
Low Wage Employers Shift Health Costs to Taxpayers

Puget Sound Sage
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PUGET SOUND SAGE

Puget Sound Sage works to promote good jobs, quality employment opportunities for disadvantaged adults, a cleaner environment, and affordable housing for low/moderate income families in the metro Seattle area. Our mission is to ensure that all families benefit from economic growth, and that local and regional policy decisions meet the social and environmental needs of our communities. Funding for the study resulted from the settlement in Mader v. Health Care Authority, King Co. No. 98-2-30850-8 SEA, on remand from Mader v. Health Care Authority, 149 Wn.2d 458 (2003).
EXECUTIVE SUMMARY:

The nature of employment in the US economy has fundamentally changed. Traditionally, employment has been an arrangement in which businesses provided pay and benefits in exchange for full-time (FT), regular labor on the part of an employee. However a growing number of workers in recent years have found themselves pushed to the outskirts of traditional employment.

An increasing share of the workforce is compelled to accept "nonstandard" work; work (PT), contract work, temporary employment, self-employment and independent contracting now make up a significant and increasing share of the US economy. Workers are not arriving at these arrangements by choice, but are pushed into these forms of employment due to shifting policies of private sector employers seeking a competitive edge through lower labor costs.

Even as the nature of employment has changed, public policy has institutionalized employer-sponsored health insurance (ESI) as the leading mechanism by which households access health insurance. The passage of the Affordable Care Act (ACA) has reinforced employment as the primary way households obtain health coverage. The ACA requires employers to offer health insurance coverage to employees working 30 or more hours per week, if they employ more than 50 FT equivalent workers, or pay a penalty.

For workers being out on the fringe of employment also means being on the fringe of ESI coverage. This report explores the proliferation of nonstandard employment in Washington State and the deteriorating access to health insurance by workers in industries heavily reliant on nonstandard workers. Our analysis suggests that an increasing share of private sector employers rely on contingent workers to cut labor costs and improve their bottom lines. As a result more and more workers are losing access to health coverage and costs will be shifted to public institutions in the form of uncompensated care, medical entitlement programs, the state health care exchange and public health programs.

Our investigation found:

**Nonstandard employment represents a growing share of all private sector employment in Washington State:**

- One third of all private sector jobs in 2010 were nonstandard (PT employment, temporary employment, self-employment and independent contracts.)
- The share of non-standard employment in the state is at its highest rate in a decade.
- A growing share of the workforce in Washington State is PT, with an increasing number of PT workers being prime age working adults (ages 25-64) who work PT because they could not find FT employment.
• Twenty six percent of private sector wage and salary workers reported working PT in 2010, and an increase of nearly 5 percentage points higher than the same ratio in 2005.

• The portion of PT workers, accepting PT employment involuntarily has more than doubled among prime age working adults since 2007 from 19 percent to 42 percent.

• In 2010 for the first time in a decade the percentage of PT, prime age workers who worked PT involuntarily exceeded those who choose PT employment.

Access to Employer-Sponsored Insurance (ESI) in Washington has declined across the labor market since the recent economic downturn and PT workers have experienced a greater reduction in access than FT workers.

• The rate of PT workers who had access to employer-based health insurance in 2003 was 27.1%; but by 2010 the rate had dropped to only 16.9%.

• As many as 4 out of 5 private sector PT workers (3 out of 4 among the prime working age population) do not have access to health insurance through their jobs.

• Employers are imposing higher cost-sharing on employees. Employee premium contributions for family coverage nearly tripled between 1999 and 2012.

Analysis of the grocery sector in the Puget Sound provides a case study of how PT workers are being pushed out of health insurance benefits by certain employers.

• Analysis of the grocery sector indicates that retail employers are raising eligibility requirements and hour per week thresholds for PT employees to qualify for health insurance. Cost sharing is also increasingly pricing many out workers out of coverage due to high premiums, deductibles and maximum out of pocket costs.

• Grocery retailers not constrained by collective bargaining contracts are requiring workers in the Puget Sound to pay up to a third of their gross earnings on premiums and qualified medical expenses: Employees at Walmart may pay between 25-30 percent. At Whole Foods, employees may pay up to 31 percent.

Service Industries that Pay Low Wages are Heavily Reliant on Contingent Workers. Many of these sectors represent a majority of all job vacancies.

• Nationally, six service industries account for nearly two-thirds of all PT employment. They include: retail trade, food services, health services, education services, social assistance and arts and recreation.

• All six of these industries pay average wages that fall below 80% of Family Median Income in Washington State.
• According to the Washington State Job Vacancy Survey Report these industries also provided a majority of job openings in 2012.¹

Conclusions:
A strong regional economy depends on a thriving working class with income stability and access to health insurance. The proliferation of nonstandard employment in Washington State not only places middle class security at risk; it also represents an increasing burden on limited state and regional government resources.

The outcomes of the Affordable Care Act for nonstandard workers are uncertain. ACA relies on employers as the key nexus for health insurance coverage, and ties worker eligibility for subsidized individual insurance to whether or not the employer offers a group plan and whether or not the worker can afford to enroll in it. Key provisions of the law leave nonstandard workers vulnerable to:

A reduction in work hours: The FT threshold under the ACA is 30 hours. While industries and firms that offer middle class wages may expand coverage to employees currently working at or just above the threshold, low wage workers are placed at risk of having their hours reduced. The workers most at risk of reduced work hours under ACA are those working 30-36 hours a week, for wages below 400% of FPL, who do not currently have insurance through their employers. Such employees are heavily concentrated in the Restaurant, Nursing Home, Accommodations, Health Care, Retail Trade, Education and Building Services industries.²

Many of these workers, already at or below the federal poverty line, will need to juggle two or more PT jobs to afford basics like food and shelter.

Exclusion from ESI unless they stay with a firm for at least one year: IRS rules will allow employers to look back 3-12 months to determine whether a worker meets an average of 30 hours. The rate of employer sponsored insurance participation in the temp industry is already low, even among workers who primarily worked in the temp industry during the year. A long look-back period allows the staffing industry to avoid financial responsibility for the health care needs of their employees.

Misclassification as contractors: A significant share of employers misclassify some employees as independent contractors in order to avoid payroll taxes and benefits.³ A critical question remains whether


² UC Berkeley Labor Center, February 2013. “Data Brief: Which workers are most at risk of reduced work hours under the Affordable Care Act?” Berkeley, CA.

³ Conservatively, at least 30 percent of firms in the US misclassify workers as independent-contractors, meaning that employers classify workers as independent contractors, when they meet the legal definition of being an employee under state and federal regulations. See U.S. Government Accountability Office (GAO), Aug. 2009, “Employee Misclassification:
the rate of misclassification will increase as employers seek to evade requirements under the ACA, and whether effective monitoring will be in place to prevent this from happening on a large scale.

The recent Obama Administration decision to delay enforcement of the employer mandate widens the window of time that employers have to make such workforce adjustments. It is as yet unclear to what extent employers will pursue these policies.

As state and regional policy makers and community leaders look to the future of economic growth in the region it will be crucial to ensure that employment arrangements in industry sectors provide workers with employment security and meaningful connections to affordable health insurance coverage.
INTRODUCTION

Middle class economic security depends on workers’ ability to have gainful, steady employment and access to health insurance. The economic crisis of 2007 shook the foundations of that security. Households not only lost jobs, they lost access to the primary means by which Americans are supposed to get health insurance: their employers.

Yet even before the recession, the nature of employment was changing. Over decades private sector businesses seeking a competitive edge have pursued an agenda of workforce divestment that has restructured their relationship to their employees. Traditionally employment has been an arrangement in which businesses provided pay and benefits in exchange for fulltime, regular labor on the part of workers. However a growing number of workers in recent years have found themselves pushed to the outskirts of traditional employment and into “nonstandard” work: PT work, temporary employment, self-employment and independent contracting.

