

MARK H. AYERS, President  
SEAN McGARVEY, Secretary-Treasurer

MICHAEL J. SULLIVAN, 1st Vice President  
JOHN J. FLYNN, 2nd Vice President  
DANA A. BRIGHAM, 3rd Vice President  
EDWIN D. HILL, 4th Vice President  
JOSEPH J. HUNT, 5th Vice President



JAMES A. GROGAN, 6th Vice President  
JAMES A. WILLIAMS, 7th Vice President  
NEWTON B. JONES, 8th Vice President  
WILLIAM P. HITE, 9th Vice President  
KINSEY M. ROBINSON, 10th Vice President  
PATRICK D. FINLEY, 11th Vice President  
JAMES P. HOFFA, 12th Vice President  
TERENCE M. O'SULLIVAN, 13th Vice President

## **Building and Construction Trades Department**

AMERICAN FEDERATION OF LABOR—CONGRESS OF INDUSTRIAL ORGANIZATIONS  
815 SIXTEENTH ST., N.W., SUITE 600 • WASHINGTON, D.C. 20006-4104

(202) 347-1461

[www.BCTD.org](http://www.BCTD.org)

FAX (202) 628-0724

### **The Building and Construction Trades Department's NATIONAL HEALTH CARE REFORM POLICY**

Access to affordable, quality health care is a basic human right and a vital part of a strong economy. Unfortunately, the promise of being able to exercise this right is increasingly illusory, as the ranks of the uninsured and under-insured in our country are growing, consumers are paying more for health care coverage, building trades union members are having to defer a greater share of their hard earned wages to fund their health care coverage and subsidize the uninsured, health care costs are putting many U.S. companies at a competitive disadvantage, and fewer Americans are able to rely on employer-based coverage. Moreover, although the U.S. spends twice as much per capita on healthcare as the average of the world's 10 other richest countries, the country has a lower life expectancy and higher infant mortality rate than other industrialized nations.

The Building & Construction Trades Department, AFL-CIO (the Department), along with its 13 affiliated unions, calls for comprehensive national health care reform that includes mechanisms for expanding coverage to all, controlling costs and ensuring quality without jeopardizing or reducing the benefits that individuals have earned over the years. Such meaningful and effective reform must rest on the following core principles:

#### **1) Provide Universal Coverage**

The best way to ensure a healthy population is through universal coverage – providing health care to all – that promotes preventive care, combats the spread of contagious diseases, and ensures effective treatment of chronic diseases. Universal coverage is also the only way to eliminate the unfair financial burden carried by those who currently pay into the system and to stop the cost shifting that puts responsible employers who offer coverage at a competitive disadvantage.

#### **2) Distribute Costs Fairly**

The costs of the health care system must be distributed fairly. Given the number of stakeholders in the current system, the transition to universal coverage would be best facilitated by a hybrid of the country's current financing system – one that includes a role for both employers and the government, recognizes and allows the continuation of the kind of well-designed health plans offered by building and construction trades unions and their employers, and requires individuals and employers that currently do not contribute to the health care system to do so.

### 3) **Control Costs and Preserve Benefits**

Steps must be taken immediately to control health care costs, including giving the government a greater role in controlling the rate of increase, preserving the concept of pooled risk, prohibiting adverse selection, and ensuring that insurers do not delay, deny or drop coverage, or raise rates, because of pre-existing conditions or an individual's health.

### 4) **Improve Quality and Delivery of Care**

Several widely accepted actions would improve the quality and delivery of care, while helping to reduce the cost of health care.

a. **Establish Standards for Care** to ensure uniform care and the best outcomes throughout the country. The government has an important role to play in defining and communicating clinical best practices, establishing incentives for providers to adopt best practices, and creating mechanisms to inform patients how to identify and find "quality care." The government is also best positioned to use the public's purchasing power to promote evidence-based protocols, negotiate lower drug and technology prices and decide how to invest in new technologies and health care.

b. **Treat Chronic Diseases Early**. Chronic diseases, the number one cause of death in the U.S., account for the largest share of health care spending. Detecting and treating chronic diseases early, and making sure that any basic health care plan covers these diseases, will enable the U.S. to improve the quality of care and reduce costs over time.

c. **Streamline Administration and Control Related Expenses**. Our fragmented health care system makes it difficult for patients and health care providers to make informed decisions about appropriate care. At the same time, it contributes to high administrative fees and spending on unnecessary or questionable activities. Using Medicare as a model, the government should work with the health industry to develop and implement new technology and procedures for coordinating care, keeping records and processing claims. Any such system must, however, be coupled with safeguards to ensure that patient privacy is protected and the collected data may never be used to limit or deny coverage or employment.

