The Hidden Cost of Jobs without Health Care Benefits

In the last half of the twentieth century, American health care financing emerged as a dual system: private, employer-sponsored care for most people was supplemented by public care for the poor and elderly. Today, however, rising health insurance premiums, shifting industrial composition, increased use of temporary and part-time workers, and a weakened bargaining position of workers in the labor market are factors leading to a marked shift in the nature of health care coverage for American workers.

Declining job-based coverage affects not only health care access and quality for those who are not covered; it also creates hidden costs for employers providing coverage and for taxpayers. Even worse: companies that pare down health benefits or adopt changes that make coverage unaffordable for workers undermine the market position of competitors, forcing them to follow suit as well. These, too, are hidden costs of nonbenefited jobs. Lawmakers at all levels in the United States are concerned about these issues and are looking for innovative solutions.

Declining Coverage and Shifting Costs

Job-based health coverage has fallen markedly since the 1970s. In 1979, 72 percent of private sector workers had coverage through their employers. By 2004, that figure had fallen to 61 percent.¹

This ongoing decline in job-based coverage is most pronounced among lower- and middle-income families. For Americans under age sixty-five with incomes less than 300 percent of the federal poverty level (roughly half of the non-elderly population), the proportion with such coverage fell from 47 percent in 2000 to 42 percent in 2004. If current trends continue, job-based coverage for low-income, non-elderly Americans is expected to fall to 37 percent by 2010.²

When employers do not provide health care coverage, other firms bear part of the cost of care to the uninsured in the form of higher premiums. According to a 2005 study by Families USA, the average annual health insurance premium for private employer coverage was $341 higher for individual coverage and $922 higher for family coverage because of the costs of uncompensated care.³ Since premiums rise with erosion of job-based coverage, and rising premiums cause other employers to scale back health benefits, a downward spiral of coverage is set into motion.

Another major portion of the cost of declining job-based coverage falls on taxpayers through increased take-
up of Medicaid and State Children’s Health Insurance Programs, increased use of public health facilities, and state and federal reimbursement to hospitals for uncompensated care. The trend in health coverage for children is illustrative: between 2000 and 2004, public coverage for children in the United States rose from 19 percent to 25 percent, while job-based coverage for dependent children fell from 64 percent to 60 percent.4

Public Costs: California

In California, “Medi-Cal”—the state’s Medicaid program—bears much of the burden of the shift away from employer-based health coverage. For example, my colleague Arindrajit Dube estimated that of the six million Medi-Cal enrollees in California in 2002, 3.3 million worked or were dependents of a person who worked, and they were not elderly or disabled. Enrollment of working family members cost more than $5.7 billion in state and federal funds.5

Enrollees are not always employees of small businesses. Dube found that 700,000 Medi-Cal enrollees were workers or dependents of workers at firms with 1,000 or more employees. An additional 440,000 enrollees were workers or dependents of workers at companies with between 100 and 1,000 employees. Together, workers and dependents in businesses with 100 or more employees accounted for $2 billion in Medi-Cal costs in 2002.

A striking finding of Dube’s research is that three-quarters of the public costs of working family members’ enrollment in Medi-Cal came from industries that are by and large location specific and do not face significant overseas or out-of-state competition. In fact, retail employees accounted for the greatest use of Medi-Cal in California. In 2002, 659,000 retail workers and their dependents were enrolled in Medi-Cal, at a cost of $1.1 billion. Retailers with 1,000 or more employees accounted for 192,000 enrollees and $340 million of the cost.

Other industries in which workers and their dependents often rely on Medi-Cal include construction, business services, and health care. According to Dube, construction had 323,000 enrollees ($562 million), business services 274,000 ($472 million), and the health care industry 260,000 ($461 million). Of the five industries with the greatest disproportionate reliance on Medi-Cal, agriculture is the only one in which global competition is a significant factor.

To be sure, not all firms in the retail and service sectors fail to provide adequate health care coverage to their workers. Yet responsible companies feel a double impact from competitors who prefer the benefit-reducing “low road” to industry competition. In addition to having a portion of competitors’ costs shifted in their direction in the form of higher premiums, “high-road” em-
employers find themselves at a disadvantage when “low-road” rivals decide to slash prices. This is a common challenge confronting retail grocers, providers of janitorial and security services, and construction companies.6

Wal-Mart

Much of the public discussion of the hidden cost of nonbenefited jobs has focused on Wal-Mart. Wal-Mart’s low labor-cost model has been cited as a driving force for declining benefits in the retail industry. As the largest private-sector employer in the United States, the company’s labor practices have received significant scrutiny.