In 2010 over one-third of private sector employment in Washington was nonstandard, leaving approximately 916,000 workers on the economic fringe and with poor access to health insurance coverage. Our analysis of state and federal data show that as the share of the nonstandard workforce grows, more and more workers are falling through the cracks of a system that relies on private, job-based health insurance as the primary means of access to health care. Just two categories of nonstandard workers in Washington state—PT workers and self-employed workers who have not incorporated as businesses—make up nearly 32% of people employed in the private sector. They also account for approximately 23% of all uninsured individuals.

This report investigates how the proliferation of nonstandard employment affects workers’ access to health insurance in Washington State. In particular, the report examines the degree to which private sector industries rely on nonstandard labor, and the barriers nonstandard workers face in participating in job-based health insurance. Our analysis is based primarily on data from government sponsored employer and household surveys, using Washington specific data where possible and inferring from national data as necessary.

In the first section, we identify key trends in PT, temporary, and self-employment in Washington. We find that nonstandard workers make up a growing share of employment in the post-recession economy, and that PT work—especially involuntary PT work—began to increase in share substantially even before the economic crisis that began in 2008.

In the second section, we analyze available data on participation in employer-sponsored health insurance (ESI) among PT and temporary workers, and private health insurance coverage among self-employed workers. We find that, in the private sector, nonstandard workers have significantly less access to insurance
coverage than the working population as a whole, with a faster decline in participation rates over time. We also highlight a decline in the quality of plans to which nonstandard workers have access, in terms of both decreased benefits and increased costs. We conclude by exploring the implications of the above findings in the context of health care reform. In particular, we note that recent and pending decisions by federal regulators on ACA implementation could result in less access to health insurance for non-standard workers and higher financial burden.

**DEFINING NONSTANDARD EMPLOYMENT**

As businesses have sought to externalize cost and risk, they have pursued workplace policies that shift work that was once performed by full-time employees, into nonstandard employment. The growth of nonstandard employment is linked to this increasingly loose relationship between employees and firms. Operationally, nonstandard employment is defined as employment other than traditional FT, permanent employment with stable attachment between employees and firms. Examples include PT, on-call, temporary, and contract or freelance labor. The following briefly describes the key types of nonstandard workers captured in this study and associated methodological issues.

*Part-Time (PT)* workers constitute a readily identifiable form of nonstandard labor. Some firms and industries continue to rely mostly on FT workers, only hiring PT workers on the margins. In other sectors, such as retail and food services, firms rely heavily on PT workers as a strategy to maximize flexible scheduling for peak business activity and also to avoid paying the benefits expected by FT workers.

PT status is readily determined in official data sources. PT work is generally classified as less than 35 hours a week in these sources. FT status for the purposes of benefit eligibility for regular—as opposed to temporary or on-call—workers varies across industries and firms, however. Under the ACA, FT status for the purpose of determining employer responsibility to provide health insurance is 30 hours or more a week.

*Temporary workers* are employed through staffing agencies or directly with an employer, whether on a FT or PT basis, with the expectation that the job is not permanent. For temporary agency employees, assignments with a particular firm may last a day, or they may continue for several years. Seasonal jobs during peak periods such as harvests, the holiday shopping season, and the summer tourist season also make up a form of

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temporary employment. While the staffing industry developed as a way to fill in for workers on leave, procure extra labor during rush periods, and provide recruitment services to fill permanent positions, it is increasingly being used as a long-term cost-saving solution. Other labels used by the staffing industry and employers include contract work and on-call work. Temp workers face job insecurity, lower pay, few if any benefits, and weaker occupational health and safety protections. Industry-level data on employment services (NAICS 7613) identifies some share of the temporary labor force, but staffing and labor contracting agencies are often categorized under the industry that they primarily serve rather than under the employment services sector.

Independent contractors include legitimate self-employed workers (but those who own incorporated businesses), such as an independent plumber who provides services directly to homeowners, and employees misclassified as independent contractors, such as many janitors and construction workers. The distinction between the two types of independent contractors lies in whether the individual is selling a product or service and has primary control over how the work is performed, or is working under some form of regular supervision.

Unfortunately, these distinctions are not captured in official data. As a result nonstandard workers are undercounted. The last study conducted by the Department of Labor on contingent labor, dated 2005, estimated that nonstandard workers made up 27% of the US labor force. More recently, the Iowa Center for Public Policy conducted a survey for the US Department of Labor from which they estimated the share of nonstandard workers at 40%. Given the limitations of data available at the state level, we rely on proxies—self-employment for independent contracting/freelance and the employment services industry for temporary employment in general—to estimate trends in nonstandard employment and health insurance access.

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8 Dietz, op cit.

A GROWING SHARE OF PRIVATE SECTOR JOBS ARE NON-STANDARD

Nonstandard work now accounts for nearly a third of private sector employment in Washington, or about 916,000 workers according to an analysis of Current Population Survey (CPS) data. Although this figure likely undercounts the share of jobs that are nonstandard, a conservative estimate shows an increase from 27.8% in 2007 to 31.7% in 2010, the latter figure exceeding the late peak of 29.6% in 2004. Figure 1 illustrates the annual share of nonstandard workers—counting PT and self-employed workers—as a percentage of private sector workers in Washington from 2000 to 2010. Because the CPS does not capture several kinds of nonstandard workers—including temporary and on-call workers employed directly by firms, and some workers hired via labor contractors—the data in Figure 1 is excludes many nonstandard workers. In addition, the CPS sample was too small to distinguish temporary staffing agencies, for Washington, but data from the state Employment Security Department and the national estimates presented later in this paper indicate that they would add another 1-2%.

Figure 1

Nonstandard Employment Share Growing in Washington Private Sector

Combined PT and Self-Employed/Not Incorporated Share of Private Sector Employment

Source: Author’s analysis of 2001-2011 CPS ASEC, for 2000-2010 data years. Nonstandard employment categories include self-employed, not incorporated workers and PT wage and salary workers. Universe is all private sector workers.
Washington State labor market review analyses confirm that this trend continued through 2011 representing a shift toward more PT and seasonal employment in the labor market. A state Employment Security Department analysis of CPS data from 2007 to 2011 found that PT employment grew twice as fast as FT, with those working FT dropping by 5% and while PT employment rose by 10%. State analysts found that this increase in PT employment has been a primary factor driving down overall median household earnings and resulting in a decrease in the percentage of people with employer sponsored insurance.¹⁰

**PART-TIME JOBS MORE LIKELY TO BE FILLED BY PRIME AGE WORKERS**

Data also show that the recession intensified the increase in nonstandard employment, not just among all workers, but that prime age workers as well – those 25 – 64 who are most likely to be those wage earners on which families rely. Overall, about one out of four private sector wage and salary workers—and about one out of five private sector workers age 25-64—worked PT in 2010. **Figure 2** illustrates changes in the share of private sector workers who worked PT, i.e., who reported an average of less than 35 hours a week in the reference year. This likely underestimates the extent of PT employment because workers who worked 35 or more hours a week through two or more jobs are recorded as working FT. Regardless, the figure shows that the PT share of employment in Washington increased significantly during the recent downturn: 26.4% of private sector wage and salary workers reported working PT in 2010, the highest rate since 2000, and nearly 5 percentage points higher than the 2005 ratio of 21.6%. The same pattern applied to private sector wage and salary workers age 25-64, ending with a high of 19.4% in 2010.