## **CONCLUSION**

The Department believes the country cannot afford to wait any longer to reform the health care system and supports reforms that build on the current system, allow an expanded role for government and employer-based plans, and take the necessary steps to control costs and improve quality and delivery of care. For decades, building trades unions and their collectively bargained labor-management health funds have evolved to meet the health care needs of their constituents and supported efforts to improve the country's health care system. We look forward to being part of a renewed and reformed health care system that not only meets the needs of our members, but all people – working, retired, disabled – young and old.

In doing so, however, those entities that have acted responsibly and provided coverage, such as building trades unions and their employers, should not end up losing benefits or bearing a greater share of the financial burden for reform. Our members have already given up wage increases to fund their own health care and, through higher premiums, have subsidized the health care provided to the uninsured for decades. It is our desire to work with all stakeholders on this national challenge, and to come up with balanced, enforceable reforms that benefit the country as a whole. We believe that if everyone has a stake in the system and the excesses of the past are reigned in, there will be adequate funds to provide quality, affordable coverage for all.

MARK H. AYERS, President  
SEAN McGARVEY, Secretary-Treasurer

MICHAEL J. SULLIVAN, 1st Vice President  
JOHN J. FLYNN, 2nd Vice President  
DANA A. BRIGHAM, 3rd Vice President  
EDWIN D. HILL, 4th Vice President  
JOSEPH J. HUNT, 5th Vice President



JAMES A. GROGAN, 6th Vice President  
JAMES A. WILLIAMS, 7th Vice President  
NEWTON B. JONES, 8th Vice President  
WILLIAM P. HITE, 9th Vice President  
KINSEY M. ROBINSON, 10th Vice President  
PATRICK D. FINLEY, 11th Vice President  
JAMES P. HOFFA, 12th Vice President  
TERENCE M. O'SULLIVAN, 13th Vice President

## **Building and Construction Trades Department**

AMERICAN FEDERATION OF LABOR—CONGRESS OF INDUSTRIAL ORGANIZATIONS  
815 SIXTEENTH ST., N.W., SUITE 600 • WASHINGTON, D.C. 20006-4104

(202) 347-1461

www.BCTD.org

FAX (202) 628-0724

### **The Building and Construction Trades Department's NATIONAL HEALTH CARE REFORM POLICY**

#### **OVERVIEW**

Access to affordable, quality health care is a basic human right, and a vital part of a strong economy. Unfortunately, the ranks of the uninsured and under-insured are growing, the cost of health care is putting many U.S. companies at a competitive disadvantage, consumers are paying more for health care coverage, building trades union members have had to defer a greater share of their hard earned wages to fund their health care coverage and subsidize the uninsured, and the employer-based coverage that the majority of Americans rely on is in jeopardy. Although the U.S. “spends twice as much per capita on healthcare as the average of the 10 other richest countries in the world,”<sup>1</sup> the country has a lower life expectancy and higher infant mortality rate than other industrialized nations.<sup>2</sup> State-level initiatives to address this health care crisis, and unsuccessful attempts through the private sector to control costs and extend coverage to all, have once again focused the country’s attention on the need for comprehensive national health care reform.

The Building & Construction Trades Department, AFL-CIO (the Department), along with its 13 affiliated unions, recognizes the need for a national approach to health care reform that includes mechanisms for expanding coverage to all, controlling cost and ensuring quality without jeopardizing or reducing the benefits that individuals have earned over the years. To achieve these objectives all parties – labor unions, employers, health care providers and the insurance industry -- must be engaged in the discussion, and government must have a role in implementation, oversight, and enforcement at the national level.

