America's Health Care System is in Critical Condition!

How Can It Be Saved?

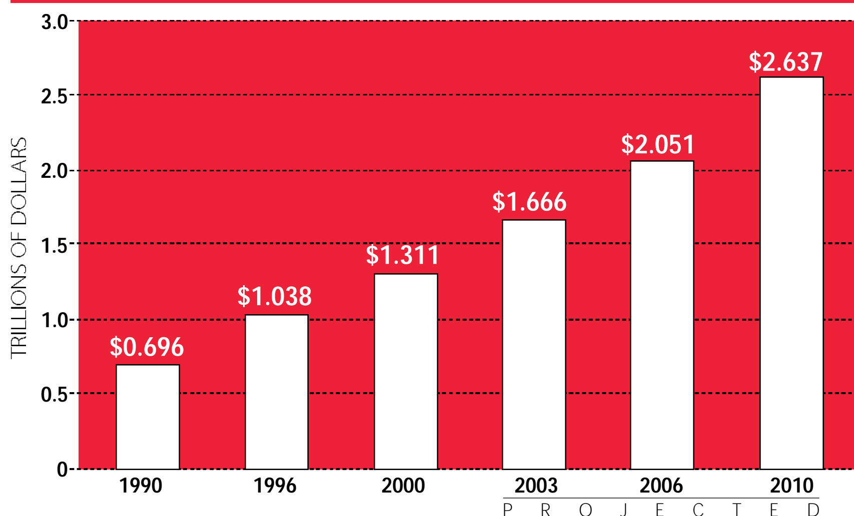
How Bad Is It, Doc?

Recent polls show that the state of the American health care system is second only to unemployment as a concern for voters. Spending on health care continues to soar, even as the economy has been struggling with slumping productivity, plant closings, low consumer confidence, and job flight. We're now spending 14% of our GNP on health care, up from 11% ten years ago.

What is causing these costs to rise so astronomically? Among other things…

- medical technology has advanced and doctors and hospitals are using it more, causing increased spending
- managed care has become less restrictive and the tight controls on costs have loosened
- hospitals have consolidated and they are more able to set their own prices
- there is a serious shortage of nurses and other health care workers and the cost of attracting and retaining workers is causing hospitals to raise prices
- prescription drugs are more expensive, in part because drug companies spend so much money on direct-to-consumer advertising and marketing, which spurs purchasing

NATIONAL HEALTH EXPENDITURES

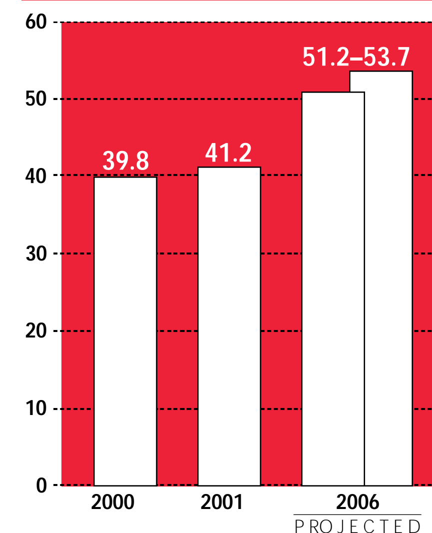


Source: Centers for Medicare and Medicaid Services, July 2002.

Because of higher costs, fewer and fewer employers are offering health insurance to workers. Forty-three million Americans have no health insurance at all, and contrary to popular opinion, most of them have jobs.

- In one year, 2002, 1.4 million Americans lost their health insurance coverage. Half of them were workers.
- Insurance premiums are rising faster than wages. In 2002, wage increases averaged just under 4%, while health care premiums rose 13%.
- The number of employers offering health benefits to retirees has dropped 44 percent in the last 25 years. Of those employers who still offer retiree benefits, 20% have eliminated it for new hires.
- The rising cost of health care is squeezing hospitals and health care workers and affecting the quality of care they provide.