**Figure 2**

Part-Time Employment Share in Washington Increased During Recession

*PT Share of Private Sector Employees*

*Washington, 2000-2010*

![Graph showing the increase in part-time employment share in Washington, 2000-2010.](image)

Source: Author’s analysis of 2001-2011 CPS ASEC, for 2000-2010 data years. Universe is private sector wage and salary workers.

**PRIME AGE WORKERS DRIVEN TO PART-TIME WORK**

Historically, most people who worked PT did so voluntarily because of care giving, work obligations, school, and—in the case of retirement-age workers—because of Social Security limits on earnings. However, as private sector employers seek to cut labor costs, workers are not arriving at PT work arrangements by choice, but are pushed into these forms of employment because they are unable to find FT employment. In fact the share of prime working age adults (25-64) who are working PT involuntarily has more than doubled since onset of the recession. In 2009, for the first time the rate of prime working age adults who are working PT involuntarily exceeded those working PT by choice.
Even after excluding young workers and retirees by narrowing the universe to 25-64 year olds, most PT employment just ten years ago was voluntary. Since 2007, however, there has been a steady increase in the share of workers reporting involuntary PT employment—i.e., those who reported that they worked PT because they couldn’t find a FT job or because there was not enough work at their place of employment (Figure 3). After hovering steadily near 20% through most of the 2000s, the rate of involuntary PT employment among 25 to 64 year old private sector PT employees has more than doubled between 2007 and 2010, from 19.7% to 42.9%, as revealed by responses to a CPS ASEC question about the reason that people worked less than 35 hours a week during any period in the previous year.

State labor market analyses indicate that despite economic growth in Washington since 2010 rates of involuntary PT employment and marginally attached employment, have remained above the national
average. The Washington Labor and Economic Annual Report notes that during the economic recovery the number of discouraged workers, marginally attached workers and those working PT involuntarily increased more than the number of all unemployed workers. Beginning in the second half of 2010 the percentage of such workers in Washington grew higher than the nation as a whole. By 2012, it was at 17%, two percentage points higher than the national average.\textsuperscript{11}

\underline{TEMPORARY EMPLOYMENT RISING AGAIN}

Temporary employment changes with the economy. When economic activity goes down, businesses cut costs by eliminating the workers to whom they have the least commitment: the temps. When the economy is growing, businesses keep labor costs low by hiring staffing services agencies to bring in temp workers, to whom no benefits are owed, and who can be terminated quickly. Figure 4 reflects the pro-cyclical nature of temp work, drawing on data for Washington from the U.S. Bureau of Labor Statistics’ Quarterly Census of Employment and Wages (QCEW), which is based on state unemployment insurance data.

After peaking at 2.3% in 2007, Employment Services’ share of total private sector wage and salary employment dropped to 1.5% in 2009. It then began a gradual climb back up, to 1.8% in 2011. These changes are closely tracked by absolute employment in the industry. As the economy is recovering, a larger share of employment is comprised of temporary work. As discussed in the Introduction, the Employment Services industry (NAICS code 5613) captures only a portion of temporary work. However, data for this industry can be used to infer overall trends in temporary employment.

Nonstandard jobs are not evenly distributed across industries, but are more prevalent in certain sectors. Both PT employment and self-employment are concentrated in service sectors that are more likely to pay low wages to their employees such as the food service, entertainment, retail and social/educational services sectors.

Figure 5 shows the share of workers in each industry who reported working PT in 2010, by age group—18 years and older and the 25-64 years old sub-group. Because of state sample size limitations in CPS ASEC, which provides valuable data on employer-sponsored insurance, data are presented for the US. Construction, Manufacturing, Utilities, Wholesale, Information, Finance/Insurance/Real Estate/Rental, and Professional/Scientific/Technical services have low-rates of PT employment.
The remaining industries in the service economy rely much more heavily on PT workers, in particular Retail (29.7%), Educational Services (27.8%), Social Assistance (32.4%), Arts/Entertainment/Recreation (34.9%), and Food Services (43.3%). These sectors, led by Food Services, also rely more on younger and older workers (i.e., not 25-64) to provide PT labor than do other sectors. It should be noted that some sectors set a threshold for FT status for the purpose of benefit eligibility that is somewhat lower than 35 hours. Workers who meet this threshold are still classified as PT in the official data.
Figure 5

Service Industries Rely Most Heavily on PT Labor

Source: Author’s analysis of CPS ASEC 2011. Universe is private sector wage and salary workers. Denominator is the number of workers who reported that the longest job held in the reference period was in that industry.
Six sectors hold the largest shares of private sector PT employees and/or rely the most heavily on PT labor. In fact, nearly two thirds of all PT jobs are in these industry sectors. **Table 1** calculates a “part-time reliance quotient.” This number is the industry’s share of private sector PT workers divided by its share of the total workforce at the US level. It also gives the average annual earnings for industry workers in Washington. Retail, Food Services, and Health Services together account for nearly 52% of PT workers in the US. Educational Services, Social Assistance, and Arts/Entertainment/Recreation make up another 12.4%. Among the top three sectors, the PT reliance quotient is slightly above average in Health Services (112%), high in Retail Trade (156%), and extremely high in Food Services (227%). Rates of PT worker utilization vary within each of these sectors. For example, PT workers in Educational Services and Social Assistance are concentrated in preschools/daycare services and homecare services, respectively. These services are also characterized by lower wages than the average for the broad sectors to which they belong. The average annual earnings in all these industries except Health Services are below two-thirds of Family Median Income in Washington State.
### Table 1

**Six Service Industries Account for Nearly Two-Thirds of PT Employment**

*Top Industries for PT Labor*

**US, 2011**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Share of PT Workers US (A)</th>
<th>Share of Workers US (B)</th>
<th>PT Reliance Quotient (A/B)</th>
<th>Average Annual Earnings, All WA</th>
<th>Percent of Family Median Income WA*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Trade</td>
<td>22.2%</td>
<td>14.2%</td>
<td>156%</td>
<td>$30,922</td>
<td>43%</td>
</tr>
<tr>
<td>Food services</td>
<td>16.2%</td>
<td>7.2%</td>
<td>227%</td>
<td>$17,152</td>
<td>24%</td>
</tr>
<tr>
<td>Health services</td>
<td>13.4%</td>
<td>12.0%</td>
<td>112%</td>
<td>$51,080</td>
<td>72%</td>
</tr>
<tr>
<td>Educational services</td>
<td>5.2%</td>
<td>3.6%</td>
<td>146%</td>
<td>$35,569</td>
<td>50%</td>
</tr>
<tr>
<td>Social assistance</td>
<td>3.5%</td>
<td>2.1%</td>
<td>170%</td>
<td>$22,836</td>
<td>32%</td>
</tr>
<tr>
<td>Arts, entertainment and recreation</td>
<td>3.7%</td>
<td>2.0%</td>
<td>183%</td>
<td>$24,946</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64.3%</strong></td>
<td><strong>41.1%</strong></td>
<td><strong>156%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


The heavy reliance of businesses in these sectors on PT labor represents a significant challenge to Washington job-seekers in need of FT employment. According to Washington’s Job Vacancy Survey Report, five of these six industries accounted for 68 percent of all job vacancies in spring of 2012\(^2\). Although the survey report does not distinguish between PT and FT job vacancies, the PT reliance quotient of these six industries and the amount these jobs pay suggest that a significant portion of vacancies are likely PT and low wage. This goes a long way toward explaining why workers feel forced into PT work in lieu of FT.

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Professional self-employed workers, including those who work as independent contractors, tend to have high earnings and greater control over their work. Business and Waste Management and Remediation services and Other Services primarily consist of temporary, building services, and personal services work. Yet this is not the case for all self-employed workers. Those in Transportation/Warehousing and Social Assistance are
more likely to experience meager earnings and/or poor working conditions over which they have little control—for instance, taxi drivers, short-haul truck drivers, and family-based day care providers.