#### **BACKGROUND**

##### **Health Care Trends**

Following World War II, the U.S. made great strides toward ensuring the health of its citizens, with the rise of employer-based health coverage beginning in the 1950s, and the introduction of Medicare and Medicaid to cover the elderly, poor and unemployed in the 1960s. But since the 1970s, employment-based health coverage has been declining. By the early 1990s, the last time the government attempted to reform the health care system, the percentage of full-time employees in medium and large private firms who participated in employer-sponsored health plans had fallen to 82%,<sup>3</sup> and it continued to drop to 74% by 2005.<sup>4</sup> The contraction for small firms, such as the majority of those in the construction industry, was even greater. In the construction industry, 79% of the companies have nine or fewer employees and only 37% of

their employees have employment-based health insurance<sup>5</sup> (although the percent of the union workforce that has coverage is much higher). A recent study by the Economic Policy Institute indicates that the “erosion of employer-sponsored health insurance” continued in 2007 and “the recent economic downturn suggests that health insurance coverage will only worsen in 2008.”<sup>6</sup>

Along with the decline in employment based coverage, the percentage of companies offering their retirees health coverage plummeted to only 31%<sup>7</sup>, and the ranks of the uninsured grew to 17% of the population<sup>8</sup>, with “[n]early one-third of the population under age sixty-five – fac[ing] a spell of uninsurance in any two-year period.”<sup>9</sup> Today, roughly 45 million people, 80% from working families, are uninsured and a growing number of Americans are relying on government health care programs.<sup>10 11</sup>

At the same time, the cost of health care has continued to escalate and employers have shifted a greater portion of the cost onto their employees. According to the Kaiser Family Foundation, “Employees now pay more money for less coverage because of escalating premium costs and dramatic rises in deductibles, co-payments, and out-of-pocket expenses for medical care.”<sup>12</sup> Since 1999, for example, “family premiums for employer-sponsored insurance have increased 119 percent, while wages have gone up 34 percent and inflation has gone up 29 percent.”<sup>13</sup>

Rising prescription drug costs are also contributing to the cost of coverage. A survey conducted in January 2008 found that 29% of adults chose not to fill a prescription in the past two years because of cost, 23% had skipped doses or cut pills in half to make the prescription last longer, and 16% considered paying for prescription drugs to be a serious problem for them or a family member.<sup>14</sup>

While health care costs for individuals and families have been rising and the ranks of the uninsured and underinsured growing, health insurance and pharmaceutical companies have been enjoying record profits. In 2002, insurance industry profits totaled \$1.3 billion; by 2006 profits had grown to \$15.39 billion – an increase of 1,084%.<sup>15</sup> The pharmaceutical industry also enjoyed significant profits, ranking as the second most profitable industry in the country in 2006.”<sup>16</sup>

Clearly, the “market driven” approach to controlling health care costs and expanding coverage has not worked.

### **Impact on Construction Workers Covered by Joint Labor-Management Health Benefit Plans**

Joint labor-management, multi-employer (Taft-Hartley) health and welfare plans have successfully provided health coverage for millions of building trades union members and their families on a large scale since the 1940s.<sup>17</sup> These plans are funded through hourly contributions – deferred wages – negotiated in collective bargaining agreements as part of the members’ wage packages, and are structured to accommodate the fact that these workers are employed in a highly cyclical industry, tend to be employed by small businesses (10 or fewer employees), and are highly mobile (working for multiple employers during the course of a year or career).

While building trades union members have better, more affordable health coverage than most Americans, they are also being negatively affected by the trend in health care costs and the lack of universal coverage. Since the government’s last attempt at health care reform, building trades union members have seen a larger portion of negotiated wage increases redirected to

cover health care costs, health plan reserves reduced, benefits cut, eligibility rules tightened and out-of-pocket payments increased. In addition, following the national trend, many plans have been forced to reduce or eliminate retiree coverage. Compounding the problem is the fact that non-union contractors have an unfair competitive advantage over union contractors because few offer health coverage. In fact, 42% of wage and salary workers in the construction industry do not have employment-based health insurance.<sup>18</sup> The cost of providing uncompensated health care to these uninsured workers results in higher premiums for building trades union members.

The sharp increase in the cost of health care and the current economic crisis are putting many building trades health care funds and their participants at great risk because:

- ✓ Tighter lending standards and cuts in state and local revenues are forcing construction projects to be put on hold or shut down. As a result, there are declining job opportunities for members and fewer contributions to health and welfare funds, even as benefit claims increase.
- ✓ Participants eligible to retire (but who might have stayed in the workforce if there were job opportunities) are retiring, which is increasing the burden on those plans offering retiree coverage.
- ✓ There is growing pressure to redirect health and welfare contributions to cover new pension funding requirements under the 2006 Pension Protection Act.

Without national health care reform, the future viability and solvency of building trades union health and welfare funds is in jeopardy.

