ON THE FRINGE: THE SUBSTANDARD BENEFITS OF WORKERS IN PART-TIME, TEMPORARY, AND CONTRACT JOBS

Elaine Ditsler, Peter Fisher, and Colin Gordon
Iowa Policy Project

December 2005

ABSTRACT: This report focuses on the intersection of two important trends in the U.S. workforce: the increasing prevalence of workers in "nonstandard" jobs—that is, those in part-time, temporary, or contract positions—and the decline in access to employer-provided health insurance. While the ongoing crisis in employer-sponsored health insurance—with fewer and fewer individuals covered under such policies and the quality of coverage diminished by higher premiums, copayments, and deductibles—has garnered much attention, there has been little focus on the status of workers in nonstandard work arrangements. These workers are particularly vulnerable—their sporadic employment status often excludes them from employer-based coverage, increasing their reliance on family members' policies or public coverage or leaving them without insurance altogether. This report compares coverage trends between standard and nonstandard workers and across different categories of nonstandard workers, and ultimately offers policy options to reach these uninsured, nonstandard workers and their families.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily of The Commonwealth Fund or its directors, officers, or staff.

Additional copies of this and other Commonwealth Fund publications are available online at www.cmwf.org. To learn more about new Fund publications when they appear, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. no. 879.

CONTENTS

LIST OF FIGURES AND TABLES

ABOUT THE AUTHORS

Elaine Ditsler, M.S., has been a research associate at the Iowa Policy Project since May 2003. Ms. Ditsler's research areas include income and poverty, employment and health insurance, and state budget and tax policy. She earned her Master of Science degree in urban and regional planning from the University of Iowa in 2002. The Iowa Policy Project is a nonpartisan, nonprofit public policy research organization based in Mt. Vernon, Iowa.

Peter Fisher, Ph.D., is research director at the Iowa Policy Project and professor of urban and regional planning at the University of Iowa. Fisher earned his doctorate in economics from the University of Wisconsin-Madison, specializing in labor economics and public finance. Fisher has been a consultant to the State of Ohio and to the Iowa Department of Economic Development. His recent book, *Grading Places: What Do the Business Climate Rankings Really Tell Us?,* was published by the Economic Policy Institute.

Colin Gordon, Ph.D., is a senior research consultant at the Iowa Policy Project and a professor of history at the University of Iowa. Gordon earned his doctorate in history from the University of Wisconsin-Madison. He is author of the books *New Deals: Business, Labor, and Politics, 1920–1935* and *Dead on Arrival: The Politics of Health Care in Twentieth-Century America.*

ACKNOWLEDGMENTS

The authors would like to thank Ben Earnhart, who was an important consultant to this project. The data analysis and research could not have been completed without his assistance.

We also wish to express our appreciation to the following individuals who provided invaluable information and assistance along the way:

- Dr. Anne Polivka of the Bureau of Labor Statistics
- Dr. Ken Hudson of the University of Oregon
- Dr. Nikolas C. Theodore of the University of Illinois at Chicago
- Dr. Bowen Garrett of The Urban Institute
- Dr. Sara R. Collins of The Commonwealth Fund
- David L. West of the Center for a Changing Workforce

EXECUTIVE SUMMARY

In an era of increasingly unstable employment-based health care coverage, with fewer and fewer individuals covered under such policies and the quality of coverage diminished by higher premiums, copayments, and deductibles, nonstandard workers are particularly vulnerable. These workers are often left without the option of employer-based health care coverage, resulting in potentially high out-of-pocket costs. They are more likely than regular, full-time workers to be uninsured or to rely on insurance through a spouse's employer or through the government.

Nonstandard workers currently make up about 25 percent of the U.S. workforce, for a total of 34.3 million workers. Part-time workers compose the largest category within this group, followed by self-employed independent contractors and direct-hire temporaries. Nonstandard workers also include on-call and day laborers, temporary help agency workers, wage and salary independent contractors, and contract company workers.

Using data from the Contingent Work Supplement (CWS), an addendum to the U.S. Census Bureau's Current Population Survey, this report compares trends between nonstandard workers and regular, full-time employees. To fill in some of the gaps in the CWS, the authors conducted a survey of nonstandard workers in late 2003 and early 2004, the Iowa Policy Project (IPP) Survey of Fringe Benefits and Nonstandard Work.

