Take My Benefits—Please!

January 11, 2020

At the June 2019 House Ways and Means Committee Hearing on Medicare for All, Texas Republican Kevin Murphy lamented, "That great health care plan that your union negotiated for you? It's gone. Banned under Medicare for All."

A right-wing congressman with a 7 percent lifetime voting score from the AFL-CIO crying crocodile tears for great union health care plans can be easily dismissed as just another absurdity of the increasingly dysfunctional American political system. But when Joe "the workingman's friend" Biden repeats the charge almost word for word and when AFL-CIO President Rich Trumka insists—on *Fox News* no less!—that "if there isn't some way to have our plans integrated into the system, then we would not support [Medicare for All]," something is certainly happening out there. Talking points, after all, don't just come out of thin air. They are carefully crafted and disseminated by a coterie of lobbyists and publicists often working on behalf of shadowy corporate and political interests.

Trumka was shortly joined by American Federation of Teachers President Randi Weingarten, who just six months earlier had delivered a full-throated endorsement of the Medicare for All Act at a rally celebrating its introduction. In her September 23, 2019, *Politico* article, Weingarten walked back that support in favor of a fictitious system in which "employer-based insurance would be allowed to exist *to the extent* that plans met or exceeded the standards set by the Medicare plan." Such a system "would allow people who like their current employer-based plan—which seven in ten Americans claim to (although it's likely they like their doctor, not the plan itself)—to keep it, allow for a gradual transition from one plan to another when necessary, and effectively improve on the model originally created by the Affordable Care Act."

The spectacle of national labor leaders defending a system that is the biggest cause of strikes, lockouts, and concession bargaining is mind-boggling. For an entire generation now, unions in the United States have traded wages and other benefits for shrinking coverage by employer-provided health insurance (or for the ever-increasing employer contributions required to maintain similarly shrinking benefits from union-sponsored health and welfare funds).

An Accident of History

The U.S. health care system's linkage to employment is unique among industrialized countries. It

emerged as an accident of history in the years just following World War II when Roosevelt's promise to enact a "Second Bill of Rights" in the postwar period was stopped dead in its tracks by resurgent capital. In 1946, the American Medical Association led the fight to defeat the Wagner-Murray-Dingell Bill that would have created a publicly funded national health insurance program. The following year saw the passage of the Taft-Hartley Act, which, combined with an orgy of anti-communism and race baiting, set the powerful postwar labor movement into a long retreat.

Unable to expand the social wage by treating public goods such as health care as a basic right available to all, labor helped craft a "second-best solution" of making access to health care a benefit linked to employment. Corporate America piled on and offered elaborate benefits to recruit and retain employees and to keep unions out. This system was flawed from the beginning. It created tiers of coverage that reinforced employment-based racial and gender disparities and massive amounts of "churn" that disrupted continuity of care for even the best insured. Particularly after the expansion of for-profit health insurance and health care providers beginning in the 1970s, more and more administrative inefficiency was built into the system to facilitate profit taking, until, by the early twenty-first century, the U.S. health care system was twice as expensive as the OECD average.

Nonetheless, in the post-World War II period of high union density and employment stability, many unions were able to negotiate a robust "private welfare state" that provided health care security for tens of millions of working-class Americans. These benefits were almost never handed to workers. Unions had to wage long and unremitting fights to expand and defend employer-based health care. By the 1980s, almost every contract negotiation was faced with employer demands for reductions in coverage and transfer of costs from the employer to the worker. Nonunion workers fared even worse as they were forced to accept whatever the employer offered. And, unlike attempts to cut social insurance benefits like Social Security or Medicare that almost always fail due to massive popular opposition, cuts to employment-based health care benefits take place company by company under cover of night and arouse little or no popular opposition. Today, even those few union members who have been able to preserve good benefits find themselves as islands in a sea of inadequate and precarious health care coverage.