### **State versus National Reform**

In the absence of any meaningful attempt during the last eight years on the federal level to address the problems with the country's failing health care system, several states have developed and begun to implement state-level reforms. While several of these initiatives have played an important role in focusing the public's attention on the health care crisis, and offered valuable insights into how to fix the system, the Department believes that a national approach is the only way to truly address the core problems with the health care system.

Further, the Department is concerned that in the absence of national reform, a series of state-level reforms, each with its own set of unique requirements, would result in higher costs and greater administrative burdens for building trades union and other multiemployer health plans, since their participants tend to work in multiple states and for multiple employers.

## **HEALTH CARE REFORM PRINCIPLES**

The Department believes that any meaningful and effective reform must include the following core principles:

### **1) Provide Universal Coverage**

Universal coverage, or providing health care to all persons, is the only way to eliminate the unfair financial burden placed on those who currently pay into the system, and to stop the cost shifting that puts responsible employers who offer coverage at a competitive disadvantage. At present, roughly two-thirds of the health care costs for the uninsured are absorbed by those with insurance, and the government uses tax dollars, a portion of which comes from those with

insurance, to cover the remaining third.<sup>19</sup> Furthermore, universal coverage is the best way to ensure the effective treatment of chronic diseases, which plague millions of Americans and account for the largest share of health care spending. Likewise, universal coverage is the only practical way to ensure the health of all citizens and to help combat the spread of contagious diseases, which is an area of growing concern among health care professionals and has a direct impact on the cost of health care.

## 2) **Distribute Costs Fairly**

The Department believes that, in addition to spreading coverage to all, steps must be taken to distribute the cost of the health care system fairly. Several models have been discussed for achieving this goal, ranging from a single-payer approach similar to the Canadian system to one that requires all individuals to obtain insurance in the marketplace. Given the number of stakeholders in the current health care system, a hybrid of the country's current financing system, which includes a role for both employers and the government, would best facilitate the transition to universal coverage. Such an approach would recognize and allow the continuation of well-designed and funded health plans, such as those offered by building and construction trades unions and their employers, and would both require and provide a mechanism for individuals and employers that currently do not contribute to the health care system to do so.

The Department supports proposals that would fairly distribute the cost of financing the health care system by, for example, requiring all employers either to provide a basic mandated level of coverage (including for example, routine and preventative care, hospital coverage, surgery, oncology and prescription drugs) directly to their employees and dependents, or to contribute to a government sponsored program that offers this basic coverage.

Taxing existing benefits as a financing option would not be fair to those who have acted responsibly in the past, and would create a disincentive for employers to continue to offer coverage since it would increase their payroll taxes.

Building trades union members and their multiemployer plans, as well as other responsible employers and employees, must not bear a disproportionate share of the cost, or be put in a position where the added cost of financing universal coverage will force their plans to reduce existing benefits or increase the cost to participants. Building trades union members have already had to forgo hard earned wage increases to fund their health care coverage, and been forced by the current system to subsidize the cost of the uninsured for decades.

## 3) **Control Costs and Preserve Benefits**

The cost of health care is a driving force behind the need for reform. When the government attempted to reform the system in the early 1990s, "the U.S. healthcare system spent as much as the gross domestic product of France. Now it spends as much as the combined GDPs of France and Spain."<sup>20</sup> On a per capita basis, the United States spends "more than double the per capita spending in the median Organization for Economic Cooperation and Development country".<sup>21</sup> The cost of health care puts U.S. companies at a competitive disadvantage when competing domestically and "with foreign companies that don't share this cost burden".<sup>22 23</sup> In addition, rising health care costs and cost shifting has placed an added burden on employees. Health premiums have risen faster than inflation and wages, and out-of-pocket costs have been

increasing steadily. Between 2006 and 2007, for example, employee out-of-pocket expenses and premium contributions increased by 11.5%.<sup>24</sup> This trend is not sustainable.

At the same time, efforts to control costs by health funds, consumers and businesses were undone by pharmaceutical and health insurance companies' high administrative fees and profits. Savings realized during the rise of the HMOs, for example, did not lower costs for consumers and businesses, but instead translated into the windfall profits for insurers and pharmaceutical manufacturers noted earlier.<sup>25 26</sup>

The lack of a requirement that all employers contribute to the system, and the absence of a mechanism to control the rate at which the cost of prescription drugs and health care premiums increase have created a situation where those paying into the system are paying more, the number of personal health care related bankruptcies is on the rise, and a growing number of people have, or are at risk of, losing coverage. In summary, our health care system is failing on every level.