While access to employer-sponsored health insurance is on the decline for all workers, it is an especially acute problem for nonstandard workers. In 2001, most standard workers (74%) had health insurance through their jobs, but only 21 percent of nonstandard workers did. As a result, nonstandard workers were uninsured at twice the rate of regular, full-time workers. Nonstandard workers also relied on government insurance at five times the rate of regular workers and were insured through a spouse's health insurance plan at three and one-half times the rate of regular workers.

In addition to being less likely to be offered employer-sponsored health insurance, nonstandard workers are also less likely to take up employer-sponsored coverage when it is available. About 87 percent of regular full-time workers are offered health insurance, compared with only 40 percent of nonstandard workers. Among those nonstandard workers who were eligible for employer-based plans, 54 percent elected to take it up. In comparison, the take-up rate for standard workers was 85 percent. Nonstandard workers

who declined coverage said it was either because they had coverage through another source or because the plan was too expensive.

Families of nonstandard workers are also affected by their unstable insurance coverage. Only 15 percent of children and 16 percent of spouses of nonstandard workers had health insurance through the nonstandard worker's employer. In fact, children and spouses were covered by the spouse's employer at three times the rate that they were covered by the nonstandard worker's employer. Almost one of five family members of nonstandard workers was uninsured (18% of children and 16% of spouses). A substantial share—10 percent of children and 6 percent of spouses—relied on public health insurance for coverage.

Because of the rising cost of health insurance, some employers and individuals—both nonstandard workers and regular employees—are turning to low-cost products like high-deductible health insurance plans, limited health insurance, and medical discount cards. While these options can appear more affordable than comprehensive health insurance, coverage is often limited. The IPP Survey found that 18 percent of nonstandard workers had discount cards, but no insurance coverage. However, almost all these workers originally—and erroneously—reported that their discount card was a health insurance policy, leading the authors to suggest that rates of uninsurance may be underestimated because some individuals who report having insurance may, in fact, have discount cards only.

Improving access to health coverage for nonstandard workers will require addressing three issues: regulating employer-employee relationships to ensure that nonstandard workers enjoy the same individual and collective rights as conventional employees; strengthening the foundation of employment-based health insurance, thereby making it easier for employers to offer coverage and workers to afford it; and expanding alternatives to employment-based coverage, including existing public programs. Policymakers must identify the obstacles facing the uninsured and underinsured and each individual's potential for eligibility, according to income, job tenure, or firm size. The task, in short, is to provide nonstandard workers an "on-ramp" to group-based insurance—by increasing access to conventional job-based coverage, creating new purchasing pools, or expanding the reach of public programs.

Short of such far-reaching reform that provides universal coverage, the health care system faces tough choices. While it is expected that individuals will be covered under

employment-based coverage, there is no requirement that employers provide it. Indeed, most employers—particularly those coping with smaller employee groups, rising health costs, and persistent competitive pressures—have powerful incentives to avoid this burden. Some have done so by dropping coverage, shifting more coverage costs to employees, or shirking conventional employee-employer relationships altogether. Incremental political solutions must address each of these problems and employ bold and inventive combinations to avoid further fragmenting coverage or shuffling those already insured from one program to another. Seamless access to group-based health coverage—for nonstandard workers and others—depends on transparent employer-employee relationships, secure and portable employment-based care, and tax-subsidized access to alternative insurance pools for those left behind.

ON THE FRINGE:
THE SUBSTANDARD BENEFITS OF WORKERS IN PART-TIME, TEMPORARY, AND CONTRACT JOBS

BACKGROUND

The broad parameters of the health care crisis are familiar. Employment-based health insurance now covers only 60 percent of the U.S. population, down from a peak of 70 percent in the mid-1970s.[1] In 2002, only two of five workers (38.5 percent) had employer-based health insurance all year in their own name and barely one-half of these policies included coverage of at least one dependent.[2] In addition to a general decline in the number of individuals with insurance coverage, the quality of existing coverage has deteriorated as higher premiums, copayments, deductibles, and restrictions have placed an increasing financial burden on American families.[3] A health care system rooted in the "old economy," where workers typically enjoyed long-term employment in stable industries like manufacturing, is giving way to a "new economy," characterized by job churning, service employment, and small firms.[4]

Nonstandard workers—that is, those not employed on a full-time, permanent, or salaried basis—are particularly vulnerable in an era of increasingly unstable employment-based coverage.[5] Their sporadic employment status often leaves them without the option of employer-based health care coverage, resulting in potentially high out-of-pocket costs. They are much more likely to be uninsured or to rely on insurance through a spouse's employer or through the government.