Finally, self-employment among 25–64 year old workers is concentrated the following sectors: Construction (19.0%), Professional/Scientific/Technical Services (11.6%), Other Services (10.1%), Financial/Insurance/Real Estate/Rental (6.1%), Business and Waste Management and Remediation Services (9.5%), and Retail Trade (7.5%) (Figure 6). Together, they account for 64% of self-employment. These can be more broadly grouped as construction, high-skill professional services, and temp work/low-skill services.

**EMPLOYERS MISCLASSIFY WORKERS AS CONTRACTORS WHO LEGALLY QUALIFY AS EMPLOYEES**

A special case of nonstandard work under self-employment consists of the misclassification of employees as independent contractors. This occurs when firms pay workers as contractors even though they meet the legal definition of being an employee under federal and state regulations, usually in order to cut costs. A 2000 study by the U.S. Department of Labor based on an audit of nine states found that up to 30% of firms misclassify workers as independent contractors. And in 2007, state auditors collectively identified over 150,000 misclassified employees. Since these were from audited firms, this figure likely represents a small fraction of the real total. Furthermore, a review of official studies on misclassification by the National Employment Law Project (NELP), notes that the studies focus on employers that participate in state Unemployment Insurance programs and do not capture employers that operate entirely off the books.

Based on existing state level studies, NELP also found that misclassification is more common in specific industries including “construction, real estate, home care, trucking, and high-tech.” Most of these sectors can be found on the left side of Figure 6, among the industries the highest concentrations of self-employed workers. The significance for the purposes of this paper is that misclassified workers lose out in terms of job-based benefits and labor protections legally due to employees, including employer-sponsored health insurance under the ACA effective 2014.

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15 Ibid.
NONSTANDARD WORKERS HAVE POOR ACCESS TO HEALTH INSURANCE

Even as the nature of employment has changed, Congress and state governments have institutionalized employer-sponsored health insurance (ESI) as the leading mechanism by which households obtain health insurance. Given that a substantial share of private sector workers in Washington are engaged in nonstandard work, what kind of health insurance access do they have?

Not surprisingly, nonstandard workers are less likely than other workers to be insured at all and make up a disproportionate share of the population lacking any kind of health insurance in Washington. Table 2 presents uninsured rates for PT workers (including the age 25-64 subgroup) and self-employed, unincorporated workers; and their shares of the total uninsured population in Washington, drawing on the American Community Survey (ACS) 3-year data for 2008-2010. Nearly 30% of PT workers nearly 25% of self-employed, unincorporated workers are uninsured, meaning that they did not have any kind of insurance, whether private or public. Together, this group makes up over 23% of the uninsured population in the state. Nearly 30% of PT workers age 25-64 are uninsured—a higher rate than the general PT workforce, likely due to less access to dependent coverage and public insurance—and make up 10.3% of the state uninsured population.
Table 2

Nonstandard Workers Are High Risk of Being Uninsured

*Washington, 2008-2010*

<table>
<thead>
<tr>
<th></th>
<th>Share of Total Population</th>
<th>Share of WA Uninsured</th>
</tr>
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<tbody>
<tr>
<td>PT age 25-64</td>
<td>4.7%</td>
<td>29.2</td>
</tr>
<tr>
<td>PT all ages</td>
<td>8.8%</td>
<td>24.6</td>
</tr>
<tr>
<td>Self-employed/uninc</td>
<td>3.4%</td>
<td>29.2</td>
</tr>
<tr>
<td>WA residents age 25-64</td>
<td>54.6%</td>
<td>16.6</td>
</tr>
<tr>
<td>All WA residents</td>
<td>100.0%</td>
<td>13.5</td>
</tr>
</tbody>
</table>

Source: Author’s analysis of ACS 2010 3-year sample.

Data suggest that participation rates have fallen since 2003 because of lower employer offer rates and increasing costs to employees. Our analysis shows that the vast majority of PT workers do not have access to ESI through their own job; estimates of PT workers’ participation in ESI range from 13% to 17% in 2010-2011. In the staffing services industry, FT employees are half as likely as other private sector workers to participate in ESI. Self-employed workers who must rely on family ESI or else purchase a plan through the individual market are significantly less likely to have any type of private insurance than private sector workers in general. Furthermore, there are significant variations in health insurance access by wage level, income, and industry. ESI and private health insurance access rates by industry and income/wage levels show clear patterns of disparity.

Many of the same industries found to be heavily reliant on PT labor also offer less access to ESI including Food Services, Social Services, Other Services, and Retail. Private sector businesses in these industries chase a competitive edge primarily by lowering labor costs rather than investing in human capital development. Self-employed workers are least likely to participate in any kind of private insurance in the following sectors: Transportation and Warehousing, Construction, Business Services (including the staffing industry), Food Services, Other Services, and Social Assistance.
PT WORKERS LACK BASIC ACCESS TO HEALTH INSURANCE

Overall, 4 out of 5 private sector PT workers do not have access to health insurance through their own job. This number is also disturbingly high for prime age working adults (ages 25-64) among whom 3 out of 4 cannot get coverage through their employers. Even when PT workers have access to coverage, actual enrollment is low. Using estimates calculated from the MEPS 2011 survey, 22.9% of private sector PT workers in Washington are eligible to participate in an employer-sponsored health insurance plan through their own jobs, and only 13.4% are actually enrolled. Using CPS data, 16.9% of private sector PT workers in Washington participated in a health insurance plan through their current or former employer at any time during 2010. The rate was 26.0% in the age 25-64 subgroup. Table 3 presents several estimates of PT workers’ access to ESI among private sector employees in Washington, distinguishing by age and firm size where possible.

16 Author’s calculations of eligibility and take-up as a percentage of the total PT workforce is based on MEPS tabulated data on the percentage of workers that are employed by firms that offer health insurance, and the eligibility and take-up rates within that population.
### Table 3

**Estimates of PT Workers’ Access to Employer Sponsored Health Insurance**

*Washington State*

<table>
<thead>
<tr>
<th>Data Source and Year</th>
<th>Total</th>
<th>&lt;50 Employees</th>
<th>50+ Employees</th>
<th>1000+ employees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEPS - 2011</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td>22.9%</td>
<td>8.8%</td>
<td>33.1%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Enrollment</td>
<td>13.4%</td>
<td>6.2%</td>
<td>18.7%</td>
<td>26.1%</td>
</tr>
<tr>
<td><strong>CPS - 2010</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation</td>
<td>16.9%</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Participation, age 25-64</td>
<td>26.0%</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>CPS - 2006-2010 5-year average</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation</td>
<td>20.2%</td>
<td>11.9%</td>
<td>25.6%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Participation, age 25-64</td>
<td>28.7%</td>
<td>16.4%</td>
<td>37.0%</td>
<td>44.1%</td>
</tr>
</tbody>
</table>

*Notes: CPS estimates include participation in a health plan related to the each worker’s current or former employer.*

Employees of smaller firms are much less likely to have access to employer-sponsored health insurance than those in larger firms (as shown in Table 2). According to 2011 MEPS data, only 6.2% of PT employees of small firms (less than 50 workers) were enrolled in a company health plan offered by their employer, compared to 26.1% of those in very large firms (1,000 or more workers). CPS-based estimates for 2006-2010 provide a similar contrast in participation between small firms (11.9%) and very large firms (30.4%).