NUMBER OF UNINSURED AMERICANS, SELECTED YEARS (MILLIONS)



Background sources: R. Mills, Health Insurance Coverage 2001, U.S. Census Bureau, September, 2002; Health Insurance Costs and Coverage, transcript, Alliance for Health Reform, August 2, 2002 (presentation by Richard Kronick); T. Gilmer and R. Kronick, Calm Before the Storm; Expected Increase in the Number of Uninsured Americans, Health Affairs, November/December 2001; J. Sheils, P. Hogan, and R. Haughr, Health Insurance and Taxes; The Impact of Proposed Changes in current Federal Policy, Appendix A; Estimating the Impact of Tax Credits on Insurance Coverage, National Coalition on Health Care, october, 1999.

A chronic and worsening shortage of nurses and health care professionals has led to severe understaffing in hospitals and clinics, resulting in excessive overtime, unreasonable schedules and increased stress. Nurses are leaving the profession in droves, and young people are thinking twice before entering the field.

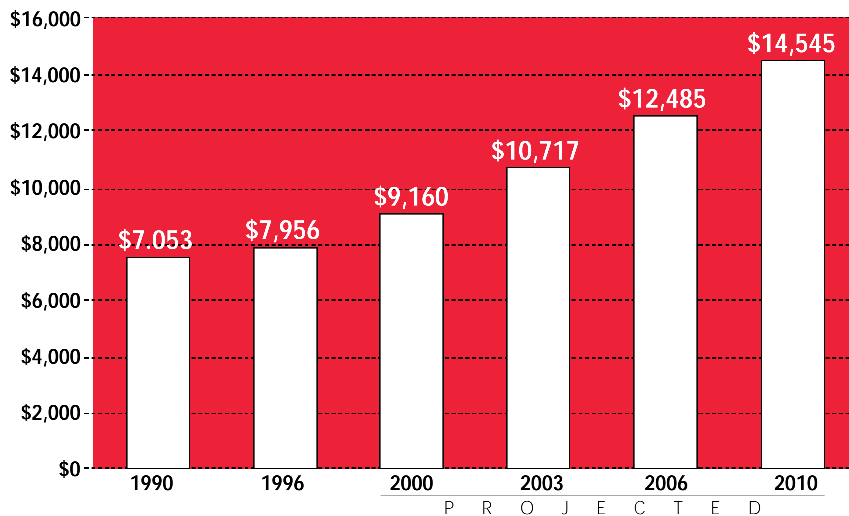
Because costs have been shifted to working people whose budgets are already stretched to the limit, health care increasingly is delivered not in doctors' offices but in hospital emergency rooms and an ever-shrinking number of public clinics — or not at all. Instead of getting preventive care or treating problems when they

are manageable, families are forced to wait until their loved ones are so sick that something must be done.

Doctors and nurses see many children in emergency rooms with serious illnesses that could have been contained if their parents had affordable insurance.

- The skyrocketing cost of prescription drugs has hit seniors on fixed incomes particularly hard. Some stop taking lifesaving medication because the cost is simply too high. Bus caravans to Canada and Mexico are becoming a popular way for U.S. residents to get less expensive medications.

AVERAGE ANNUAL PREMIUMS FOR EMPLOYER-SPONSORED FAMILY HEALTH COVERAGE, 2001 TO 2006



Source of underlying data: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, Annual Salary, 2001,2002; Towers Perrin 2003 Health Care Cost Survey, Report of Key Findings, 2003; Survey of Small, Medium and large Businesses, Covering the Uninsured Week/Public Opinion Strategies, march 13,2003;2002 Mercer U.S. Health Care Survey Results, Mercer Human Resource Consulting, December 9,2002; Health Care Cost Increases Expected to Continue Double-Digit Pace in 2003, Hewitt Associates, October 14,2002.

Don't Collective Bargaining Agreements Protect Our Health Benefits?

Workers with collective bargaining agreements are more likely to have health insurance coverage than those without. But the percentage of union-represented workers is shrinking, which makes it harder for those of us who do have coverage to hang on to it in negotiations. 73% of union workers have health insurance, compared to only 51% of non-union workers.