Some nonstandard workers—day laborers, for example—work on the margins of the labor market. Many of these workers, like agricultural workers, have historically worked on a transient basis, without benefit of a formal payroll. This kind of work pattern has hindered them from receiving employer benefits. Other workers, like temporary or leased employees, occupy niches in the labor market that evade conventional employer-employee relationships and the accompanying responsibilities.

Using data from the Contingent Work Supplement (CWS), an addendum to the U.S. Census Bureau's Current Population Survey, the authors compare trends between nonstandard workers and regular, full-time employees.[6] To fill in some of the gaps in the CWS, the authors conducted a survey of nonstandard workers in late 2003 and early 2004, the Iowa Policy Project (IPP) Survey of Fringe Benefits and Nonstandard Work. This national survey provided more details about the health insurance coverage of nonstandard

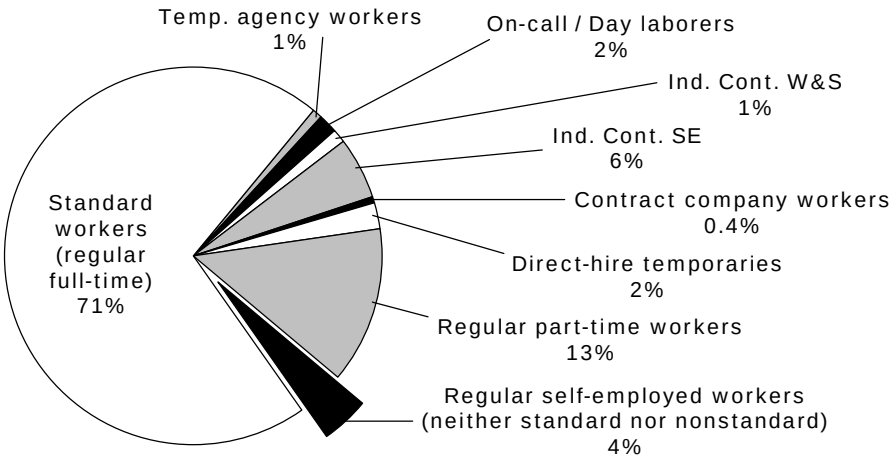
workers and their families. (For more information on the IPP survey, see Appendix B.) Drawing on these findings, the authors find that the current employment-based insurance system often leaves nonstandard workers excluded from the benefits enjoyed by their full-time counterparts and reliant on either public coverage or insurance through a family member's policy, or without insurance altogether. The authors offer an overview and assessment of various policy options, including mandating or subsidizing employment-based coverage, pooling the uninsured, and expanding access to public programs, to reach uninsured, nonstandard workers and their families.

Who Are Nonstandard Workers?

Terms such as "nonstandard," "alternative," and "flexible" have been used to describe any work schedule that is not full-time, permanent, wage-based, or salaried. In this report, the term nonstandard is used to encompass the following work arrangements: temporary help agency work, on-call labor, day labor, independent contracting, contract company work, direct-hire temporary work, and part-time work.[7] Independent contractors were divided into two categories depending on whether they described themselves as employees of another company or as self-employed.

According to the most recent data available from the CWS, nonstandard workers make up about 25 percent of the workforce, for a total of 34.3 million workers (Figure 1).[8] Part-time workers, defined as workers who usually work fewer than 35 hours per week in an otherwise "standard" job, are the largest category of nonstandard workers. In 2001, there were 18.3 million part-time workers, representing approximately 13.3 percent of U.S. employment. Self-employed independent contractors were the second-largest group, representing about 5.5 percent of total U.S. employment in 2001, or 7.6 million workers. The third largest group consisted of direct-hire temporaries, who represented 2.2 percent of total employment in 2001, or 3 million workers. The remaining nonstandard workers, including on-call and day laborers, temporary help agency workers, wage and salary independent contractors and contract company workers, totaled 5.4 million workers, or 4 percent of total U.S. employment, in 2001. The rest of the workforce includes standard workers (71 percent) and the regular self-employed (4 percent). Standard workers have full-time, permanent, wage, and salaried positions. The regular self-employed are small business owners who are not independent contractors. In this report, the regular self-employed are excluded from most analyses and considered neither standard nor nonstandard workers.

