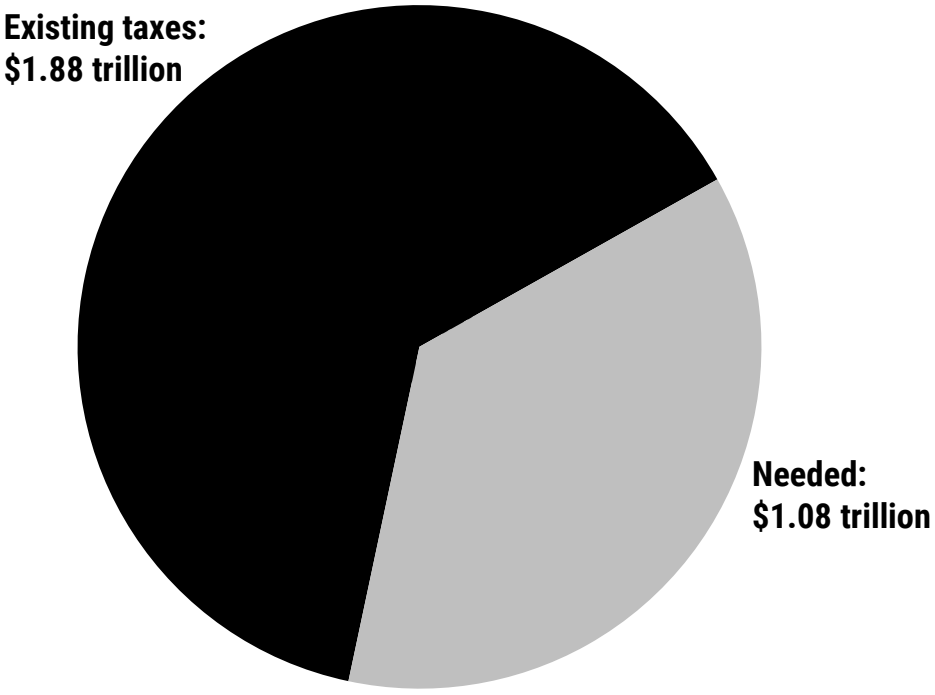
We Don't Need to Tax Ourselves to Pay for Improved Medicare for All

As we saw on the previous page, 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 $2.96 TRILLION NEEDED 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 Profit and Federal Tax Rebates

2018, in millions

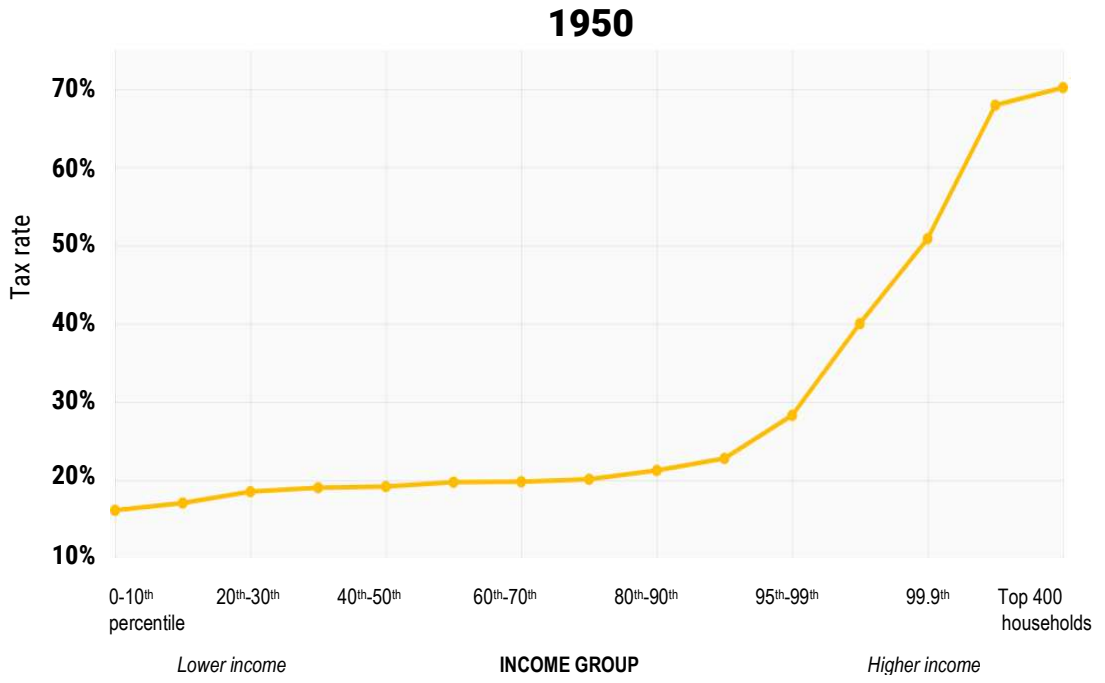
Company	U.S. Profits	Tax Rebate
Amazon.com	$10,835	($129)
Delta Air Lines	$5,073	($187)
Chevron	$4,547	($181)
General Motors	$4,320	($104)
EOG Resources	$4,067	($304)
Occidental Petroleum	$3,379	($23)
Duke Energy	$3,029	($647)
Dominion Resources	$3,021	($45)
Honeywell	$2,830	($21)
Deere	$2,152	($268)
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)

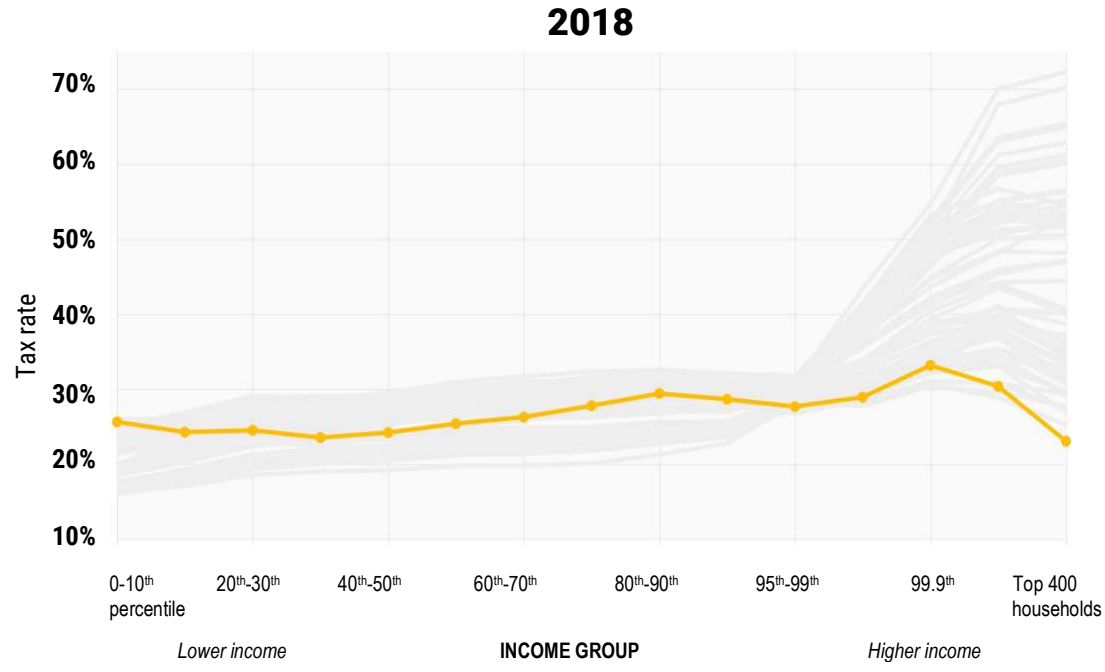
Company	U.S. Profits	Tax Rebate
Whirlpool	$717	($70)
MGM Resorts Int'l	$648	($12)
Atmos Energy	$600	($10)
Eli Lilly	$598	($54)
Alaska Air	$576	($5)
Cleveland-Cliffs	$565	($1)
UGI	$550	($3)
IBM	$500	($342)
Celanese	$480	($142)
Activision Blizzard	$447	($228)
Goodyear	$440	($15)
U.S. Steel	$432	($40)
Owens 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