A System in Crisis

Like it or not, employment-based health care is simply unsustainable. The Milliman Medical Index reports that the 2018 total health care costs for a family of four with decent employment-based coverage exceed $28,000 per year. That is $14 per hour worked for a full-time employee—almost twice the federal minimum wage. The employer pays $15,000 of that, and $13,000 is paid by the worker through co-insurance, out-of-pocket charges, co-pays, deductibles, and all of the other myriad ways that the medical industrial complex extracts money from our pockets. These amounts already exceed the average hourly wage in food services and retail occupations and are increasing two times faster than the rate of wage increases for all workers, putting them on track to exceed average wages in manufacturing and other core industries within the next decade. The percentage of total health care costs paid by the worker has gone up nearly every year since it was first tracked in the 1990s. Employment-based health care is coming up upon the limits of Stein's Law, formulated by economist Herbert Stein in 1985: "If something can't go on forever, it will stop."

Employment-based health care is also a major driver of wage stagnation. Every worker trades wages for health care. A recent Gallup poll found that 61 percent of Americans would be willing to trade 10 percent of future wage increases for a guarantee that their health care costs would not go up for five years. This puts workers and their unions at a huge bargaining disadvantage and goes a long way toward explaining why wages continue to stagnate at a time of low unemployment and growing corporate profits.

And even the best employment-based health care is not there when we need it the most: when we lose our jobs, change jobs, go on strike, or struggle with long-term illness.

What was once a source of pride in the "union advantage" has become an anchor around the necks of the U.S. working class. No union leader in their right mind can conjure a scenario where the system of employment-based health care could be stabilized in ways that could provide sustainable health care security for workers and their families. That is why unions representing a majority of organized workers now support HR 1384 – The Medicare for All Act of 2019 and why the AFL-CIO at its 2017 convention unanimously voted to support policies to "move expeditiously to a single-payer Medicare for All system."

The Medicare for All Solution

Medicare for All would take health care off the bargaining table and increase union bargaining leverage in nearly every negotiation. It would allow union-sponsored health and welfare funds the opportunity to reallocate revenues currently sunk into the world's most expensive and inefficient health care system. Savings could be applied to new "union advantage" programs such as enhanced disability benefits, supplemental unemployment benefits, tuition and training programs, legal services, child- and eldercare, and others. Some revenues could also potentially be reallocated to shore up endangered pension plans.

Medicare for All would also provide better coverage than any employment-based plan in existence today. Opponents of Medicare for All often conflate the constricted benefits offered under today's Medicare program after more than 50 years of underfunding and privatization attempts with the greatly expanded and improved benefits proposed under Medicare for All. HR 1384—Rep. Pramila Jayapal's Medicare for All Bill with 119 cosponsors—proposes to cover the following benefits without a single co-pay, deductible, or other out-of-pocket cost:

Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs. (2) Ambulatory patient services. (3) Primary and preventive services, including chronic disease management. (4) Prescription drugs and medical devices, including outpatient prescription drugs, medical devices, and biological products. (5) Mental health and substance abuse treatment services, including inpatient care. (6) Laboratory and diagnostic services. (7) Comprehensive reproductive, maternity, and newborn care. (8) Pediatrics. (9) Oral health, audiology, and vision services. (10) Rehabilitative and habilitative services and devices. (11) Emergency services and transportation. (12) Early and periodic screening, diagnostic, and treatment services, as described in sections 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)). (13) Necessary transportation to receive health care services for persons with disabilities or low-income individuals (as determined by the Secretary). (14) Long-term care services and support (as described in section 204).

By comparison, the highly touted federal employees' health benefit plan merely offers the choice of a number of fairly comprehensive private insurance products with the typical array of co-pays, deductibles, and narrow networks. For all of this, federal employees must kick in 28 percent of the weighted average premium for all plans.