---

**PT WORKERS LOSING JOB-BASED COVERAGE**

Since 2003 participation in job-based health insurance for all private sector PT workers fallen, including those prime age workers in the job age 25-64 subgroup. The peak in the last decade was in 2003 for both
categories. For all PT workers, the rate was 27.1% in 2003; but by 2010 the rate was only 16.9%, reflecting a statistically significant decrease.\textsuperscript{17} The estimated rate of job-based health insurance participation for PT workers age 25-64 declined from 33.2% in 2003 to 26.0% in 2010.

**Figure 7**

**PT Workers’ Access to Job-Based Health Insurance Has Declined since 2003**

*Share of PT Workers Who Are ESI Policyholders*

*Washington, 2000-2010*

During the economic downturn, access to ESI in Washington declined across the labor market, and PT workers experienced a greater reduction in access than FT workers.\textsuperscript{18} There are two reasons for this decline. First, fewer employers are offering insurance to any of their PT workers. According to the Washington Employment Security Department Employee Benefits Survey, the share of employers that offer health

\textsuperscript{17} Statistically significant at 95% confidence level.

insurance to any of their PT workers declined from 14.2% in 2006 to 12.1% in 2012.\textsuperscript{19} Second, employers are imposing higher cost-sharing to employees and downgrading health plans, so that plans are less affordable for workers and offer less benefit. For instance, employee premium contributions for family coverage nearly tripled between 1999 and 2012, the share of employees enrolled in high-deductible health plans increased from 4% in 2006 to 19% in 2012.\textsuperscript{20} The impact of rising costs to employees is evidenced in the MEPS Insurance Component survey, which yields a statistically significant decline in the percentage of eligible PT employees that were enrolled in ESI, from 70% in 2008 to 53% in 2011.

Even among PT workers access to health insurance coverage is not equal. Those who work for lower wages experience greater disparity in coverage: workers employed by firms in the lowest earnings quartile are only 6% likely to be enrolled compared to 45% likely to be enrolled for those employed by firms in the highest quartile (\textbf{Figure 8}).


TEMPORARY WORKERS HALF AS LIKELY TO HAVE JOB-BASED COVERAGE

Temporary workers whether FT or PT are much less likely to participate in job-based health insurance as in the economy as a whole (Figure 9). Data for the US is presented because of limited sample size for Washington. In the Employment Services sector, only 3 out of 10 FT workers (30.3%), and 1 out of 10 PT workers (10.1%) were policyholders for job-based health insurance at any time in 2010, compared to 59.7% and 16.4%, respectively, among all private sector employees. That is, FT temp workers are half as likely as the private sector employees in general to have ESI and PT temp workers are two-thirds as likely.

The temp industry tends to frame the low rates of health insurance coverage in terms of worker choice, pointing out that the rate of uptake is low because of high turnover and because workers move on to more
permanent jobs. However, the data presented here for temp workers includes only those who reported that their longest job during the reference year was in the Employment Services sector. This would indicate that workers who rely on temp work not as a short-term stepping stone or source of “supplemental” income, but as their primary source of employment, have difficulty accessing job-based health insurance in the staffing services industry. Limiting the population to prime working age temp workers—25-64 year olds—slightly increases the rate of job-based health coverage slightly to 12.2% for PT, but actually decreases it to 55.1% for FT.

Furthermore, only 57% of workers in the Employment Services industry versus 74% for all private sector wage and salary workers have any kind of private health insurance coverage, according to further analysis of CPS ASEC data by the author. This indicates that temp workers are not simply relying on other sources of coverage, e.g., another family members’ employer health plan or the individual market, and highlights the existence of structural barriers to health insurance access within the staffing services industry.

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MOST SELF-EMPLOYED WORKERS WITH LOW INCOMES LACK INSURANCE

In general, self-employed/not incorporated workers do not have access to a group health insurance plan through their own employment. If they cannot get coverage as a dependent on a family member’s job-based group plan, they can theoretically purchase insurance on the individual market—if they have enough income to do so.

Figure 10 shows private health insurance coverage among self-employed/not incorporated workers who were “substantially” employed during the year, defined here as working 30 or more hours per week for at least 40 weeks, in 2006-2010. These made up nearly 160,000 of the annual average of 267,000 self-employed/not incorporated workforce in Washington. Looking at the first column, a significant share of substantially self-employed workers, 37.4%, did not have private insurance coverage at any time during the year. Limiting the population to age 25-64 (38.1%) makes little difference.
Two out of Five “Substantially” Self-Employed Workers Lack Private Health Insurance

Private health insurance coverage among self-employed, not incorporated workers who worked 30+ hours/week for at least 40 weeks
Washington, 2006-2010

However, there is marked income-based disparity among self-employed workers’ access to insurance. A majority (57.7%) of substantially self-employed workers in families whose incomes were $50,000 a year or less have no private health coverage, compared to 24.0% of those in families with incomes of $100,000 or more. In general, self-employed workers in high skill jobs tend to earn enough to purchase private insurance, and are more likely to have a spouse or domestic partner with access to family health insurance through their job. Low-wage self-employed workers, on the other hand, find it expensive to purchase quality private insurance and are less likely to have family members with access to affordable job-based family plans.

PT WORKERS IN SERVICE SECTORS HAVE LOWEST RATES OF JOB-BASED COVERAGE

Not only do PT workers have less access to health insurance through their employers, but those who work for low wages in the service industry are most likely to be uninsured. Figure 11 ranks major industries based on PT workers’ participation in employer-sponsored health insurance through their own job. The universe is limited to the 25-64 age group in order to exclude the effects of Medicare eligibility among older adults and some young adult’s student status and eligibility to be included in their parents’ insurance. Low-wage,
service sectors have the lowest rates of PT worker participation: Food Services (15.2%), Agriculture (13%), Other Services (12.6%), Social Assistance (12.6%), and Business Services (12.5%). Retail, a sector that also relies heavily on PT workers, comes in at 22.9%, slightly below the US private sector PT average of 23.5%.

The industry categories above do not tell the whole story, however. Within the sector categories, analysis by subsector also reveals large differences. In retail, motor vehicle dealers and grocery stores have the highest participation in ESI among PT workers, exceeding 30%, while retail sectors dominated by small establishments tend to have roughly half as much participation. Within Social Assistance, the direct care industry offers particularly low access; only 6.7% of vocational rehabilitation and 9.9% of child day care services participate in ESI. The Other Services sector is comprised mostly of personal services such as hair salons, nails salons, and dry cleaners and is dominated by small businesses. Within business services, the sectors with significant PT employment and particularly low rates of access to ESI include staffing services (11.1%), building cleaning and maintenance (10.6%), and landscape services (5.5%).

Significantly, major retail and food service chains—led by Walmart, McDonalds, Safeway, Kroger, Yum! Brands, and Jack in the Box—make up a large majority of the top 30 firms ranked by the number of workers most workers reliant on publicly subsidized health care through the Washington State Department of Social and Health Services (DSHS).22

Finally, access to health insurance among substantially self-employed/unincorporated workers (those working at least 30 hours a week for 40 or more weeks during the year) also varies significantly across industries. Figure 12 ranks US non-farm industries by workers’ participation in private health insurance of any kind—through their employer’s group insurance, as a dependent in a family members’ ESI, or through the individual market. The self-employed farm sector is excluded for the purpose of this analysis because most self-employed farmers are essentially business owners.

Notably, the sectors highlighted by NELP as having high rates of employee misclassification as independent contractors are the lowest ranked in terms of self-employed workers’ participation in private health insurance: Transportation and Warehousing (52.2%), Construction (48.0%), Business services (46.4%), Food Services (54.6%), and also Social Assistance (58.1%). These rates may appear high in comparison to ESI access among PT workers, but a more appropriate point of comparison is the rate of private health insurance (including ESI and individual market) coverage for all US private sector wage and salary workers, 73.5%. All except the high-skill industries compare unfavorably to this figure.