The Wealthiest Now Pay the Lowest Taxes

TOTAL TAX RATE (FEDERAL, STATE, AND LOCAL)





Source: David Leonhardt, "The Rich Really Do Pay Lower Taxes Than You," New York Times, 10/6/2019, www.nytimes.com/interactive/2019/10/06/opinion/income-tax-rate-wealthy.html

Can the Super-Rich Afford It?

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

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 more than $40 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 more than $14 million a year for the next 50 years.

It's enough to spend $40,000 <u>every single day</u> for the next 50 years.

Amazon CEO Jeff Bezos, the richest person on the planet, has over $190 billion. How much is that?

It's enough to spend $10.4 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 $140 billion, enough to spend $2.8 billion a year for the next 50 years.

It's enough to spend $7.7 million <u>every single day</u> 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. 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 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. Medicare for All is one way to take some of that back.

Activity 3: How Do Insurance Companies Make Money?

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

We've looked at one defining aspect of the U.S. healthcare system: it's based on employment. Now we'll look at the other defining feature: 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 <u>typical</u> 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."

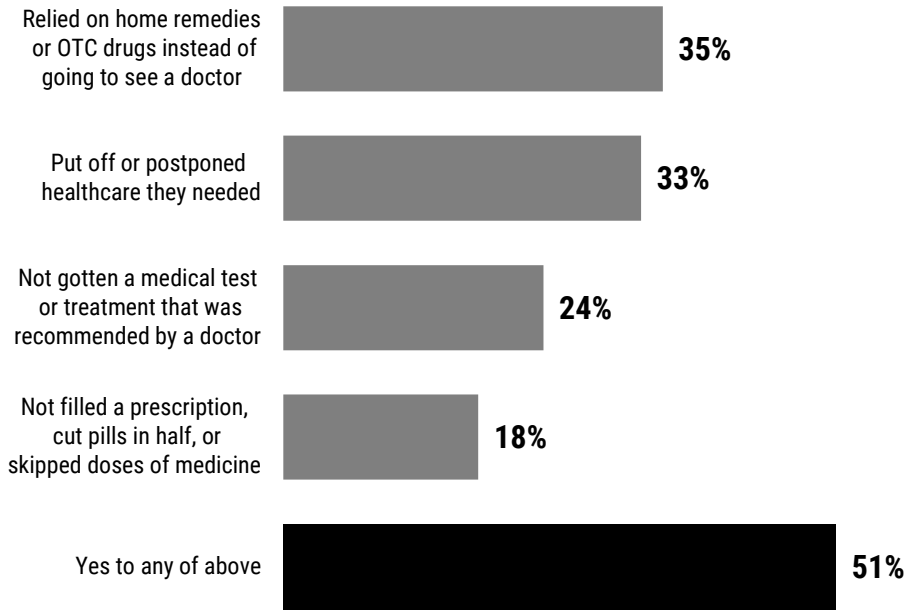
Sources: Linda Peeno, M.D., testimony before the U.S. House Subcommittee on Health and Environment, 5/30/1996, www.hospicepatients.org/drpeenotestimony.html#c3; Interview in "Sicko," 2007

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

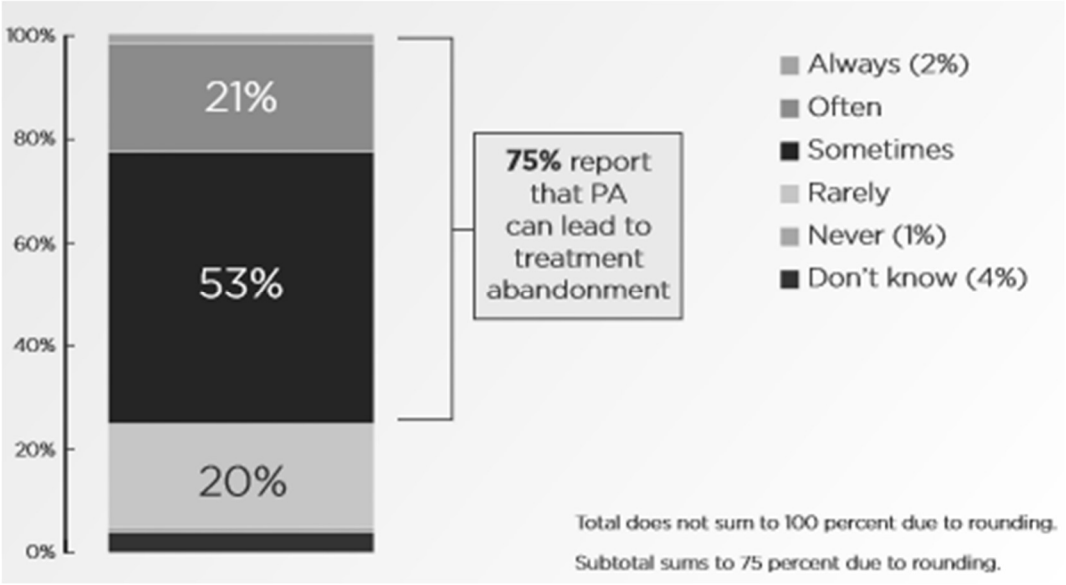


Source: Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance, 5/2/2019, www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance

"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

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.

Activity 4: What's the Alternative to Employer-Based, For-Profit Health Insurance?

Task 1: Positives and Negatives of Canadian Medicare

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. In your small groups, please make a list of the positive and negative things you've heard about the Canadian healthcare system. One member of your group should take notes and report back.