The Department recognizes that steps must be taken immediately to control health care costs, and would support a greater role for government in controlling the rate of increase, preserving the concept of pooled risk, prohibiting adverse selection, and ensuring that insurers do not delay, deny or drop coverage, or raise rates, because of a pre-existing condition or an individual's health. The Department recognizes that this will not be easy. Health insurance and pharmaceutical companies have significant power and influence. In fact, in the first half of 2007 alone, "the health care sector doled out more than \$227 million for lobbying efforts."<sup>27</sup> Although there will undoubtedly be resistance, reform cannot happen unless all parties – including the health care industry – change how they do business.

#### 4) **Improve Quality and Delivery of Care**

The United States is frequently recognized for the high quality of its health care and health care professionals. Yet, structural problems with the system result in fewer positive outcomes than one would expect. As a result, U.S. life expectancy ranks behind Japan, Europe, Jordan, Guam and the Cayman Islands, and the U.S. infant mortality ranks 29<sup>th</sup> in the world.<sup>28 29</sup>

In addition, the country's health care dollars are spent disproportionately on a small percentage of the population and limited number of diseases. There are several widely accepted actions that would help to improve the quality and delivery of care and as an added benefit would also help reduce the cost of health care.

a. **Establish Standards for Care** to ensure uniform care and the best outcomes throughout the country. The Department sees an important role for government in defining and communicating clinical best practices, establishing incentives for providers to adopt best practices, and creating a mechanism to inform patients about what constitutes and where to find "quality care." However, recognizing that consumers of non-preventive services do not possess the knowledge or sophistication to make informed decisions about clinical services, this step should not be used as an excuse to penalize patients or deny payment for services for patients who fail to use available information.

Further, the Department believes the government is best positioned to use the public's purchasing power to promote the use of evidence-based protocols, negotiate lower drug and technology prices, and decide how to invest in new technologies and health care.

b. Treat Chronic Diseases Early. Contrary to popular belief, cancer, trauma, infectious disease, and maternity “are not the major cost drivers.”<sup>30</sup> Chronic diseases, such as diabetes, congestive heart failure, coronary artery disease, asthma and depression, are the number one cause of death in the U.S and account for the largest share of health care spending. In fact, the majority of health care dollars are spent on only 10% of the population, and “people with chronic disease account for more than 70% of the nation’s health care expenditures.”<sup>31</sup> There is strong evidence that by treating these chronic diseases early, and making sure that any basic health care plan offered by an employer or through a government program covers these diseases, the U.S. will be able to improve the quality of care provided and reduce costs over time.

c. Streamline Administration and Control Related Expenses. The current fragmented nature of the health care system makes it difficult for patients and health care providers to make informed decisions about appropriate care. It also contributes to high administrative fees and spending on unnecessary or questionable activities. In fact, “[i]nsurance administrative overhead has been the fastest rising component of health spending in recent years.”<sup>32</sup> For comparison, Medicare’s administrative fees are under 3%, while the average for private insurance companies is 15%, and for small companies the fee is as high as 20%, and up to 40% for individual coverage.<sup>33</sup> Studies have found that even a small reduction in administrative fees “to the level of countries, such as Germany and Switzerland with mixed public-private insurance systems... would save \$32 to \$46 billion.”<sup>34</sup> Entities, such as non-profit health insurance providers, with track records of offering comparable service for lower administrative fees, should be encouraged.

A related area with potential for improvement and savings is in “denial management,” in other words the time and money spent by insurance companies when they deny coverage and are then challenged. It is estimated that “this tug of war is costing health care providers and insurers about \$20 billion in wasteful, unnecessary administrative costs.”<sup>35</sup> As a result, “resources that could have been used to pay for medical care are instead wasted in a zero-sum struggle over who ends up paying the bill... it’s an arms race between insurers, who deploy software and manpower trying to find claims they can reject, and doctors and hospitals, who deploy their own forces in an effort to outsmart or challenge the insurer. And the cost of this arms race ends up being borne by the public, in the form of higher health care prices and insurance premiums.”<sup>36</sup>

Recommendations for reducing administrative fees and providing health care providers with access to better patient information include the use of interoperable technology (i.e., database systems that can communicate with each other) for recordkeeping and claims processing, and the use of standardized forms. Using the Medicare system as a model, the Department believes the government should work with the health industry to develop and disseminate the technology and create incentives to encourage payers and providers to implement new procedures and technology. While interoperable technology, greater sharing of information, and central data collection can lead to lower administrative costs and more informed health care treatment, such a system cannot be put in place without adequate safeguards to ensure that patient privacy is protected and the collected data may never be used to limit or deny coverage or employment. In addition, steps taken to reduce administrative costs should address the waste resulting from “denial management” practices.