Figure 1. Nonstandard Workers as a Share of the Workforce



Notes: Ind. Cont. W&S = wage & salaried independent contractor;
Ind. Cont. SE = self-employed independent contractor.
Source: Authors' analysis of the 2001 Contingent Work Supplement.

HEALTH INSURANCE COVERAGE AMONG NONSTANDARD WORKERS

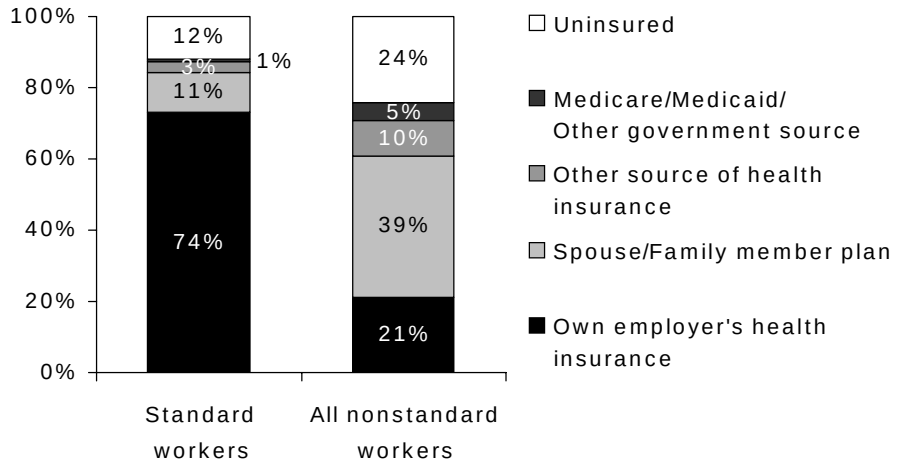
Employer-Sponsored Health Insurance

The number and share of Americans covered by job-based health insurance has declined from 64 percent in 2000 to 60 percent in 2004.[9] While access to employer-sponsored health insurance is on the decline for all workers, it is an especially acute problem for nonstandard workers.

In 2001, most standard workers (74%) had health insurance through their jobs, but only 21 percent of nonstandard workers did (Figure 2).[10] As a result, nonstandard workers were uninsured at twice the rate of regular, full-time workers. Nonstandard workers also relied on government insurance at five times the rate of regular workers and were insured through a spouse's health insurance plan at three and one-half times the rate of regular workers.[11]

Among nonstandard workers, contract company workers were the most likely to have employer-sponsored health insurance (56 percent) and the least likely to be uninsured (16 percent). Agency temporaries were the least likely to have employer-sponsored health insurance (12 percent) and the most likely to be uninsured (50 percent).

Figure 2. Health Insurance Coverage Among Workers, 2001



Notes: Self-employed independent contractors are excluded from this analysis. "Other source of health insurance" includes insurance from the individual market, from another job, from a previous job, or from an association, school, or other unidentified source.

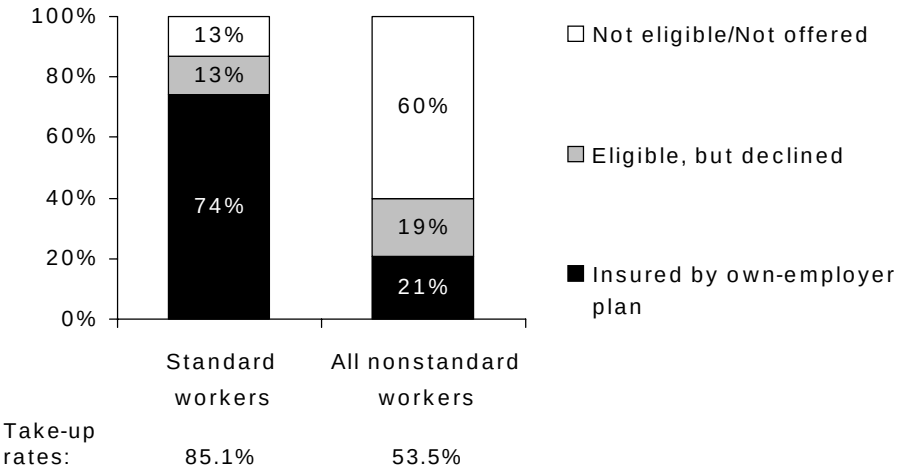
Source: Authors' analysis of the 2001 Contingent Work Supplement.