By negotiating flat dollar copays, many bargaining units have protected members from the rising cost of care. But in recent years, as these costs have grown,employers are looking for relief. Employers are trying to shift health care costs to employees in the form of higher deductibles, copayments, and co-insurance. In the past few years negotiations over health benefits have been contentious, not only for CWA but for all unions. For example, in 2003, GE workers were able to hold the line against the company's cost-shifting proposals only by staging a three-day walkout that shut down virtually every unionized GE worksite. At Verizon,member solidarity, an AFL-CIO-led corporate campaign, and an unexpected strategy to work without a contract enabled CWA to achieve its bargaining goals of preserving employment security and health care benefits for workers and retirees.

We need to assess employers' cost shifting proposals in relation to their ability to pay and the total economic package they are are offering. Cost shifting is acceptable only if the system is affordable, accessible, and fair for workers at all different wage levels.

What Do We Want?

CWA wants the American health care system to embody the following principles:

- Universal coverage
- Comprehensive benefits
- Affordable for all
- Financed fairly, all employers contribute
- Quality care delivery

This means that all Americans would be covered without regard to age, sex, employment status, or health status. We would have access to the widest range of

comprehensive health services possible, including all necessary doctor and hospital care, long-term care, mental health services, and prescription drugs. It would be financed through progressive taxes on employers and individuals according to ability to pay.

So, What Are Our Options?

We need to go beyond the bargaining table to protect and improve our health care benefits. Only wide-ranging legislative action can rescue a health care system that is on its deathbed. Here are some solutions that have been suggested:

Single payer (national health insurance)

State or national governments act as the single purchaser of health services. Consumers would pay a tax to a single trust fund to be used solely for health care expenditures. This is the system used in Canada. Medicare is also a single-payer system.

The advantages are:

- saves money by cutting administrative costs and waste rather than rationing care
- eliminates insurance hassles
- covers everyone, regardless of income or work status
- controls costs throughout the system since it controls payments for virtually all health services.

CWA's position: This is a comprehensive and equitable solution to the problem. It addresses the five CWA health care principles:universal coverage, comprehensive benefits, affordable, financed fairly, quality care delivery. However, it has been and is likely to continue to be resisted by insurance companies, employers, and portions of the general public who fear change and doubt the government's ability to run a health plan.

Pay or play

Every employer would be required to provide health coverage for its workers or pay into a government-sponsored insurance pool which would provide that coverage. This builds on the current employer-based system and uses existing insurance companies. It maintains the system for those who are comfortable with their

employer-provided coverage, while offering those without coverage a viable alternative.

CWA's position: This proposal has fewer adversaries, and so may be more likely to pass. To work most effectively, pay or play would include safeguards that set minimum benefit standards, cost controls, and eligibility rules. The insurance industry profits from insuring better-paid workers, but the government still pays for poor, elderly, disabled, unemployed.

Medical savings accounts

This system consists of an insurance policy with a high deductible and a tax-advantaged savings account. Individuals pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy pays for most or all of the costs of covered services once the deductible is met.

CWA's position: This proposal would lower the cost of coverage for a handful of wealthy and/or temporarily healthy individuals, while shifting costs to others. Medical savings accounts do not achieve universal coverage, do not control costs, are not financed fairly, and have no impact on quality of care.

Managed competition

In system, everyone would be covered by managed care plans that would compete on the basis of cost and quality. The system would maintain private insurance. This is the concept behind the reorganization of Medicare.

CWA's position: Experience has proven that the health care marketplace does not operate efficiently in a competitive environment. In the past decade costs have continued to rise, after a few years' pause, but quality of care has not perceptibly improved, and more people are uninsured. Without regulations to require participation and to monitor and evaluate plan performance, the system cannot be sustained.

Is There Any Hope?

There is some cause for hope. Progress is being made at the local level. State initiatives are being tried in:

California

A "pay or play" system has passed. Covered employers are required to pay a user fee into a state health purchasing fund. Employers would get a credit against the fee if they provide coverage to workers.

Maryland

Proposed system would provide universal,market-based coverage. All empl,oyers must make a fair share contribution to a fund for the uninsured. All residents of the state will have a responsibility to purchase health insurance coverage or contribute to a fund for the uninsured.

Maine

A system is in place that provides expanded access to health care. A new, independent executive agency will arrange for the provision of health coverage to small employers (under 50 employees),their employees and dependents, unemployed workers, and individuals on a voluntary basis.