PT Workers’ Access to Job-Based Insurance is Lowest in Services, Construction, and Agriculture

Source: Author’s analysis of CPS ASEC, 2011. Universe is private sector wage and salary workers age 25-64.
Figure 12

“Substantially” Self-Employed Workers’ Participation in Private Health Insurance

Source: Author’s analysis of CPS ASEC, 2011. Universe is self-employed, not incorporated workers who worked at least 30 hours a week for 40 or more weeks during the reference year.
True access to health insurance for workers is not determined solely by employer rates and eligibility criteria. Access to coverage also depends on the cost and quality of plans. Multiple factors affect cost and quality and can represent significant barriers to coverage: the employee’s share of insurance premiums, cost-sharing through deductibles, co-pays, and other out of pocket costs heavily influence whether or not employees are able to buy-in and maintain insurance.

Data from the Kaiser Family Foundation Employer Benefits Annual Survey provides valuable national data on these issues. Premium data is not available for PT workers, but survey data indicate that between 1999 and 2011, the average amount paid by workers towards ESI premiums increased from $28 to $77 a month for single coverage and from $129 to $344 for family coverage. The share of health insurance premiums paid by insurance varies across major industries. Workers in Retail pay the greatest share: 25% for single coverage and 35% for family coverage, compared to the average rates of 18% and 28%, respectively in 2011.23

Cost-sharing is another determinant of the cost of health plans to workers. For example 16% of workers in Health Maintenance Organizations and 81% in Preferred Provider Organizations have some kind of deductible. It goes without saying all workers in High Deductible Health Plans (HDHPs)—31% of all workers with ESI—have a deductible, with a minimum of $1,000 depending on plan type. Other cost-sharing mechanisms include co-pays and co-insurance.

HDHPs are common among small businesses and in the individual market, and increasing in usage among larger firms, where they are often paired with employer-funded pre-tax health spending accounts.24 A Towers Watson survey of large employers found that 29% said they would offer a high deductible plans paired with spending accounts such as a Health Reimbursement Account (HRS) or Health Spending Account (HSA) as the default option for eligible employees in 2013.25


For self-employed workers, including employees misclassified as independent contractors, the plans that they can afford on the individual market are usually HDHPs. One study found that “More than half of Americans who had individual insurance in 2010 were enrolled in plans that would not qualify as providing essential coverage under the rules of state health insurance exchanges in 2014.”26 These plans will pay, on average, less than 60% of the cost of participants’ health care.

Unfortunately, plans with high levels of cost-sharing, like HDHPs, are proven to cause people to self-ration and delay necessary care. One study focused on individuals with chronic health conditions found that the odds of delaying or foregoing care were “three to four times greater for adults and children in HDHP families compared to traditional plan families.”27

Lastly, some “insurance plans” are not really insurance plans at all. The Iowa Public Policy Center survey of nonstandard workers found that while 82 percent of employed respondents reported having health insurance, “some had only a medical discount plan, reducing the real coverage rate ... to 78 percent.”28 Medical discount plans are not true insurance, offering only negotiated discount rates from participating healthcare providers for a monthly fee.

Similarly, many low-wage service sector employers only offer “limited benefit” insurance policies that provide insurance coverage that is capped at amounts ranging from less than $100 a day to more than $250,000 a year. While these plans are more affordable, they can leave workers catastrophically underinsured if their health care requires more than a couple of office visits.

The case study below presents a key example of some of the above dynamics at work for nonstandard workers in the retail grocery industry.

**CASE STUDY: PART-TIME HEALTH BENEFITS IN THE GROCERY SECTOR**

The retail sector, including the grocery sector, relies heavily on PT workers. In 2011 there were about 308,000 workers in the retail sector in Washington State, including 50,000 in supermarkets and other


28 O’Connor et al., op cit., p. vi.
Nationally, about 34% of retail workers and 43% of grocery store workers work PT. The grocery sector has somewhat higher rates of employer sponsored insurance (ESI) participation among PT workers than the retail sector as a whole (17% versus 12%), due to the significant level of unionization. Union grocery employers in the Puget Sound region include Safeway, Albertsons, QFC and Fred Meyer (both Kroger companies), and other independent and regional companies that negotiate with United Food and Commercial Workers (UFCW). Walmart, the largest grocery employer, is not unionized. Neither is Whole Foods, another national grocery chain with a growing presence in Western Washington.

There are two significant trends in PT health insurance in the grocery sector in Washington. One is the trend towards reduced benefits for PT workers at key firms in terms of eligibility criteria—including average number of hours worked per week and waiting periods—and costs borne by workers. The other is marked disparity between union and non-union grocers on each of these counts.

*Eligibility for individual and dependent coverage.* Nearly 30% of grocery employees work less than 35 hours a week, but the actual threshold for FT-level health benefits varies across firms, as does the level of benefits available to PT workers.

For instance the FT health benefit threshold is 34 hours a week at Walmart, which recently tightened eligibility criteria for its health insurance plans. In the late 2000s, the company began offering insurance to all PT workers and reduced their waiting period from two years to one year. These changes increased the rate of ESI participation among Walmart workers in the US from 45.5% to 50.2%. However beginning in 2012, citing increased costs, Walmart eliminated health insurance coverage for new Associates who work less...

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29 QCEW 2011.
30 Author’s calculations from CPS ASEC, 2011.
31 Unless otherwise stated, data for Walmart, Whole Foods, and union grocers, respectively, are from Walmart’s “2012 Benefits Book” and “2012 Enrollment Guide”; and Whole Foods’ “2012 Team Member Advantage Program Enrollment Guide”; and UFCW Local 21.
32 FT benefits are set by each firm, and generally include family/dependent coverage. Benefits extended to PT workers may include longer waiting periods, limited eligibility for coverage other than individual coverage, and greater cost-sharing.
than 24 hours a week on average, and eliminated spousal and family coverage (but retained employee plus child coverage) for new Associates who work 24-33 hours a week.  

At Whole Foods, the eligibility threshold for FT health benefits is 30 hours a week. The firm offers individual and family health coverage to PT workers who work an average of 20-29 hours a week, but at a significantly higher premium cost than FT workers with 800 or more service hours.

Union grocers have the lowest threshold for health benefits: 60 hours a month (approximately 14 hours a week) for individual coverage and 80 hours a month (about 18.5 hours a week) for family/dependent coverage. All workers above these thresholds receive the same employer contributions toward healthcare.

**Waiting periods.** In industries characterized by high turnover, such as retail, long waiting periods can winnow down the share of PT workers who participate in their employer’s health plan. Walmart PT workers who work 24-33 hours a week must wait one year (360 days) before they can be covered. Whole Foods PT workers who work 20-29 hours a week must wait until they have worked 400 hours, which translates to approximately 93-140 days. Union grocery workers have the shortest waiting period: those who work at least 15 hours are eligible for coverage after three months.

**Premiums, Deductibles, and Maximum Out of Pocket Costs.** Grocery employers each provide a range of health plan options for PT workers in term of costs and benefits. At some firms, the plans with the lowest premiums can have extraordinarily high deductibles, while more generous plans may have premiums that a typical PT worker would not be able to afford. For the sake of comparability, this section examines basic plans that cover 80% of medical service costs after any deductible, and which would likely be chosen by a worker with moderate healthcare needs given the premium-deductible trade-offs among available plans. Table 4 compares the cost structures of these plans for Walmart, Whole Foods, and union grocery employees in Washington.