## CONCLUSION

The Department believes the country cannot afford to wait any longer to reform the health care system, and supports reforms that build on the current system, allow an expanded role for government and employer-based plans, and take the necessary steps to control costs and improve quality and delivery of care. For decades, building trades unions and their collectively bargained, labor-management health funds have evolved to meet the health care needs of their constituents and supported efforts to improve the country's health care system. We look forward to being part of a renewed and reformed health care system that not only meets the needs of our members, but all people – working, retired, disabled – young and old.

In doing so, however, those entities that have acted responsibly and provided coverage, such as building trades unions and their employers, should not end up losing benefits or bearing a greater share of the financial burden for reform. Our members have already given up wage increases to fund their own health care and, through higher premiums, have subsidized the health care provided to the uninsured for decades. It is our desire to work with all stakeholders on this national challenge, and come up with balanced, enforceable reforms that benefit the country as a whole. We believe that if everyone has a stake in the system and the excesses of the past are reigned in, there will be adequate funds to provide quality, affordable coverage for all.

The Department urges the new Administration and Congress to act quickly to adopt health care reform legislation that provides universal coverage, controls costs, preserves our members' benefits, and improves the quality and delivery of care.

---

<sup>1</sup> Henry Aaron, "Why healthcare reform fails," Los Angeles Times 6 Nov. 2007: A-21.

<sup>2</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO); U.S. Census Bureau, International Database, 28.

<sup>3</sup> Office of the Chief Economist, U.S. Department of Labor, "A Look at Employers' Costs of Providing health Benefits," DECLINE IN EMPLOYEE HEALTH COVERAGE, 31 July 1996, 17 Nov. 2008 <http://www.dol.gov/oasam/programs/history/reich/reports/costs.htm> .

<sup>4</sup> CPWR – The Center for Construction Research and Training, produced with support from the National Institute for Occupational Safety and Health grant number OH008307. The Construction Chart Book, 4<sup>th</sup> ed. (Silver Spring, MD: Publications CPWR, 2007) 26.

<sup>5</sup> CPWR – The Center for Construction Research and Training, produced with support from the National Institute for Occupational Safety and Health grant number OH008307. The Construction Chart Book, 4<sup>th</sup> ed. (Silver Spring, MD: Publications CPWR, 2007) chart 26b.

<sup>6</sup> Elise Gould, "THE EROSION OF EMPLOYER-SPONSORED HEALTH INSURANCE: Declines continue for the seventh year running," EPI Briefing Paper 9 Oct. 2008: 21.

<sup>7</sup> "Survey of Employer Health Benefits 2008," Kaiser Family Foundation and Health Research & Educational Trust 25 Sept. 2008; Exhibit 11, "Among All Large Firms (200 or more workers) Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988 - 2008.

<sup>8</sup> Kaiser Family Foundation, "Health Insurance Coverage of the Nonelderly Population, 2007." Fast Facts, Section 1, Figure 1.1, 7 Oct. 2008, 27 Oct. 2008 < <http://facts.kff.org/chart.aspx?cb=55&ch=732> > .

<sup>9</sup> Marie Gottschalk, "Back to the Future? Health Benefits, Organized Labor, and Universal Health Care," Journal of Health Politics, Policy and Law, Vol. 32, No. 6, Dec. 2007: 927.

<sup>10</sup> Kaiser Family Foundation, "Uninsured Nonelderly vs. All Nonelderly, by Family Work Status, 2007" and "Health Insurance Coverage of the Nonelderly Population, 2007." Fast Facts, slides 2 and 9, 7 Oct. 2008, 17 Nov. 2008, <http://facts.kff.org/results.aspx?view=slides&topic=4> .

<sup>11</sup> Elise Gould, "THE EROSION OF EMPLOYER-SPONSORED HEALTH INSURANCE: Declines continue for the seventh year running," EPI Briefing Paper 9 Oct. 2008: 1. "Over the 2000-2007 period, the trends indicate a significant shift from private to public coverage, especially among children. In particular, since 2006, public insurance was the only reason that more Americans did not become uninsured as coverage through work fell."

