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NEGOTIATING AMERICA'S HEALTH INSURANCE CRISIS

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The United States faces a health care crisis of unprecedented proportions. The swelling ranks of the uninsured are one cause for alarm: Most current estimates peg the number of Americans lacking health insurance at about 40 million, or more than fifteen percent of the nation's people.

Some Americans are uninsured because they are not employed in full-time, permanent positions which carry benefits. Others are self-employed or work for smaller companies with limited benefits packages. The skyrocketing cost of independently-purchased insurance policies have placed all but the most urgent care out of reach for these people and their families.

But the uninsured are not the only Americans for whom the cost of health care has become an urgent issue in the 1990s. Until recently, full medical coverage was an important, accepted component of full-time employment in many industries, and especially in those with a strong trade union presence. Today, however, even workers in strong unions cannot take health coverage for granted. As the cost of health care and health insurance coverage climb, more and more employers are seeking ways to reduce the amount they must pay toward their employees' health insurance. There are a number of possible strategies for cutting health care costs. Unfortunately, most companies merely seek to shift part of the cost for health coverage to workers through benefits reductions, worker deductibles, or worker payments for care. Traditional collective bargaining is increasingly unable to halt this trend.

Cost-Shifting: From Employers to Workers

In a nationwide 1991 survey by the Bureau of National Affairs, 70% of management respondents planned to seek additional "cost containment" measures in their 1992 contract talks; over half planned to ask for increased health contributions from employees.¹ Many companies already require employee contributions to health care premiums. At the time of the California Benchmark Survey of 1991, nearly sixty percent of California employers had instituted cost-sharing policies. The survey results predict another eight percent increase in such practices for the current year.²

Unions, in the meantime, struggle harder each year to protect their members' benefits packages. Both businesses and unions list health care costs as one of their biggest concerns in contract negotiations. According to the Bureau of National Affairs, negotiators can now expect to spend nearly 60% of their time resolving health insurance disputes. Health costs are on the table in virtually every major negotiation, and AFL-CIO officials report that the percentage of strikes involving health care issues leapt from 18% in 1986 to 78% in 1989. Another recent survey of union leaders showed that 73% were willing to strike in order to stop cutbacks in health benefits.³

The threat of strike can sometimes fend off a unilateral imposition of cost shifts by employers, but more and more often union concessions are required. Often, as in the case of the UFCW's 1991 contract with one of New England's largest supermarket chains, workers avoid absorbing health costs by switching from traditional insurance coverage to prepaid or "managed care" plans such as HMOs and PPOs. While many observers have raised concerns about the quality of care in these managed plans, their policy costs, deductibles and co-payment fees tend to be significantly lower than fee-for-service plans. Other negotiators are able to deflect health benefit reductions only by making wage concessions.

Health Costs: The Key Problem

The key underlying problem in this newly intensified conflict between business and labor is the fact that health costs in the United States are rising at out-of-control rates. Most commentators frame the negotiating issue in terms of American trade competitiveness: U.S. employers face a much greater health care burden than do their business rivals in other industrialized countries, many of which have some form of national health coverage.

For example, a University of Michigan study recently found that U.S. steel firms spend \$7,600 per employee on health care, compared to the \$3,200 spent by Canadian firms.⁴ Canada's health care system involves a government-sponsored universal insurance plan which regulates costs and makes care available to all, regardless of employment status. In contrast, health care and insurance are priced and sold on a market basis in the U.S., with employers traditionally covering their workers and government programs assisting only a small segment of the population.

The cost of medical care in the United States *has* risen dramatically in recent years. According to government statistics, total national health spending nearly tripled between 1981 and 1991, as medical costs rose more than twice as fast as the Consumer Price Index.⁵ In 1992 about 14% of the U.S. Gross National Product was spent by individuals, their employers, and public agencies on health care. AFL-CIO officials compared U.S. spending to that of major trade competitors with nationwide health systems, and found that we spend 40% more than Canada, 90% more than Germany, and over 100% more than Japan. Even when other labor costs are lower in the U.S., this "health care differential" can price American goods out of the market.⁶

There are many reasons for such high inflation rates in health costs. Among the many oft-cited problems are booming malpractice insurance costs, industry-wide administrative excesses, the lack of federal cost controls on medical practitioners and pharmaceuticals manufacturers, and the public cost of "uncompensated" care which the uninsured must get but cannot pay for. Estimates presented by the AFL-CIO at its 1991 Convention show that without reforms, health care spending by the nation as a whole will increase at a rate of 12 to 15 percent annually for the next five years.