Arguably, union employees working for the City of New York might have some of the best coverage of any working-class American. They can get fully employer-paid coverage in the default Emblem Health/HIP plan which has almost no co-pays or deductibles (workers may also choose other private insurance plans that do require employee contributions). They also receive generous dental, optical, and prescription coverage. But even here, workers must use a narrow provider network or face

substantial co-pays, and the plan falls far short of HR 1384 in its coverage of long-term care, disability services, and community and home-based care. Moreover, every contract negotiation is held hostage to the imperative to hold on to these extraordinary benefits at almost any cost. *I challenge any advocate of employment-based coverage to show me a plan that matches the level of comprehensive services, freedom of choice, and absence of out-of-pocket costs proposed by HR 1384.*

Like global warming, the case for replacing our dysfunctional, multipayer, for-profit health care system with a publicly funded, universal system with a single standard of care for all is so compelling that it has reached the level of scientific fact. Nonetheless, too many national labor leaders continue to sing the praises of employment-based health care benefits, while too many others give merely rhetorical support for Medicare for All—passing resolutions at conferences and conventions to please union activists while continuing to devote the bulk of their union's mobilizing and legislative efforts to support for incremental and defensive policy fixes. Only a few national unions have begun to commit the kind of resources and organizing capacity that will be needed to defeat the concentrated political and economic power of the medical-industrial complex.

Union Backpedaling

As momentum for Medicare for All builds, we are witnessing more backpedaling within the labor movement. And not all of it is confined to national labor leaders (though it certainly is more pronounced at that level). In New York, a single-payer-style state bill—NY Health—has twice passed the State Assembly and is edging toward passage in the State Senate backed by a growing popular movement. While the bill does have considerable labor support, including from the state's powerful hospital workers and nurses unions, a significant section of the labor movement has gone into open opposition. In June of 2018, James Cahill, the president of the New York State Building and Construction Trades Council, joined the CEO of the Business Council pf New York State in co-authoring an op-ed in *Crain's New York Business* opposing the bill and "government-run health care."

Taken by itself, this expression might be dismissed as another sign of the class collaborationism and conservatism than infects significant sections of the building trades. But they were joined by a number of other unions, including the 380,000-member Municipal Labor Council—whose affiliates include a number of "progressive unions"—which told *Politico* that they "dread the impact of the single-payer proposal in Albany." It is true that, unlike national proposals, state-level single-payer-style plans are notoriously complex to design and difficult to fund. But this hostility goes beyond having legitimate questions about implementation. The fact that major sectors of the labor movement refuse to engage in an effort to make health care a birthright in a state with near-Canadian levels of union density is profoundly unsettling for those of us who believe that, in order to succeed, labor must be in the forefront of the fight to win Medicare for All.

So what is driving this opposition? Perversely, in New York some of it derives from precisely these high levels of union density. Unions still think they have a seat at the table and may sincerely believe that they can bargain better and more secure benefits that would not be subject to the precariousness of annual state budget debates. This parochial perspective ignores the reality that New York unions are only one election or economic downturn away from catastrophe. They only need to look across the Hudson to see what anti-union Governor Chris Christie did to New Jersey public sector workers' ability to bargain for health care during his administration (aided and abetted, I would add, by Democratic political elements associated with some of the most politically influential building trades locals).

Putting aside the idiosyncrasies of New York labor politics, many union leaders may also believe that

“the members aren’t ready” to support Medicare for All. Loss aversion plays a central part in shaping that belief. Behavioral scientists have observed that people are much more likely to be motivated by the fear of losing something they have than by the prospect of gaining something they want. Fear of loss of health insurance is a major driver of working-class insecurity in the United States. It is no surprise, then, that the lobbyists and publicists working on behalf of the medical-industrial complex would focus on this theme in their effort to scare the American people away from a just health care system. Some of that fear has infected union members. The failure to confront such fears, of course, is a classic mistake that anyone who’s ever been through an organizing campaign would know to avoid. The real problem here is union leaders who fail to articulate a vision of working-class politics that will inspire and unify union members.

These concerns are compounded in the wake of the *Janus* decision, which has made public sector union membership completely voluntary. Many public sector union leaders are convinced that the best way to persuade workers to maintain their union membership is to show how the union adds value in their workplace. Negotiating health insurance benefits that are much better than those enjoyed by most other working-class Americans is one way to do that without necessarily having to engage in risky internal organizing and mobilizing activities that may end up undermining existing union leadership.