Access and Take-Up Rates

Nonstandard workers are less likely than standard workers to be offered employer-sponsored health insurance and also less likely to take up employer-sponsored coverage when offered. About 87 percent of regular full-time workers are offered health insurance, compared with only 40 percent of nonstandard workers (Figure 3). Among nonstandard workers, contract company workers were the most likely to be offered employer-based health insurance—about 80 percent were offered health insurance.[12] However, this was the only group of nonstandard workers where more than 50 percent of individuals were offered an employer-sponsored health insurance plan.

There are various reasons why nonstandard workers do not receive employer-based benefits. Some work for companies that do not offer insurance to any employees, while others are ineligible for company plans because they do not work enough hours per week or because their status as temporary or contract workers excludes them from the plans. Typically, part-time workers are also often excluded from receiving employee benefits. In a 2003 survey of employers, about 54 percent of companies reported that only full-time workers were eligible for health benefits.[13]

Figure 3. Access to Job-Based Health Insurance, 2001



Notes: Self-employed independent contractors are excluded from this analysis. "Not eligible/Not offered" includes workers who are not eligible for the company plan as well as workers who are not offered coverage because their company does not sponsor a health insurance plan.

Source: Authors' analysis of the 2001 Contingent Work Supplement.

Among those nonstandard workers who were eligible for employer-based plans, 54 percent elected to take it up (Figure 3).[14] In comparison, the take-up rate for standard workers was 85 percent. Nonstandard workers who declined coverage said it was either because they had coverage through another source or because the plan was too expensive.

Lapses in Health Insurance Coverage

To complement the point-in-time estimate of uninsurance presented in Figure 2, the IPP survey measured the consistency—or stability—of health insurance coverage over a longer period. Workers were asked if there was a time in the previous 12 months when they did not have health insurance. About 41 percent of nonstandard workers reported being without insurance either currently or at some point in the previous 12 months (Figure 4). While no comparison with regular full-time workers is available, this figure is much higher than the 26 percent of all working-age Americans (i.e., individuals, ages 18 to 64, both working and not working) who lacked health insurance at some point during 2003.[15]

Figure 4. Nonstandard Workers Currently Uninsured or Without Coverage at Some Point During Previous Year

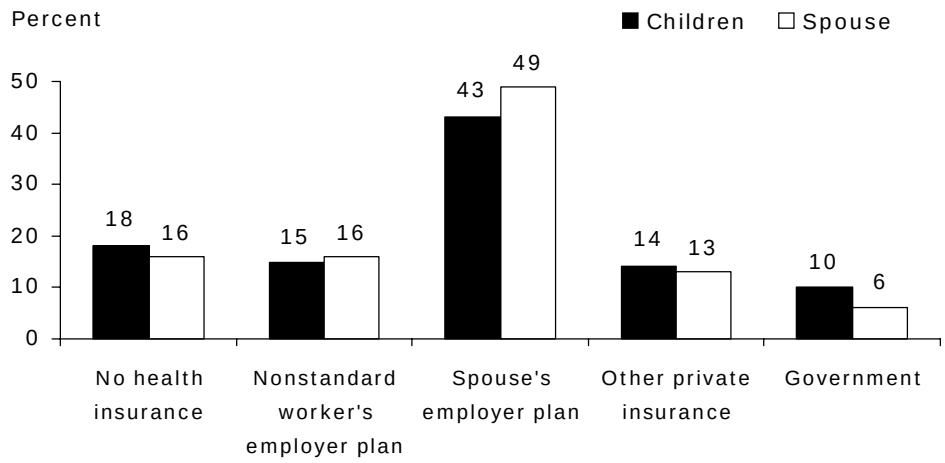
Notes: Includes workers who were uninsured at the time of the survey as well as workers who were uninsured at some point during the previous 12 months. An explanation for how temporary workers, independent contractors, and part-time workers were defined in the IPP survey is included in Appendix B.

Source: Iowa Policy Project Survey of Fringe Benefits and Nonstandard Work.