Positive things you've heard about the Canadian healthcare system:

Negative things you've heard about the Canadian healthcare system:

Task 2: Debunking the Myths

Canada's Medicare system is similar to proposals for Improved Medicare for All in the U.S.

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

- Play the video from your desktop. It will not run properly from Google Drive.
- After the video, point out the information under "More Resources" and then move to the next activity

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.

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

More Resources

Wait Times for Care

- Canadian healthcare is very transparent about wait times. Each Canadian province publishes wait times for procedures: *www.waittimealliance.ca/for-professionals/provincialterritorial-wait-time-links*

Americans Go Abroad to Afford Healthcare

- According to the American Journal of Medicine, in 2017, more than 1.4 million Americans went abroad for more affordable healthcare. When complex procedures are involved, the total cost for hospitalization, physician fees, airfare, and hotel expenses for the patient and spouse can be far less than the cost of the procedure in the U.S. *www.amjmed.com/article/S0002-9343(18)30620-X/fulltext*

Campaigns of "Fear, Uncertainty, and Doubt"

- Wendell Potter lays out the tactics of fear, uncertainty, and doubt that the U.S. insurance industry uses to spread disinformation*: www.tarbell.org/2018/08/how-corporate-health-care-interests-nervous-about-their-profits-are-trying-to-scare-you*

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 5: How Would Improved Medicare for All Affect Hospitals?

Task: How Would Improved Medicare for All Affect Hospitals?

We'll now take a closer look at hospitals, which account for more than one-third of healthcare spending. In your small groups, please review the information on pages 60-67 then answer the questions below. Please choose a different member of your group to take notes and report back.

1. How would you respond to the following statement?

> "Our hospitals can't survive under Medicare for All. Medicare payments are just too low and we need the higher payments from private insurers to offset them. Medicare for All could force hospitals to limit the care they provide or to close altogether. It would be a disaster for hospitals, patients, and workers."

Your response:

2. Of the fact sheets on pages 60-66, which ONE do you think would be most important to share with your co-workers?

Page ___

Title of fact sheet _____

Why did you choose this fact sheet?

Improved Medicare for All Would Cut Hospitals' Costs

Improved Medicare for All would cut billions in hospital spending.

Safety net care

- Hospitals currently provide about $40 billion in uncompensated care every year, according to the American Hospital Association. Under Medicare for All, there would be no such thing as uncompensated care.
- Medicaid currently reimburses hospitals significantly less than Medicare or private insurance. Safety net hospitals that rely heavily on Medicaid reimbursements would be made more secure.

Better access to primary care

- Because everyone could afford primary and preventative care, Medicare for All would dramatically lower expensive ER admissions.

Lower overhead and administrative costs

- Medicare for All would slash hospital administrative costs, which are approximately 25% of American hospitals' total revenues. Compare that to 12% in single-payer systems in Canada and Scotland.

Lower spending

- High salaries for hospital executives and top administrators would be limited through global budgeting, freeing up millions for patient care.
- Hospital costs for prescription drugs and medical devices and equipment would be cut by up to 50% (to bring them in line with Canada and other wealthy nations).
- Extravagant and duplicative services and facilities meant to attract the global elite as cash paying customers would no longer be necessary.

Lobbying & political donations

- The American Hospital Association spent $48.2 million on lobbying and political donations for the last election cycle (2017-18).

Sources: American Hospital Association, "Uncompensated Hospital Care Fact Sheet," Jan. 2020, https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost; Ron Shinkman, "Billing for medical services costs hospitals huge amounts of time and money, study finds," FierceHealthcare, 2/26/18, www.fiercehealthcare.com/finance/study-billing-for-medical-services-costs-huge-amounts-time-and-money; Center for Responsive Politics, www.opensecrets.org/orgs/summary.php?id=D000000116&cycle=2018

Improved Medicare for All Would Drop the "Fee for Service" Model

Private insurance, Medicaid, and current Medicare are based on **"fee for service."** Because current Medicare reimbursements rates are perceived as being too low, some conclude that hospitals would not be able to survive under Medicare for All.

But under Medicare for All, hospitals would be funded using **"global budgets,"** the same way we currently fund public services like libraries and fire departments.

Fee-for-Service Fire Departments?

Imagine if our fire departments were run like today's hospitals, with a "fee for service" model. Your neighborhood firehouse would send a bill whenever it put out a fire. The longer and more complicated the fire, the higher the fee.

After the fire, each firefighter would fill out paperwork for every person and pet they rescued, using a complex schedule incorporating the length, complexity, and/or intensity of every rescue.

Firefighters would collect co-pays and deductibles from you, which would vary according to which "fire insurance" plan your employer offered.

(This isn't such a stretch. Insurance-based firefighting used to be common. Firefighters were organized and paid for by insurance companies and only responded to fires at addresses that were insured by their company.)

Billing Costs Hospitals Huge Amounts of Time and Money

According to a study in the Journal of the American Medical Association:

- The cost of billing and insurance-related activities **for a single primary-care doctor is $99,000 a year,** about 14% of the bill.
- For **emergency room billings,** the proportion goes even higher—to 25% of all dollars collected.

TIME AND COST TO PROCESS A HOSPITAL BILL

Primary care	13 minutes	$20.49
E.R. visit	32 minutes	$61.54
Inpatient surgical	100 minutes	$215.10

Layers of complexity

- The academic health center that was examined for the study devoted so many resources to the process of "revenue cycle management" it **started a separate company** that employs 1,500 **to handle all the billing.**
- The study didn't even take into account the time and cost on the end part of commercial payers to process the bills they receive from the providers.

Electronic health records

- Electronic health records (EHR) may in some way actually be expanding the amount of labor required to complete the billing process: "[I]f anything, administrative time needed for billing has increased for physicians and other staff as EHRs have become more widespread."
- They noted that the study did not even take into account the expense of installing EHRs, which would likely drive up costs another 44% to 68%.

Source: Ron Shinkman, 2/26/18, https://www.fiercehealthcare.com/finance/study-billing-for-medical-services-costs-huge-amounts-time-and-money

Top Hospital Executives Are Paid Millions

Both for-profit and non-profit hospitals pay their top executives millions. The chart below shows the highest paid person at each hospital system. Usually that's the CEO, but in some cases it's another person.

At most of these hospitals, there are several other people who are paid at least $1,000,000 a year.