Some unions have raised the specter of job loss as a reason to oppose Medicare for All. This is a legitimate concern. Studies have shown that close to two million workers will be displaced due to the administrative efficiencies of Medicare for All. While both the House and Senate bills provide funding for transition benefits for these workers, decades of working-class experience with bearing the cost of environmental-, trade-, and automation-related job losses have made workers rightly skeptical of any promises of economic security. The Labor Campaign for Single Payer has called for centering these worker concerns in the political and legislative battles to come and has warned that a failure to do so will give our opponents the opportunity to divide workers against each other.

Unions have also expressed concern that employers would reap the benefit of all of the sunken wages that unions have agreed to divert to maintain decent private insurance coverage. This would assume that, in the transition to Medicare for All, unions would be so weak and/or incompetent that they would be unable to recapture those already bargained monies. Even assuming a worst-case scenario, this objection is tantamount to someone opposing student loan forgiveness because they’ve already paid off a chunk of their loan.

There are also a number of institutional factors that can work to discourage union support for Medicare for All. Union health and welfare funds often have substantial brick-and-mortar investments in union facilities and provide a range of member services that often strengthen members’ union identification. A vast web of relationships also exists between union officials and health care vendors, brokers, intermediaries, attorneys, and various hangers on. Some are outright corrupt. Others are more benign, such as the insurance company that subsidizes their stewards training or the broker that they can call to get a member rapid placement in a substance abuse treatment program. Nonetheless, all of these relationships are ultimately corrupting because of the entailments of obligation that they engender with players who have a vested interest in maintaining the status quo.

However, the biggest factor by far that drives union opposition to Medicare for All is many union leaders’ fear of disrupting their political relationships. Unions are multi-issue organizations, and many of their bargaining and organizing goals are impacted by local and national political concerns. The ascendancy of a right-wing, anti-labor political regime is an existential threat to the institutional labor movement as well as to a wide range of working-class concerns. Unions routinely pull their punches in the interest of maintaining these relationships. For example, with a few notable

exceptions, unions were nowhere to be seen in the 2016 Democratic Party platform fight around Medicare for All and other issues of central concern to the working class led by Bernie Sanders supporters. Enmeshed in the two-party system and with diminishing leverage, unions often see no alternative. Every election cycle is the most important one in the history of the nation, and, whatever the outcome, unions nearly always emerge weaker from each round.

This political practice engenders cynicism and apathy among union members and provides the space for right-wing populism to take root within some sections of the working class. The past decade has seen the reemergence of a refreshing political independence in some of the most dynamic sections of the labor movement. By challenging the status quo, they have inspired their members to take risks and have forced important concessions from the political establishment. Medicare for All, because it seeks to reclaim a public good on behalf of the entire working class, can be an important wedge issue in building out an independent working-class politics.

The Path Forward

Our experience in the Labor Campaign for Single Payer has shown that support for our cause is greatest at the front lines of the labor movement, where leaders and staffers have to deal on a daily basis with the consequences of private, for-profit health care. Our goal has been to work with those activists as they find ways to constructively engage with national labor leadership. After AFL-CIO President Trumka's Labor Day appearance on *Fox News*, for example, we asked unionists to write him to remind him that support for Medicare for All is the official policy of America's largest labor federation. Over 2,500 people answered the call. These are the leaders who will drive change in our movement and ultimately bring the formidable political and mobilization resources of institutional labor into the battle to make health care a right for everyone in America. When that happens, we will win.

As Washington State Labor Council President Larry Brown stated, "Unions do not serve their members well by trying to circle the wagons around an unsustainable model of employment-based health care." Our labor movement will thrive when we express the aspirations of all workers and speak on behalf of the entire working class.

Union members should be justly proud of the long battle that unions have waged to protect their right to access affordable, quality health care, and the Labor Campaign for Single Payer stands in solidarity with all workers everywhere who fight to protect these hard-won gains. But our movement is at an historic juncture. Now is not the time to muddy the waters or bargain against ourselves. We need labor to lead as we work to make this a key issue in the 2020 elections and to hold politicians accountable in 2021 and beyond. And we have the right to expect that the union leaders who represent us and the politicians that we support will do more than just parrot the talking points crafted by health care industry lobbyists.

Notes

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