Individuals are increasingly wary about rising health costs, especially since the devastating problems of the uninsured have alerted us to the high stakes of living without health benefits. Health costs represent an unpredictable risk even for people with relatively secure employment and stable income. Recent surveys of workers show that a large majority prefers to take lower wage increases instead of picking up the tab for health insurance. As many as eighty percent of surveyed union leaders ranked health benefits as a higher priority than winning wage increases, and 60% of employed individuals surveyed by Gallup said they would take a reduction in employer contributions to pension plans rather than accept health cuts. Gallup respondents equated the value of their health benefits to an average wage increase of \$4,835 per year. Eighteen percent said they would want wage increases of \$10,000 or more if they had to forsake health coverage.⁷

Beyond the Bargaining Table

Employer efforts to shift the cost of health care to workers seem destined to meet continued resistance, possibly even catalyzing a new wave of labor militancy. On the other hand, while organized labor can still mobilize some leverage to stave off the cost-shifting efforts of employers, its bargaining ad-

vantage will probably shrink as expenses continue to rise and companies exercise an expanding range of cost-cutting options, reducing the full-time workforce or relocating operations to other states or countries.

The problem is that the strategy of shifting rising medical costs to workers by trimming health benefits cannot halt the rate of health cost increases in this country. Settlements reached this year may look much less satisfactory to both sides in two or three years, when health costs have jumped by another twenty to thirty percent. Given the broader dimensions of the nation's health care crisis, labor advocates such as Service Employees International Union President John Sweeney emphasize that the problem has grown beyond the reach of the bargaining table. Sweeney is echoed by California Congressman Henry Waxman, who argued before a 1992 AFL-CIO legislative conference that "no matter how aggressive it is, collective bargaining may no longer be enough" to protect union members' health benefits. The task before us, as Sweeney, Waxman, and a growing host of others argue, is to formulate a national solution which addresses both the causes and the consequences of skyrocketing health costs.⁸

Consensus is growing among labor leaders and even among some company officials that the company-by-company approach is failing both employers and workers. Further cost escalation can only intensify conflict and impede contract negotiations. It is possible, advocates of a national solution insist, to find alternatives capable of resolving the problems of companies AND their employees. To this end, many unions sponsor legislative task forces focusing specifically on national health care reform.

Another promising development is the emergence of such organizations as the National Leadership Coalition for Health Care Reform. This broad-based coalition, made up of corporations, unions, consumer groups, associations of health care providers, and public interest officials, has formulated a reform proposal which addresses the interrelated problems of rising health costs, the swelling ranks of the uninsured, and the uneven quality of care in the United States.⁹ While some take issue with elements of the proposal, most observers feel that the coalition represents an important new understanding that business, labor, and the general public have a common stake in the resolution of the health care crisis on a national scale. While the bargaining efforts of each union are crucial to protecting the immediate needs of their members, they will be most effective only when combined with a renewed national commitment to secure health care for all.

SOURCES

1. LRA's *Economic Notes*, March-April 1992, pp. 4-5.
2. Bureau of National Affairs' *Daily Labor Report*, No. 169, 8/30/91, p. A-3.
3. BNA's *Daily Labor Report*, No. 216, 11/7/91, p. A-19.
4. BNA's *Daily Labor Report*, No. 25, 2/6/92, p. A-14.
5. *San Francisco Chronicle*, 8/20/92.
6. BNA's *Daily Labor Report*, No. 219, 11/13/91, p. A-11.
7. BNA's *Daily Labor Report*, No. 243, 12/18/91, p. A-2.
8. BNA's *Daily Labor Report*, No. 11, 1/18/92, p. A-11; No. 40, 2/28/92, p. A-2.
9. For more information, write The National Leadership Coalition for Health Care Reform, 555 - 13th Street, N.W., Washington, D.C. 20004, or call (202) 637-6830.

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