ANNUAL COMPENSATION FOR HIGHEST PAID PERSON

2016, 2017, or 2018 (most recent year available for each hospital)

For profit hospitals	
Community Health	$ 7,024,719
Encompass	$ 6,388,227
HCA Healthcare	$ 21,419,906
LifePoint	$ 14,811,715
Quorum Health	$ 3,905,565
Tenet	$ 14,984,022
Universal Health	$ 23,588,883
Non-profit hospitals	
Adventist	$ 3,538,936
Ascension	$ 13,627,686
Banner Health	$ 25,549,644
Catholic Health	$ 4,042,972
Kaiser	$ 16,082,753
Memorial Hermann	$ 18,957,123
Northwell Health	$ 4,096,767
Northwestern	$ 11,164,000
Providence St. Joseph	$ 11,583,060
Sutter Health	$ 6,266,645
Trinity Health	$ 2,504,883

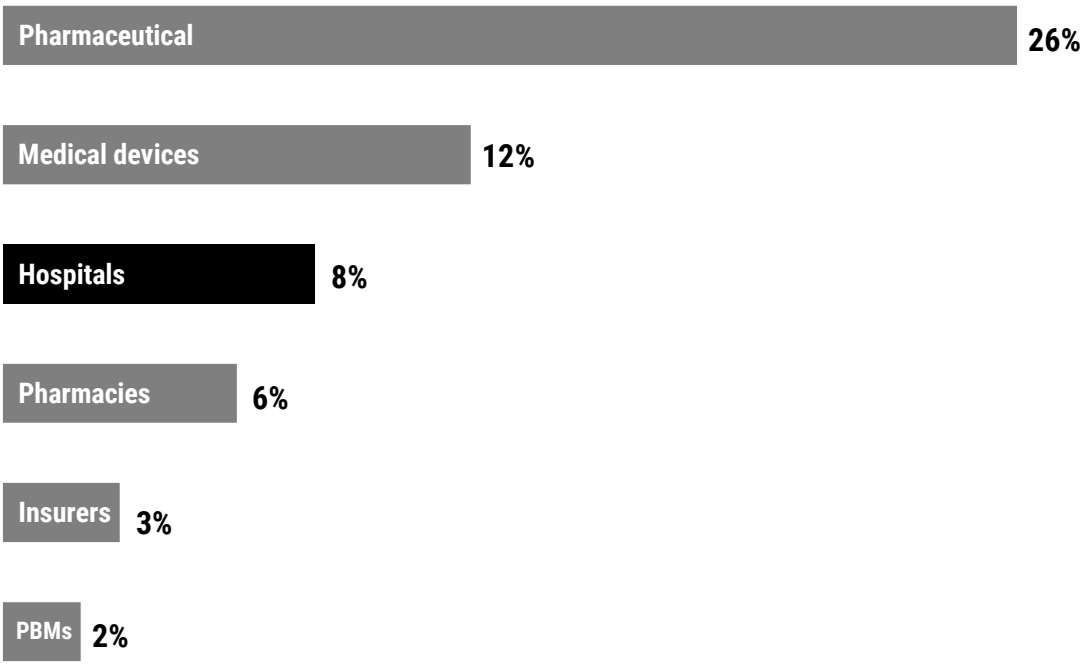
Sources: Executive Paywatch, AFL-CIO, aflcio.org/paywatch, Form 990s, Schedule J, available at ProPublica Nonprofit Explorer, projects.propublica.org/nonprofits

Many Hospitals Are Highly Profitable

Collectively, hospitals have a profit margin of 8%, higher than pharmacies (6%) or the insurance industry (3%).

Experiences among individual hospitals vary, however. About 75% of hospitals (for-profit and not-for-profit) made money in 2016 while about 25% of hospitals lost money.

HEALTHCARE INDUSTRY PROFIT MARGINS



Pharmacy benefit managers

Note: Percentages have been rounded to the nearest whole number. Data points in the table come from multiple sources and do not all cover the same time period.

Sources: Neeraj Sood and others, "The Flow of Money Through the Pharmaceutical Distribution System" (Los Angeles: University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics, 2017), available at https://healthpolicy.usc.edu/wp-content/uploads/2017/06/USC_Flow-of-MoneyWhitePaper_Final_Spreads.pdf; American Hospital Association, TrendWatch Chartbook 2018: Table 4.1: Aggregate Total Hospital Margins and Operating Margins; Percentage of Hospitals with Negative Total Margins; and Aggregate Non-operating Gains as a Percentage of Total Net Revenue, 1995 – 2016" (Chicago: 2018), available at https://www.aha.org/system/files/2018-05/2018-chart-book-table-4-1.pdf; U.S. Government Accountability Office, "Medical Device Companies: Trends in Reported Net Sales and Profits Before and After Implementation of the Patient Protection and Affordable Care Act" (Washington: 2015), available at https://www.gao.gov/assets/680/671094.pdf.

Source: Emily Gee, "The High Price of Hospital Care," CAP, 6/26/19, www.americanprogress.org/issues/healthcare/reports /2019/06/26/471464/high-price- hospital-care; American Hospital Association, TrendWatch Chartbok 2018

A Wall Street Grab for Hospital Real Estate

Wall Street investors are finding plenty of ways to squeeze money out of hospitals. They have been buying up hospitals, building mega-chains, consolidating, and finding ways to wring out as much money as possible. Here's one current example in Philadelphia:

Safety Net Hospital in Gentrifying Neighborhood Shut Down

- Wall Street investor Joel Freedman bought Hahnemann Hospital in Philadelphia, a safety-net hospital with 400 beds and an E.R. that saw 40,000 patients a year. Two-thirds of patients admitted were Black or Latinx.
- Freedman "had scant experience in day-to-day hospital management and displayed little patience with the executives he brought in to run the two hospitals." He made no major capital investments to improve the hospital.
- Less than 18 months after buying it, Freedman declared bankruptcy and shut down the hospital.

Valuable Real Estate Kept Out of Bankruptcy

- Usually with a bankruptcy, all assets—land, buildings, equipment, etc.—are sold to meet financial obligations.
- Hahnemann Hospital sat on valuable real estate in a gentrifying area of the city and Freedman managed to keep the land out of the bankruptcy—leaving him free to sell the land to the highest bidder.

Wall Street Wins

- Many believe that Freedman never seriously tried to save the hospital. Eileen Applebaum, of the Center for Economic and Policy Research, "said she is worried that a separate sale of the Hahnemann property to a developer will lay **a road map for private equity firms** around the country:

  "**Buy older hospitals in areas that are gentrifying, separate the hospital from its real estate, let the hospitals go downhill, and then sell the real estate to the developers.**"

Sources: "Many fear Hahnemann's story will send a message: Buying a failing hospital pays,"whyy.org/articles/many-fear-hahnemanns-story-will-send-a-message-buying-a-failing-hospital-pays; whyy.org/articles/hahnemann-hospital-owner-announces-closure-citing-losses; Philadelphia Inquirer, www.inquirer.com/business/health/hahnemann-closure-joel-freedman-real-estate-money-sanders-20190805.html

Head of Largest Public Hospital System Supports Single Payer

Mitchell Katz, M.D., the president and CEO of New York's public hospital system (NYC Health + Hospitals), testified in favor of New York state's proposed single payer health law. ("Single payer" is the general term for programs like Medicare for All.)