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Table 4

Cost Structure of Selected Health Plans for PT Grocery Workers – New Hires

<table>
<thead>
<tr>
<th>Plan Name/Type</th>
<th>Walmart</th>
<th>Whole Foods</th>
<th>Union Grocers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HRA enhanced (PPO)</td>
<td>Team Member Advantage Plan (PPO)</td>
<td>Sound Health &amp; Wellness Plan B (HMO)</td>
</tr>
<tr>
<td><strong>Annual premium paid by employee</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$1,256 non-tobacco</td>
<td>$2,575 non-tobacco</td>
<td>$260</td>
</tr>
<tr>
<td></td>
<td>$2,114 tobacco</td>
<td>$2,835 tobacco</td>
<td></td>
</tr>
<tr>
<td>Employee + spouse</td>
<td>not eligible</td>
<td>$7,210</td>
<td>$780</td>
</tr>
<tr>
<td>Employee + children</td>
<td>not eligible</td>
<td>$6,179</td>
<td>$468</td>
</tr>
<tr>
<td>Family</td>
<td>not eligible</td>
<td>$10,814</td>
<td>$988</td>
</tr>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$1,750 individual</td>
<td>$2,200 individual</td>
<td>$250 individual</td>
</tr>
<tr>
<td></td>
<td>$2,200 family</td>
<td>$1,100 prescription deductible</td>
<td>$500 family</td>
</tr>
<tr>
<td><strong>Routine preventive care</strong></td>
<td>$0, not subject to deductible</td>
<td>$0, not subject to deductible</td>
<td>$0, not subject to deductible</td>
</tr>
<tr>
<td><strong>Employee cost for office visits</strong></td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Employee cost for hospital services</strong></td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Employee cost for other non-routine services (exc. preventive care)</strong></td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Maximum out of pocket</strong></td>
<td>$5,000</td>
<td>$6,600 medical/$2,200 prescription</td>
<td>$2250 individual/$4500 family</td>
</tr>
<tr>
<td><strong>Employer Funded Health Expense Account (e.g., HRA)</strong></td>
<td>$250 per year individual</td>
<td>None for 20-29 hrs/week $0-1,800/year for 30+ hrs/week depending on hours worked</td>
<td>$500 individual $1,000 family for in-network expenses</td>
</tr>
</tbody>
</table>

To begin, Walmart and Whole Foods both rely primarily on several high-deductible plans through PPO networks for PT workers, with HMO plans offered at a much higher cost. Union grocers offer both a PPO and an HMO plan with a modest deductible. Union employers pay for a much larger share of insurance premiums for PT workers, evidenced by the low premium costs borne by their employees compared to Walmart and Whole Foods employees. Union workers pay $260 a year, while Walmart employees who do not smoke pay nearly five times as much ($1,256 for non-tobacco users) and Whole Foods employees pay ten times as much ($2,575 for non-tobacco users).35

Whole Foods has the highest deductibles, after raising individual deductibles to $2,000 for medical and $1,000 for prescriptions in 2011 and again to $2,200 and $1,100, respectively, in 2012. The Walmart plan has an individual deductible of $1,750. The union grocery plan has a modest deductible of $300 for individuals.

Maximum out of pocket costs (the threshold for employee spending on qualified expenses, after which the insurance plan pays 100% of costs) varies from $2,250 individual/$4,500 family in the union plan to $6,600 at Whole Foods in addition to a separate $2,200 prescription deductible. Most employers fund some type of health expense account such as a Health Reimbursement Account (HRA) to defray part of the deductible and/or coinsurance costs in high deductible plans. The union plan offers $500 for individuals and $1,000 for families, and Walmart offers $250. Whole Foods excludes PT employees who work less than 30 hours a week from this benefit.

Notably, all three plans offer routine preventive care—such as annual exams and mammograms—at no cost to the employee, not subject to the deductible requirement. This is largely due to new requirements imposed by the Affordable Care Act (ACA). However each plan includes a somewhat different array of services under the free preventive care umbrella, with the union plan offering the most extensive array.

What does this all mean in terms of affordability for PT workers? Figure 13 compares health plan affordability for Walmart, Whole Foods, and union grocers in Washington by calculating different types of employee cost as a share of annual wages for an entry level cashier who works 29 hours a week (just under the new FT threshold set by the ACA beginning in 2014). Wages for each firm (with Safeway as a proxy for union grocers) were interpolated by adding one-fourth of the difference between the lowest and highest wage in Payscale.com to the lowest wage figure.

35 Union groceries also offer vision and dental coverage at no cost to employees who work 80 or more hours a month. Whole Foods offers vision and dental at extra cost to PT employees who work at least 20 hours a week. PT workers at Walmart are not eligible for these benefits.
Walmart and Whole Foods Health Plans Are Much Less Affordable than Union Grocer Plan

Annual Health Plan Costs as a Share of Pay for Entry Level Cashier Who Works 29 Hours a Week, Individual Coverage

Source: Health plan costs from Walmart’s “Your Guide to 2012 Annual Enrollment,” Whole Foods Market’s “2012 Team Member Advantage Program Enrollment Guide,” and UFCW Local 21. Minimum employee spending before insurance benefits apply includes premiums plus deductible minus applicable employer-funded health expense accounts. Interpolated 25th percentile estimates of $8.12, $10.22, and $10.20 an hour for Walmart, Whole Foods, and Safeway (for union grocers), respectively, were derived from www.payscale.com wage data for these firms.

The chart reveals a significant difference in the cost burden associated with insurance premiums alone. But the most telling indicator is the share of income that has to be spent in order for insurance benefits to apply, shown in red. By the end of a given year, a worker who received any insurance benefit other than routine
preventive care will have spent a significant percentage of their gross earnings on premiums and qualified medical expenses if they worked at Walmart (25-32% depending on tobacco status) or Whole Foods (31%, not including the prescription deductible). In contrast, a union grocery worker will only have spent 3% of their earnings. Given recent research findings on high deductible plans, this indicates that PT workers in Walmart and Whole Foods health plans face a significant barrier to accessing medical care compared to PT union grocery workers.

High deductible plans are often presented as protection against catastrophic illness. While it is true that the Walmart and Whole Foods plans limits annual out of pocket expenses so that participants are protected from large medical debt, a worker who averages 29 hours a week can expect to spend half or three-quarters of their gross pay on medical expenses in the event of a serious accident or illness. Assuming that most PT grocery workers use their pay for basic living expenses rather than luxuries, these plans do not protect against serious financial hardship from major medical costs. Only the union grocery sector offers real protection, by limiting out of pocket expenses to about 13% of the worker's pay.
CONCLUSION:

Nonstandard workers make up a significant share of the state workforce, but are much less likely to be insured through work than the private sector workforce as a whole. Furthermore, a handful of industries rely heavily on nonstandard workers while offering less access to health insurance compared to other industries. This reflects a low-road labor strategy in which firms avoid responsibility for their workers’ healthcare needs and in effect, externalize these costs onto taxpayers and other employers.

Given these findings, it is clear that nonstandard workers must be incorporated into policy strategies to increase health insurance access and participation and reduce the uninsured rate. However, workers are likely to continue to face serious challenges as healthcare reform takes shape. For regular low- and middle-wage FT workers in larger firms), and not counting family coverage, the impact of the ACA is relatively straightforward: either the employer offers a quality, affordable health insurance plan, or the worker purchases a plan through the state health insurance exchange with a tax subsidy, in which case the employer pays a penalty that partially funds the new system. While PT workers’ hours are counted towards the 50 FTE threshold for large firms, the requirement that employers provide adequate health insurance or pay a penalty applies only to workers who qualify for FT status.

On the one hand, ACA offers increased health insurance coverage opportunities for nonstandard workers through expanded Medicaid for low-income workers among participating states, and access to state health insurance exchanges with income-contingent tax subsidies. However, there are key uncertainties about how nonstandard workers will fare under the ACA that stem in part from firm and industry behavior and in part from recent decisions by regulators regarding how key provisions of ACA will be implemented.