Over the last several years, a number of states have released data on Medicaid enrollment for employees. According to the state of Georgia, the first state to make the data public, dependents of Wal-Mart employees accounted for 10,000 of the 166,000 children enrolled in the state’s Children’s Health Insurance Program (PeachCare) in 2003. Similar disproportionate use of public-health programs has been reported by states where Wal-Mart has its greatest density.7

Wal-Mart recently carried out its own survey of employee health coverage. While the methodology cannot be verified and the survey did not include questions on adult dependent coverage, it is illustrative to compare its findings with official U.S. government data on health insurance and Medicaid use by large retail employees. Wal-Mart reports that 48 percent of its workforce has job-based coverage; this compares to 53 percent for large retailers in the United States and to 61 percent for large retailers in California. Figures on Medicaid use of those without insurance can be found in Table 1.8

What is the hidden health care cost of Wal-Mart jobs? Wal-Mart reports 1,330,000 workers in the United States. The average annual cost for an adult on Medicaid is $1,771; the average cost for a child is $1,271. Using the U.S. government’s average number of children per retail worker (0.74), it follows that Medicaid for Wal-Mart employees and their child dependents costs $455 million a year. At an average cost of $800 per uninsured worker, we also estimate that uncompensated care to Wal-Mart workers adds an additional $220 million in costs shifted to public and private sources.

Moreover, Wal-Mart’s impact on health coverage appears to go beyond the company’s own workforce. In September 2003, California’s major grocery chains cited competition from Wal-Mart as the central motivation behind proposed health care cuts to their workforce (resulting in a bitter four-and-a-half-month strike). While the resulting contract maintained benefits for current employees, it significantly curtailed eligibility and employer spending on health benefits for new hires.

Given the high profile of Wal-Mart and the company’s oversized role in the economy, that employer has been the main target of many of the recent state-level health policy initiatives. Yet Wal-Mart is by no means the only large company that fails to provide health benefits. The issue for policymakers is not only Wal-Mart itself, but also the broader “Wal-Martization” of the economy.

New Burden

In the two-track American system of employer-sponsored health care for working families and public programs for the elderly, poor, and disabled, employers affect public finances when they make decisions about health spending on workers. The erosion of job-based coverage is placing a significant new burden on an already underfunded safety-net system. In response to rising health expenditures and increased demand, many legislators at all levels of government are looking for new ways to curb public insurance coverage and benefits, threatening further erosion of health care access.

In countries with national health care systems that separate health coverage from employment, employer spending on health benefits is not a factor in competition. All employers benefit equally from the public provision of health care. In the United States, where the majority of workers and their dependents continue to receive health coverage through their jobs, employers who do not provide coverage are able to shift costs onto their competitors and the public. Short of moving toward a universal health care system, it is rational for state and local governments to pursue “fair share” policies that require employers to meet minimum health care spending standards.

Local Initiatives

Some of the more interesting recent attempts to address the decline in job-based coverage are coming from cities. San Francisco and Chicago have been

| Table 1. Uninsurance and Medicaid, Wal-Mart and Large Retailers |
|-------------------|----------|----------|----------|
|                   | Uninsured | Medicaid | Total    |
| Dependent Children|          |          |          |
| Wal-Mart          | 19%       | 27%      | 46%      |
| Large Retail      | 7.4%      | 21.7%    | 29.1%    |
| Workers           |          |          |          |
| Wal-Mart          | 19%       | 5%       | 24%      |
| Large Retail      | 17.6%     | 4.9%     | 22.5%    |

Sources: See Note 8. Other sources of coverage for Wal-Mart workers include Medicare, veterans’ benefits, job-based coverage through a spouse or parent, and individual plans.
the highest-profile cases. In June 2006, San Francisco passed an ordinance that combines a minimum health care spending mandate on employers with a new program that will provide a comprehensive set of health services to city residents and their employers for a reasonable monthly fee. While this Health Access Program will broaden access to preventive care that keeps people out of emergency rooms, the minimum health care spending requirement will help level the playing field for the majority of businesses that already pay for their workers’ coverage (by discouraging other companies from dumping even more of their workers into the taxpayer-financed public health system).

In July 2006, the Chicago City Council passed an ordinance requiring large retailers to pay a minimum wage of ten dollars and spend a minimum of three dollars on health benefits. The legislation, which still needs mayoral approval as this article goes to press, addresses the broader decline in wage and benefit standards in the retail industry. Large retailers such as Wal-Mart and Target are seeking to expand into inner-city urban areas, having built up in rural and suburban markets to the point of saturation. Their need for new markets puts cities in a strong position to require that retailers deliver good jobs, harnessing economic development for the benefit of local communities.

No one believes that the health care crisis in America can be solved at the local level. While serving to reduce the impact of the crisis locally, such policy efforts can provide important laboratories of innovation and demonstrate to the broader body politic that change is not only necessary, it is also possible. Those would not be small achievements.

NOTES


2. Ibid.


4. A. Dube et al.

5. A. Dube, “Working Family Members on Medi-Cal: Enrollment and Cost by Industry and Size of Employers,” (working paper, U.C. Berkeley Institute of Industrial Relations, August 2003). Cost numbers have been adjusted to reflect both state and federal funds. Counting only families where a member worked at least fifty weeks out of the year, the cost was $4 billion. Total Medi-Cal spending in California for the non-disabled and non-elderly in 2002 was $8.1 billion.


8. S. Chambers, “Reviewing and Revising Wal-Mart’s Benefits Strategy” (memorandum to the board of directors, Board of Directors Retreat FY06); A. Dube and S. Wertheim, “Wal-Mart and Job Quality—What Do We Know, and Should We Care?” (presentation, Center for American Progress, October 2005).