> "Expanding access to health insurance coverage and implementing a single payer system would **support NYC Health + Hospitals mission to provide high quality health care services** to all New Yorkers regardless of their ability to pay. Health + Hospitals is the largest public health care system in the nation and serves over a million patients each year, of which nearly 400,000 are uninsured."
>
> "As a primary care doctor, what is most important is care. A single payer system would allow me to **spend more time on patient care** then checking formularies. The current system makes me check formularies of each insurance company rather than providing prescriptions that I know work for my patients. It would also **alleviate administrative burdens** that safety net hospitals face. Health + Hospitals is currently fighting to make sure insurance companies pay us back when they have underpaid us in the past for care provided to patients."
>
> --Mitchell Katz, M.D., president and CEO of NYC Health + Hospitals

NYC Health + Hospitals is New York City's 11-hospital public healthcare system with approximately 40,000 employees. Katz is former director and health officer of the San Francisco Department of Health and former director of the Los Angeles County Department of Health Services.

Source: Mitchell Katz testimony before the New York Joint Senate and Assembly Committees on Health, 5/28/19, www.nychealthandhospitals.org/new-york-state-hearing-new-york-health-act

Takeaways

1. We can fund our hospitals the way we fund our libraries and fire departments.
2. That type of global budgeting will allow hospitals to treat healthcare as a public service, not an investment that has to turn a profit.
3. Hospitals will be funded based on the medical needs of the patients that they serve and resources will be shifted to patient care.
4. Eliminating profiteering and administrative waste and inefficiency will save billions and strengthen the financial stability of hospitals.

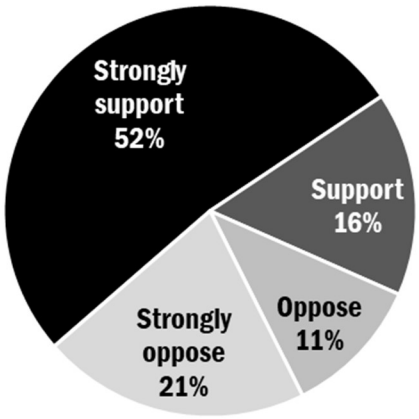
Activity 6: Why Do Doctors, Nurses, and Other Healthcare Professionals Support Medicare for All?

Task: Healthcare Professional Support Medicare for All

We hear that Medicare payments are too low, and that doctors would make less money under Medicare for All. Yet polls show that a majority of healthcare professionals support a single-payer system like Medicare for All. Why is that?

In your small groups, please review the information on pages 70-75 and answer the questions below. Please choose a different member of your group to take notes and report back.

Healthcare professionals* who support single-payer health insurance



*Physicians, nurses, and administrators.
www.medscape.com/viewarticle/9067

1. Why do you think a majority of healthcare professionals support a single-payer system like Medicare for All?

2. Of the fact sheets on pages 70-75, which ONE do you think would be most important to share with your co-workers or community?

Page _____

Title of fact sheet _____

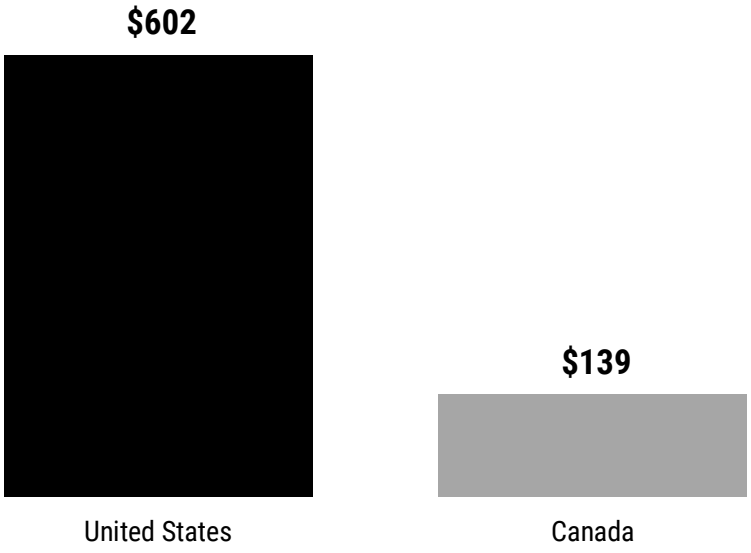
Why did you choose this fact sheet?

Dealing with Billing and Insurance Companies Is Expensive

American physicians spent far more on office and billing expenses than their counterparts in Canada.

PHYSICIANS' OFFICE AND BILLING EXPENSES

2018; $ per capita, PPP adjusted



Findings of other studies

- A 2006 study by Health Affairs found that the cost of the time spent by physicians, medical support personnel, and administrators on billing tasks: $68,000 per year per physician.
- For every 10 physicians providing care, almost seven additional people are engaged in billing-related activities.

Source: Austin Frakt, "The Astonishingly High Administrative Costs of U.S. Health Care," New York Times, 7/15/18, nytimes.com/2018/07/16/upshot/costs-health-care-us.html; Woolhandler/Campbell/Himmelstein NEJM 2003; 349:768 (updated). Excludes dentists and other non-physician, office-based practitioners.

Insurance Companies Are Forcing Doctors to Collect More from Patients

Doctors Are Forced to Collect Higher Payments

- As insurance plans with high deductibles and high co-pays become more common, doctors are required to collect larger amounts from patients before they can even submit a claim for reimbursement.

More People in High-Deductible Plans

- 21% of people with employer-sponsored health insurance are in a high-deductible plan, according to the Kaiser Family Foundation.
- A high deductible is defined as at least $3,000 for an individual or at least $5,000 for a family.

Physicians Devote More Resources to Billing

- In a LinkedIn survey, 64% of physicians say they have implemented measures to collect from patients with high-deductible plans, including:
    - offering payment plans
    - requiring payment up front
    - hiring additional staff, like financial counselors, to handle payment issues
- A Harvard study of claims from doctor's offices found that only 67% of bills over $200 are paid within one year.
- Harvard health economist Michael Chernew summed it up: "As patients are required to pay more money out of pocket, providers devote more resources to collecting it."