Family Coverage

Nonstandard workers were more likely to either have health insurance through a spouse's employer or to be uninsured than they were to have coverage through their own employer. As a result, family members of nonstandard workers cannot depend on receiving insurance coverage through the nonstandard workers' job. Only 15 percent of children and 16 percent of spouses of nonstandard workers had health insurance through the nonstandard worker's employer (Figure 5).[16] In fact, children and spouses were covered by the spouse's employer at three times the rate that they were covered by the nonstandard worker's employer. Almost one of five family members of nonstandard workers was uninsured (18% of children and 16% of spouses). A substantial share—10 percent of children and 6 percent of spouses—relied on public health insurance for coverage.

Figure 5. Health Insurance Coverage for Family Members of Nonstandard Workers



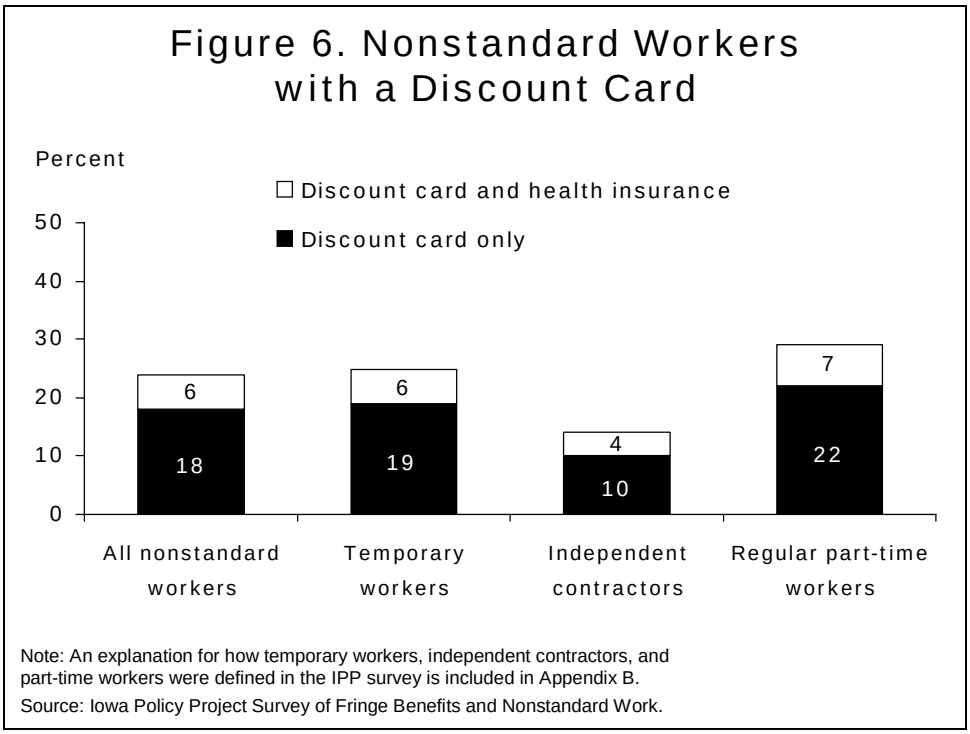
Note: "Other private insurance" includes plans that are purchased directly or that come from some private source other than the nonstandard worker's or spouse's current employer.

Source: Iowa Policy Project Survey of Fringe Benefits and Nonstandard Work.

Medical Discount Cards and Limited Health Insurance

Because of the rising cost of health insurance, some employers and individuals are turning to low-cost products like high-deductible health insurance plans, limited health insurance, and medical discount cards. While these options are often more affordable than comprehensive health insurance, coverage is often limited.

Medical discount cards appear to be an attractive option to nonstandard workers. However, these cards are not health insurance policies, and instead offer health care services and prescription drugs from participating providers to consumers at a discounted rate. The cardholder is responsible for paying any claims and typically pays the full cost up-front. The IPP Survey found that 18 percent of nonstandard workers had discount cards, but no insurance coverage (Figure 6). However, almost all these workers originally—and erroneously—reported that their discount card was a health insurance policy.[17] An additional 6 percent of nonstandard workers had discount cards as a supplement to health insurance.



Note: An explanation for how temporary workers, independent contractors, and part-time workers were defined in the IPP survey is included in Appendix B.