Oregon

The "Health Care for All Children" initiative would guarantee employer-supported health care for all children in Oregon by means of a 2% tax. The tax would be offset by whatever employers pay to support health care for their workers' children,thereby leveling the playing field for good employers that provide full-family benefits.

Wisconsin

A proposed Employer-Based Mandatory Pooling plan would be financed by an employer-paid assessment for each employee. A Labor-Management Commission would set the level of assessment. The plan would be a quality-driven comprehensive plan,not just a bare-bones or catastrophic coverage plan.

What Can We Do to Help Fight for a Better Health Care System?

CWA members and others concerned about the state of America's health care can take action to improve it by:

- Spreading the word about the current trends and what will happen if we *don't* do something.
- Bargaining for guaranteed access to quality, affordable health care for workers and retirees.
- Supporting bargaining, legislative, and community agendas to improve working conditions for health care workers.
- Supporting candidates with progressive agendas for health care reform
- Supporting legislation to protect and build on social insurance programs as a way to secure affordable, quality coverage for all.

Join Your Local Union and Other Working People In the Effort to Secure Affordable, Fair Health Care for All

Glossary

All Payer System — Prices for health services are the same for all parties. Uniform fee bars health care providers from shifting costs from one payer to another.

Catastrophic Health Insurance — Provides protection against high cost of treating severe or lengthy illnesses. Policies cover all,or a percentage, or medical expenses above a specified amount.

Cherry Picking — When insurance companies cover only businesses or people that are good health risks. Also called "skimming."

Coinsurance (Copayment) — Portion of bill not covered by health insurance policy — must be paid out of pocket by patient. Coinsurance refers to a percentage;, copayments are stated as a flat amount.

Cost Shifting — When a seller of a health service increases charges for some payers to offset losses due to uncompensated or indigent care or lower payments from other payers. Also, when an employer shifts increased health care costs to workers in the form of higher premiums and increased deductibles and co-payments.

Deductible — A fixed amount patient must pay directly to the provider before health insurance plan begins to pay for any costs of the insured medical services.

Defined Benefit — Health benefit model where health services covered under the plan are standardized and guaranteed, e.g., Medicare. (Contrast with Defined Contribution.)

Defined Contribution — Health benefit model where health services covered may fluctuate based on choice of plan,but the employer or government contributes a set amount (percentage or dollar amount), e.g., Federal Employee Health Benefit Program.Limits the financial liability of employers or the government, because the contribution is defined, or fixed.

Employer Coverage Mandate — Requires employers to offer and partially pay for health care benefits to workers or dependents or both, or face stiff penalties. Hawaii has had such a mandate since 1975.

Health Maintenance Organization (HMO) — Managed care plan gives members comprehensive health care from a network of affiliated providers. Enrollees pay limited copayments and usually are required to select a primary care physician through which all care must be coordinated.

Indemnity Insurance — A traditional health insurance plan which pays providers on a fee-for-service basis. Consumers face few restrictions on provider selection,but may have greater financial liability, including a deductible and coinsurance, than in many managed care plans.

Long-Term Care (LTC) — Ongoing health and social services provided for individuals who need continuing assistance with daily living activities because of physical or mental disability.

Managed Care — Any health care delivery system that attempts to control or coordinate use of health services by its enrolled members in order to contain spending, improve quality, or both, e.g.,HMOS and indemnity insurance plans with utilization review.

Medical Savings Account (MSA) — A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy pays for most or all costs of covered services once the deductible is met.

Medicaid — Public health insurance program,financed by state and federal funds, that provides coverage for some low-income persons and families for acute and long-term care.

Medicare — Federal health insurance program for virtually all persons age 65 or older, and some severely disabled persons under age 65.

Medigap Insurance/Medicare Supplemental Insurance — Privately purchased insurance that supplements Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance, balance bills, and payment for services not covered by Medicare, such as outpatient prescription drugs.

Payer — Any person or organization paying a health care provider for services or goods, such as insurance companies and Medicare and Medicaid.

Single Payer System — A proposed health plan that would designate one entity (usually the government) to function as the only purchaser of health care services. Under such a plan, consumers would pay a tax to a single trust fund to be used solely for health care expenditures. Canadian provinces operate insurance coverage for residents under this system.