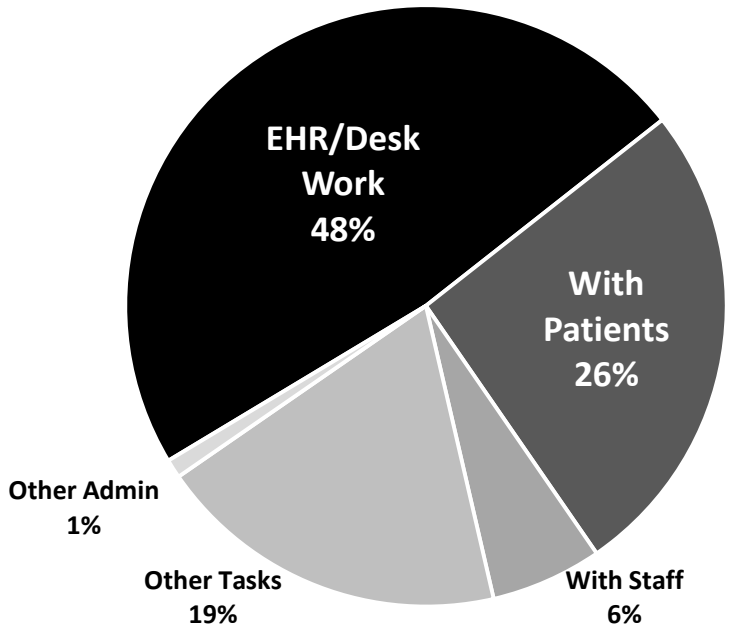
Sources: Kaiser Family Foundation, 5/2/2019, www.kff.org/private-insurance/press-release/kff-los-angeles-times-survey-highlights-financial-challenges-facing-people-with-employer-health-benefits; Austin Frakt, "The Astonishingly High Administrative Costs of U.S. Health Care," New York Times, 7/15/18, nytimes.com/2018/07/16/upshot/costs-health-care-us.html; Beth Kutscher, "Insurance is Driving Physicians Mad; Nearly Half Now Say They'd Prefer Single-Payer," 3/30/2017, www.linkedin.com/pulse/insurance-driving-physicians-mad-nearly-half-now-say-theyd-kutscher

Doctors Can Only Spend a Quarter of Their Time with Patients

Doctors spend almost half of their time in the office on electronic health records (HER) and desk work. Outside office hours, they spend another 1 to 2 hours of personal time each night doing additional computer and other clerical work.

PERCENTAGE OF OFFICE HOURS SPENT ON TASKS

2016



Based on time/motion observation & home diary. Doesn't include 1-2 hours of desk work at home at night.

Source: PNHP, citing Sinsky et al., "Allocation of Physician Time in Ambulatory Practice," Annals of Internal Medicine, 9/6/2018, annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties.

Time Spent on Insurance Companies Instead of Patients

In addition to the cost of employing people to handle billing, physicians report on the many headaches of dealing with private insurance companies. The reasons physicians gave in a recent survey for supporting a single-payer plan included:

- Administrative hassle of working with multiple insurance companies, each with its own rules and billing procedures.
- To help patients avoid out-of-network costs, doctors and their staff spend hours looking for in-network labs, pharmacies, and physical therapists.
- Having to call when their treatments are denied coverage.
- Having to change their prescribing plans when certain drugs aren't covered.

The conclusion that many have come to is that any financial loss they might experience under a single-payer plan "would be more than mitigated by getting out of the collection business."

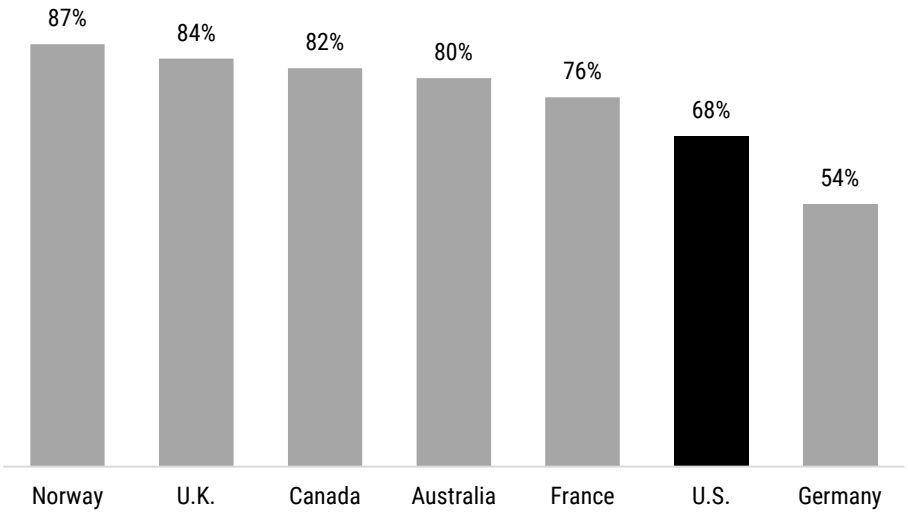
The Burden of "Pre-Authorizations"

Source: Beth Kutscher, "Insurance is Driving Physicians Mad; Nearly Half Now Say They'd Prefer Single-Payer," 3/30/2017, www.linkedin.com/pulse/insurance-driving-physicians-mad-nearly-half-now-say-theyd-kutscher; American Medical Association, "2018 AMA Prior Authorization Physician Survey," www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf

U.S. Doctors Less Satisfied Than Others

Doctors in other countries report being more satisfied than doctors in the U.S. do.

PERCENT OF PRIMARY CARE DOCTORS SAYING THEY ARE SATISFIED OR VERY SATISFIED



Source: PNHP citing Commonwealth Fund Survey of Primary Care Physicians, Nov. 2012

Healthcare Professionals in Their Own Words

"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

"We have pledged to 'do no harm' in our pursuit of medicine; however, our current for-profit insurance system in the United States routinely harms patients. Physicians and other providers often deny patients life-saving care because they lack the proper insurance, causing tens of thousands of preventable deaths every year."

—UC Berkeley-UCSF Students for a National Health Program

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; blogs.berkeley.edu/2019/03/08/medical-students-advocate-for-medicare-for-all; student.pnhp.org/private-health-insurance-harmful-health

Takeaways

1. American doctors, nurses, medical students, and other healthcare professionals are frustrated by the inefficiency and inequity of our system of private insurance. A majority of healthcare professionals now support a single-payer system like Medicare for All.
2. Physicians and their staff spent inordinate amounts of time and money on billing and dealing with insurance companies.
3. Doctors are forced to spend twice as much time on desk work as they do with patients.
4. Compared to doctors in other countries, doctors in the U.S. are less satisfied.

Activity 7: How Would Improved Medicare for All Affect Workers?

Task: 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.

What kind of protections and benefits should displaced workers receive? Allocating 2-5% of the health care budget for a specified time period would pay for robust benefits for a "just transition" for these workers. In your small groups, please review the fact sheets on pages 78-83 and answer the two questions below.

1. 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?

Should displaced workers receive these benefits?	Why or why not?
Wage replacement for some period of time	
Early access to full Social Security benefits (current age for full benefits is 67)	
College education/trade or technical school	
Relocation assistance for school or job	
Other ideas	

2. Should the labor movement fight for these benefits for dislocated workers? Why or why not?

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

Medicare for All will create new jobs delivering healthcare and administering Medicare, but they won't necessarily be jobs that displaced people will want or be qualified for or live in the right place for.