Source: Iowa Policy Project Survey of Fringe Benefits and Nonstandard Work.

These discount card findings have important implications for the design of future surveys, including the Census Bureau's Current Population Survey. While questions have been added to that survey to verify that individuals are uninsured, none were included to substantiate insurance coverage. The IPP Survey suggests some individuals who report having insurance may in fact only have a discount card, meaning that rates of uninsurance may be underestimated.

A recent Commonwealth Fund study of medical discount cards revealed serious problems, including high-pressure sales tactics and deceptive marketing that overstates savings and exaggerates the number of participating providers.[18] Because discount cards are not subject to insurance regulations, states have few tools with which to regulate them. Better protecting consumers will require legislative action like licensing companies and setting standards to regulate provider networks, disclosure requirements, marketing campaigns, and rates.

NONSTANDARD WORK AND HEALTH CARE: POLICY OPTIONS

Public programs like Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) remain the default option for those nonstandard workers without access to employer-based coverage. These programs evolved as a means of supporting and supplementing job-based insurance—picking up coverage for those with tenuous ties to

the labor market, like the poor and elderly. Now, these programs play an important role in sustaining nonstandard and low-wage employment. Many employers routinely refer low-wage, part-time, and nonstandard workers to public sources of individual or family health coverage. In doing so, such employers are relying on public programs to subsidize inadequate benefits.[19]

These trends pose a dilemma for state and federal policymakers. While public programs have dramatically reduced poverty and uninsured rates among target populations, there are dangers in using them as sweeping alternatives to private coverage. The same economic conditions that create new demand for public programs also create budgetary pressures that make them harder to fund. In recent years, many states have pared eligibility and spending as demands increase or have sustained programs with rainy day funds, tobacco settlement income, or tax increases.[20] In reshaping public programs, it is important to fill the gaps left behind by private provision without either saddling states with new fiscal burdens or offering employers the opportunity or incentive to curtail employment-based plans.

Improving access to health coverage for nonstandard workers will require addressing three issues: regulating employer-employee relationships to ensure that nonstandard workers enjoy the same individual and collective rights as conventional employees; strengthening the foundation of employment-based health insurance, thereby making it easier for employers to offer coverage and workers to afford it; and expanding alternatives to employment-based coverage, including existing public programs. Policymakers must identify the obstacles facing the uninsured and underinsured and each individual's potential for eligibility, according to income, job tenure, or firm size.[21] The task, in short, is to provide nonstandard workers an "on-ramp" to group-based insurance—by increasing access to conventional job-based coverage, creating new purchasing pools, or expanding the reach of public programs, as in the following three strategies:

Expanding Access to Employment-Based Care

In a health care system organized around job-based benefits, public policy has historically focused on sustaining or expanding those benefits by subsidizing employment-based coverage, mopping up around its edges, and—in a raft of state and federal efforts since the 1970s—mandating employers to offer basic coverage.[22] The goal has been to expand job-based plans toward universal or near-universal coverage, while holding the line against further decline in employment provision. Policy options include tax and regulatory

changes which either sustain private efforts to control costs or make it easier for small employers to offer coverage, and direct mandates which require employment-based coverage from certain firms. The key problem with such job-based reforms is that they require stable and transparent employment relationships, which tend to elude nonstandard workers. Both employment-based care, and the reforms and regulations that surround it, are premised on employee groups that are both clearly defined and (in actuarial terms) large enough to sustain group insurance. On both scores, nonstandard workers are typically excluded.

New efforts to broaden employment-based health coverage must address certain conditions and take heed of past experiences, as follows:

- Legislation must be accompanied by labor law reforms that accord nonstandard and part-time workers the same status as regular wage and salaried employees.
- Nonstandard workers (long-term temps, contract workers, on-call workers, and part-time workers) must be explicitly identified as "covered employees," as in California's short-lived "SB-2" proposal.[23]
- Policymakers must navigate the intricacies of the federal Employment and Retirement Income Security Act (ERISA), which explicitly preempts or overrides state or local laws relating to employee health benefits.[24]
- Policymakers must also be wary of mandating coverage for very low-wage workers whose employers cannot bear the costs.