---

<sup>12</sup> Marie Gottschalk, "Back to the Future? Health Benefits, Organized Labor, and Universal Health Care," Journal of Health Politics, Policy and Law, Vol. 32, No. 6, Dec. 2007: 928.

<sup>13</sup> Kaiser Family Foundation, "Cumulative Changes in Health Insurance Premiums, Inflation, and Workers' Earnings, 1999-2008." Fast Facts 24 Sept. 2008, 17 Nov. 2008 < <http://facts.kff.org/chart.aspx?ch=707>>.

<sup>14</sup> Kaiser Family Foundation, "Serious Problems Paying, Not Filling Prescriptions and Skipping Rx Drug Doses Because of Cost, 2008." Fast Facts 10 Oct. 2008, 17 Nov. 2008 < <http://facts.kff.org/chart.aspx?ch=404>>. USA Today/Kaiser Family Foundation/Harvard School of Public Health: The Public on Prescription Drugs and Pharmaceutical Companies (conducted January 3-23, 2008).

<sup>15</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), 24.

<sup>16</sup> "A Report by the Alliance for Retired Americans Educational Fund, "Outrageous Fortune: How the Drug Industry Profits from Pills," August 2007: 21.

<sup>17</sup> BCTD Health Care Committee 2008: The members of the building and construction trades unions, have been seriously impacted by escalating health care costs and the recessions in the early 1990s, 2001 and the current financial crisis, since their employment is highly cyclical, they work for multiple employers over the course of a year, their eligibility for health care is, in most cases, directly linked to the number of hours they work, and their employers frequently compete for work with other employers who do not offer health care to their workers.

<sup>18</sup> CPWR 2008 Chartbook chart 26

<sup>19</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), 10.

<sup>20</sup> Henry Aaron, "Why healthcare reform fails," Los Angeles Times 6 Nov. 2007: A-21

<sup>21</sup> Gerard F. Anderson and Bianca K. Frogner, "Health Spending in OECD Countries: Obtaining Value Per Dollar" Health Affairs, 27, no. 6 (2008).

<sup>22</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), 12

<sup>23</sup> Toni Johnson and Lee Hudson Teslik, "Healthcare Costs and U.S. Competitiveness," Council on Foreign Relations – Backgrounder 18 Mar. 2008 < <http://www.cfr.org/publication/13325#2>> .

<sup>24</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), 5.

<sup>25</sup> "Kaiser seen as biggest earner as HMO profits soared in 2003," Managed Care Magazine Oct. 2004, "Kaiser seen as biggest earner as HMO profits soared in 2003," "The industry's soaring profits continue to irk both consumers and businesses who are shouldering skyrocketing health care costs without any perceived improvements in benefits," says Mellissa Gannon, Weis Ratings Vice President."

<sup>26</sup> BCTD Health Care Committee April 29, 2008, presentation by Mark Blum, Executive Director, America's Agenda, Health Care for All, to the BCTD Health Care Committee.

<sup>27</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), 19.

<sup>28</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), U.S. Census Bureau, International Database, 28.

<sup>29</sup> Gardiner Harris, "Infant Deaths Drop in U.S., but Rate Is Still High," New York Times 16 Oct. 2008

<sup>30</sup> George Halvorson, Health Care Reform Now! A Prescription for Change (John Wiley & Sons, Inc., 2007) 4. .

<sup>31</sup> George Halvorson, Health Care Reform Now! A Prescription for Change (John Wiley & Sons, Inc., 2007) 2 &3.

<sup>32</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), 22.

<sup>33</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), Government Accountability Office, 10/01; Jacob Hacker, 1/07; Commonwealth Fund, 5/02, 22.

<sup>34</sup> Sarah R. Collins, Ph.D., Congressional Testimony - UNIVERSAL HEALTH INSURANCE: WHY IT IS ESSENTIAL TO ACHIEVING A HIGH PERFORMANCE HEALTH SYSTEM AND WHY DESIGN MATTERS, Commonwealth Fund, 26 June 2007.

<sup>35</sup> FACTS ABOUT AMERICA'S BROKEN HEALTH CARE SYSTEM (AFL-CIO), 23.

<sup>36</sup> Paul Krugman, "The Health Care Racket," New York Times, February 16, 2007