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

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			

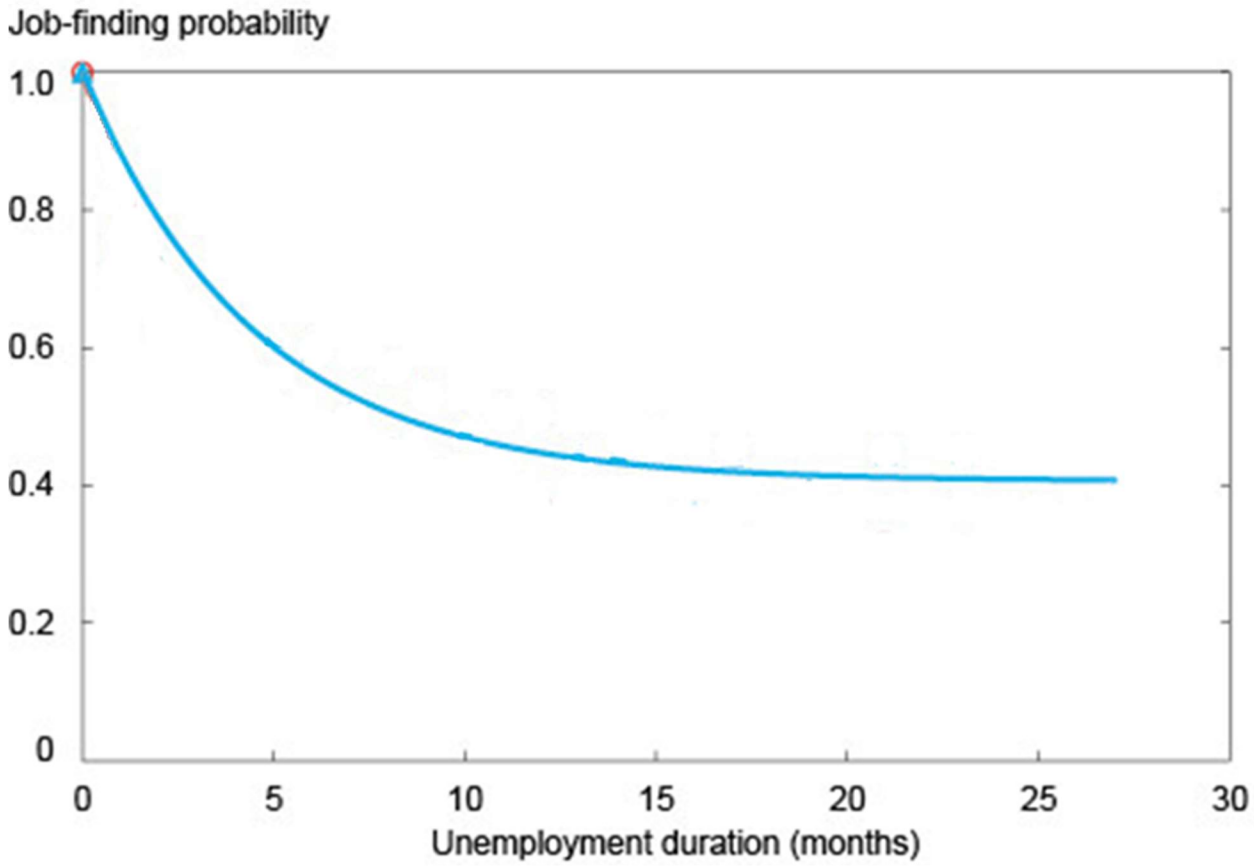
**A handful of states provide an additional weekly allowance for dependents.*

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 Longer You're Out of Work, the Harder It Is to Find a Job

- The probability of finding a job goes down the longer one is unemployed.
- Less educated workers have lower job-finding rates than more educated workers and remain unemployed for longer.

MONTHLY JOB-FINDING PROBABILITY OF UNEMPLOYMENT DURATION

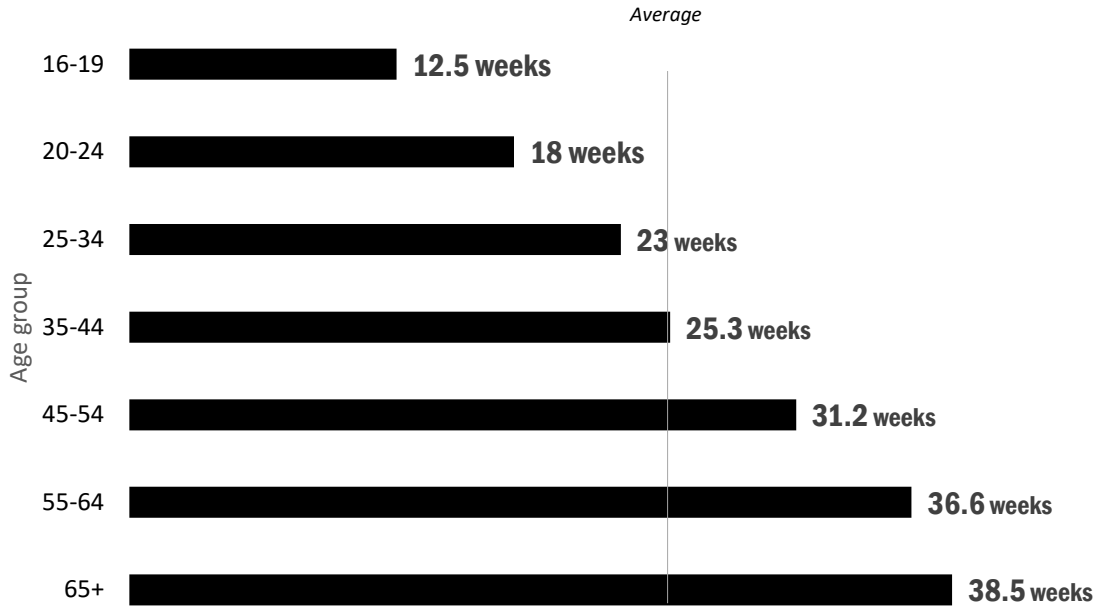


Source: Gregor Jarosch and Laura Pilossoph, "The longer you're unemployed, the less likely you are to find a job. Why?", World Economic Forum, 8/8/2016, www.weforum.org/agenda/2016/08/the-longer-youre-unemployed-the-less-likely-you-are-to-find-a-job-why

It's Harder for Older Workers to Find Jobs

- Compared to younger workers, older workers "are substantially less likely to be re-employed," according to labor economist Henry Farber.
- Job seekers 55 and older tend to be out of work for much longer than younger job seekers—more than 36 weeks on average for those 55 to 64 and 38.5 weeks for those 65+.
- Many workers over 55 "get funneled into lower-paying 'older person jobs' — from retail sales clerks to security or school crossing guards to taxi drivers"

AVERAGE NUMBER OF WEEKS UNEMPLOYED, BY AGE
2017



Sources: "More 55-plus workers delaying retirement, but how hard is it to get a job?", San Diego Tribune, 9/2/2018, www.sandiegouniontribune.com/business/economy/sd-fi-older-workers-20180902-story.html; Robert Weisman, "Workers stuck in 'old person jobs' pin hopes on tight labor market," Boston Globe, 8/28/2018, www.bostonglobe.com/metro/2018/08/28/workers-stuck-old-person-jobs-pin-hopes-tight-labor-market/KPQvb9Wpy0zKATf2ntjZJP/story.html

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

Takeaways

1. Improved Medicare for All might displace 1.8 million workers who work for private insurance companies or who do insurance-related work for healthcare providers.
2. It's up to the labor movement to make sure these workers are protected by defining a "just transition" and fighting for it.