Potential Reduction in Work Hours. The FT threshold under the ACA is 30 hours, but current thresholds vary significantly across industries. Some firms that offer middle class wages and that already have relatively low thresholds for FT benefits may expand coverage to workers that now fall between the 30 hour threshold and existing thresholds for FT benefits which vary across sectors.

Given past trends, however, it is likely that many low-wage employers will reduce worker hours in order to keep them from meeting the 30 hour threshold for employer responsibility. With the high reliance on nonstandard work in low wage industry sectors some workers will be more vulnerable than others to a reduction in work hours. An analysis of CPS data by the UC Berkeley Labor Center indicates that the workers most at risk of reduced work hours under ACA are those working 30-36 hours a week, for wages below 400%
of the Federal Poverty Level, who do not have insurance through their employers. Such employees are heavily concentrated in the Restaurant, Nursing Home, Accommodations, Health Care, Retail Trade, Education and Building Services industries. Many of these workers, already at or below the federal poverty line, will need to juggle two or more PT jobs to afford basics like food and shelter.

Anecdotal evidence in the retail sector indicates that some employers are already reducing work hours. The ultimate effect would be to shift the cost for coverage onto the federally subsidized state health care exchange and state and federally funded Medicaid. Recently the Obama administration announced that it will postpone the implementation ACA’s mandate that larger employers provide coverage for their employees or pay a penalty until 2015. The delay may merely give employers more time to reduce work hours or change employees’ status to avoid the mandate.

**Look-Back Period for Full-Time Status Determination.** One particular issue of concern for temporary and seasonal workers is exactly how FT status is required to be calculated. ACA requires that employers with the 50 or more FT-equivalent employees (FTEs) are required to provide health care to workers working 30 hours a week or more—or else pay a fine. However, IRS rules will allow employers to look back 3-12 months to determine whether a worker meets an average of 30 hours. The staffing industry lobbied intensively for longer rather than shorter look-back periods in order to avoid having to offer insurance or pay penalties in a high-turnover context—in short, to avoid assuming financial responsibility for their workers' health insurance needs. This has the potential to exclude most FT temporary employees from ESI coverage unless they stay with a firm for at least one year.

The staffing industry lobbied for relatively long look-back periods because they are concerned that they will be subject to penalties otherwise. However, the low rate of employer sponsored insurance participation among workers who primarily work in the temp industry, along with a high percentage of uninsured among those workers, supports the idea that the staffing industry needs to pay their fair share of the costs of providing health insurance to its labor force.

36 UC Berkeley Labor Center, February 2013. “Data Brief: Which workers are most at risk of reduced work hours under the Affordable Care Act?” Berkeley, CA.

37 UFCW reports anecdotal evidence from grocery and big box retail workers about increasing difficulty getting enough shifts to meet existing thresholds for health benefit eligibility.


39 See Lenz, op cit.
Independent Contractors. Finally, given that significant share of employers misclassify some employees as independent contractors—in order to avoid payroll taxes and benefits—a critical question remains whether the rate of misclassification will increase as employers seek to evade requirements under the ACA, and whether effective monitoring will be in place to prevent this from happening on a large scale.

In conclusion, the outcomes of ACA reform for nonstandard workers in Washington are uncertain. Some stand to benefit from the ACA—in particular, through eligibility. Because the ACA relies on firms as the key nexus for health insurance provision and ties worker eligibility for subsidized insurance to whether or not employers provide health insurance, and whether or not the employee accepts it, the idea of employer responsibility remains relevant to nonstandard workers’ access to affordable insurance and quality health care.

The disparities in the grocery industry are just one example of the uneven playing field on health insurance that both employers and employees face. Competition from low-road retailers has resulted in grocery strikes as well as legislative proposals to level the playing field. Given this reality, and existing patterns of low-road labor practices among key sectors that rely disproportionately on nonstandard workers, insurance coverage for nonstandard workers should be a priority at the national, state and local levels.
The following is an explanation of key data sources and variables on health insurance coverage used in this study.

The **Medical Expenditure Panel Survey (MEPS)** Insurance Component is an annual survey of employers by the U.S. Department of Health and Human Services/Agency for Health Care Research and Quality. The advantage of MEPS is that it asks employers how many of their workers were actually eligible for the company health plan at a given point in time, and how many were enrolled, distinguishing between FT and PT workers. However, MEPS does not provide data on worker characteristics. A disadvantage is that it the MEPS Insurance Component lacks demographic information about workers and covers only wage and salary employees, and does not allow for detailed industry analysis. Data is released in tabulated form, and microdata for the Insurance Component is not available to the public.

The **Current Population Survey Annual Survey of Economic Conditions (CPS ASEC)**, also known as the CPS March Supplement, is an annual household survey by the U.S. Department of Labor/Bureau of Labor Statistics. It asks a detailed series of questions about household members’ family structure, income, and labor force status. It also includes a series of questions about health insurance coverage that allows researchers to distinguish whether a worker had insurance through their own job (rather than a family member’s). The advantage of this survey is that it allows researchers to determine employer-sponsored insurance coverage of workers through their own job and analyze differences by worker characteristics such as age. A key disadvantage is that the sample size is limited for states the size of Washington, requiring aggregation of several years of data and the use of the national sample to analyze coverage for PT workers.

In most cases, the author accessed CPS microdata available through Integrated Public Use Microdata Series (IPUMS), a project of the University of Minnesota. Most of the IPUMS CPS variables used in this study such as age and class of worker (e.g., self-employed, not incorporated and private sector wage and salary), are self-explanatory. A few critical variables warrant explanation:

- **GROUPOWN** – whether the individual was a policyholder for a health insurance plan through their current or former employer or union at any time during the previous year. In theory, the group that answered “yes” may include some workers who were enrolled in an employer-sponsored plan
through a job other than the one that they held during the reference year, e.g., through COBRA coverage through a previous job.

- **PHINSUR** – whether the individual was covered by any type of private health insurance (whether an employer-sponsored plan or a privately purchased plan from the individual market) at any time during the previous year.

- **FULLPART** – whether the individual usually worked full-or PT during the previous year. FT is defined as at least 35 hours a week. The underlying data on usual hours worked (UHRSWORK1) is recorded in one hour increments. Whether FT or PT workers may have worked any number of weeks during the year, though a large majority worked year-round.

The work and health insurance CPS variables used in this study were all related to the previous year. The single exception is the age of worker. Because the survey is conducted relatively early in the year (March), the age data was not adjusted.

There has been some critique of CPS health insurance data as yielding estimates of the uninsured that are too high. In order to correct the imputation bias that causes this, the State Health Access Data Assistance Center (SHADAC) created a set of enhanced summary health insurance variables and weights for CPS IPUMS. However, for the samples analyzed in this paper—in particular, PT workers in Washington—the use of the weights tended to yield lower employer sponsored insurance coverage estimates compared to the regular March Supplement weight, even as it increased estimates of overall private and public insurance coverage. It also decreased the weighted counts of PT workers by about 17%. Because of all these distortions all CPS data in this paper were generated using the March Supplement weight instead of the health insurance weight.

For estimates of the uninsured, the author relies on the American Community Survey.

The **American Community Survey (ACS)** is an annual household survey by the U.S. Department of Commerce/Bureau of the Census. It has a significantly larger sample than CPS and contains detailed demographic information about workers as well as industry and occupation data. The survey asks detailed questions about health insurance coverage, but does not distinguish whether someone was covered by an employer sponsored plan through their own job, or as a dependent. Another problem is that the FT/PT and number of weeks worked variables are related to the previous year, while the health insurance coverage variables are related to the time at which the survey was taken. The data was weighted with person weights.