Activity 8: Objections and Responses to Improved Medicare for All

Task 1: Objections

Healthcare will continue to be used as an issue to pit workers against each other. As union leaders and activists, we can help take charge, shut down false information and rumors, and have more productive conversations that emphasize that we're on the same side.

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

What are the biggest objections you've heard or think you will hear about Improved Medicare for All?

Task 2: 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. (The table of contents at the front of the workbook will help you locate relevant fact sheets.)

Your assigned objection: _____

Your best responses:

Final Takeaways

1. Change is coming to the U.S. healthcare system. It's imperative that the labor movement be prepared to shape the change to serve our members and all working people.
2. The $3.24 trillion we currently spend on healthcare could be used to pay for a system based on humane principles.
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 working people of trillions of dollars of wealth that we created. 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. Does Improved Medicare for All sound too good to be true? That's why opponents spend tens of millions to attack the bill.

Appendix

Unions That Have Endorsed Medicare for All

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

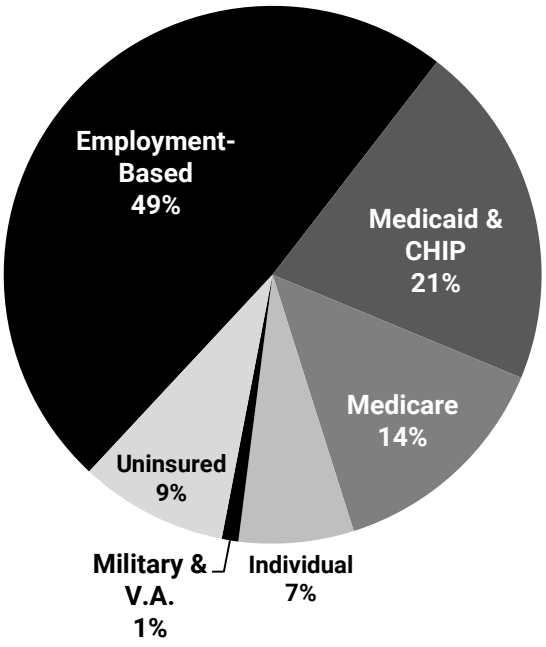
The Medicare for All Act of 2019 (H.R. 1384) Endorsers

- Amalgamated Transit Union
- American Federation of Teachers
- American Federation of Government Employees
- American Postal Workers Union
- Association of Flight Attendants-CWA
- 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

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).

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 (V.A.)
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.

Questions to Ask About Healthcare Reform Proposals

It can be hard to distinguish between the different healthcare proposals being discussed. Here are some questions you can ask to compare them.

- How will you pay for your proposal?
- Will your proposal cost more or less than the $3.24 trillion we currently spend on healthcare per year?
- Does your proposal have any cost savings to offset covering the 28 million people who don't have health insurance now?
- Does your proposal provide any administrative savings for doctors or hospitals?
- Does somebody who already has private insurance save money? How?
- How does your proposal affect union members?
- How does your proposal benefit seniors?
- What services does your proposal cover? Does it cover dental, hearing, vision, mental health, prescriptions, reproductive and maternity care?
- Does your proposal cover long-term care?

Americans Want the Wealthy and Corporations to Pay Their Fair Share

Here's a sample of recent polling that finds that average Americans know that the wealthiest people and corporations aren't paying their fair share—and they want that to change.

Support a 2% tax on wealth over $50 million *New York Times, July 2019*	**66%**
Corporations are paying too little in taxes Gallup, April 2019	**69%**
Raise the highest tax rate to 70% The Hill-HarrisX, Jan. 2019	**59%**
Raise taxes on those earning over $10 million Fox News, Jan. 2019	**70%**
Wealthiest Americans should pay higher taxes Morning Consult + Politico, Feb. 2019	**76%**
Corporations should pay higher taxes Morning Consult + Politico, Feb. 2019	**75%**

Sources: www.nytimes.com/2019/07/21/business/wealth-tax-polling-democrats.html; news.gallup.com/poll/1714/taxes.aspx; thehill.com/hilltv/what-americas-thinking/ 425422-a-majority-of-americans-support-raising-the-top-tax-rate-to-70; www.news.com/politics/fox-news-poll-voters-favor-taxing-the-wealthy-increasing-domestic-spending; morningconsult.com/wp-content/uploads/2019/02/190202_crosstabs_POLITICO_RVs_v1_AP.pdf, pp. 295, 299.

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

Workshop Evaluation

Date _____

Overall workshop	Excellent	Very good	Good	Fair	Poor
Introduction: Medicare and Medicare for All	Excellent	Very good	Good	Fair	Poor
Activity 1: H.C. Benefits and Collective Bargaining	Excellent	Very good	Good	Fair	Poor
Activity 2: Can We Afford Better Healthcare?	Excellent	Very good	Good	Fair	Poor
Activity 3: How Do Insurance Cos. Make Money?	Excellent	Very good	Good	Fair	Poor
Activity 4: What's the Alternative? (Canada)	Excellent	Very good	Good	Fair	Poor
Activity 5: How Would M4All Affect Hospitals?	Excellent	Very good	Good	Fair	Poor
Activity 6: Why to H.C. Professionals Support M4A?	Excellent	Very good	Good	Fair	Poor
Activity 7: How Would M4All Affect Workers?	Excellent	Very good	Good	Fair	Poor
Activity 8: Objections & Responses to M4All	Excellent	Very good	Good	Fair	Poor
Trainer _____	Excellent	Very good	Good	Fair	Poor
Trainer _____	Excellent	Very good	Good	Fair	Poor

Would you recommend this workshop to your friends, family, or co-workers?	Definitely	Maybe	No
How useful was the written material?	Very	Somewhat	Not
Do you think you will become more active in trying to win Improved Medicare for All as a result of this workshop?	Definitely	Possibly	No

What was the best part of this workshop? *(please use the back if you need more room)*

What would you improve or like to see in the future? *(please use the back if you need more room)*

Name & organization (optional) _____