In recent months, some states and localities—following efforts to identify the major employers of their SCHIP- or Medicaid-eligible populations—have pressed ahead with versions of a "play or pay" employer mandate aimed at prominent employers. Designed to avoid ERISA's preemption, "play or pay" laws expand coverage by requiring employers to either "play" by providing health coverage or "pay" a tax premium in support of broader public programs. Such efforts include the "fair share" laws recently passed in Maryland, New York City, and Suffolk County, Long Island.[25]

Pooling Nonstandard Workers

Insuring nonstandard workers not only raises issues of access and affordability, but involves the enormous task of determining how to assemble workers into groups large enough—in the eyes of private insurers—to make them worth the actuarial risk. There are many competing strategies for grouping or pooling nonstandard workers, including offering

open enrollment in existing public programs, purchasing cooperatives for individuals or small groups, initiating new options for private employer pools, and establishing public authorities to serve as employers-of- record for certain nonstandard workers.

One option is to help nonstandard workers access existing group-based public coverage, as opposed to means-tested public programs such as SCHIP or Medicaid. One example of this strategy—raised recently in Senator John Kerry's (D-Mass.) 2004 presidential campaign—is to allow uninsured individuals to enroll in the Federal Employees Health Benefits Program (FEHBP).[26] There have also been promising efforts on the state level. Maine's Dirigo Health Plan, for example, creates an actuarial pool composed of uninsured individuals, the self-employed, and firms employing fewer than 50 workers.[27]

Private multi-employer health plans have shown less promise. In their current form, multi-employee welfare arrangements (MEWAs) used in industries characterized by either self-employment (accountants, auto dealers) or transitory employment (agriculture) have been plagued by insolvency and instability. Similarly, the association health plans proposed by the Bush Administration would offer coverage pools largely exempt from federal or state regulation.[28]

A promising strategy, particularly for workers on public contracts or paid with public funds, is the establishment of employers-of-record for otherwise fragmented employee groups. State legislation in Washington, Oregon, and California has created public authorities to serve as employers-of-record for home health care workers.[29] Unlike MEWAs, such agreements are regulated under relevant state and federal insurance and labor law.

Tax Policies for Group and Nongroup Coverage

As part of a broader strategy for expanding coverage, the tax system could serve as a means of identifying the uninsured by asking filers to report health care premiums and expenses and of easing their enrollment into group coverage through income-based tax credits. The success of this approach, however, will depend on the design of the tax subsidy. Credits or deductions linked to high-deductible coverage are likely to simply shuffle some of the younger and healthier insured individuals out of group plans.[30] One promising alternative would be to couple income-based tax credits with enrollment in a new public insurance pool—either an extension of FEHBP or a plan modeled on FEHBP.[31] That is to say, tax credits should be used by the uninsured to buy into group coverage, not by the young and

healthy to buy out of group coverage. Under one such proposal, personal income tax filings would serve as a mechanism for identifying the uninsured, enrolling them in a public insurance pools (FEHBP or equivalent), and providing tax credits towards that coverage. Tax filers, declaring their health coverage along with their taxable income, would qualify for tax credits based on declared income and the insured status of themselves and dependents.[32]

As strategies for expanding coverage, these options pose both peril and promise. Employment-based solutions build on the foundation of our current system, but this is a foundation that has served nonstandard workers poorly. Alternative insurance pools for individuals and small businesses, including many nonstandard workers, build on the actuarial logic of group-based insurance, but also run the risk of encouraging existing group plans to dump coverage. Furthermore, initiatives to expand options for nongroup coverage run the risk of fragmenting existing groups under the guise of increasing coverage by cherry-picking the young and healthy. The success of such strategies—in both expanding coverage generally and reaching nonstandard workers—depends largely on the ways in which they are designed and combined.

CONCLUSIONS

Since the last push for more comprehensive health reform in the early 1990s, conditions have deteriorated even further. After slowing briefly in the mid-1990s, health costs have risen sharply, driven in most recent years by high drug prices. The foundation of employment-based health insurance has continued to crumble as fewer employers offer coverage and those who do have shifted more costs to their workers. In addition, even as the ranks of the uninsured continue to grow, a persistent fiscal crisis has pressed many states to constrain public coverage. Circumstances are particularly dire for nonstandard workers, who often lack job security and a stable employer-employee relationship. Indeed, the characteristics of nonstandard work, like low wages and a hands-off employment relationship, make it inherently difficult for these workers to either take advantage of group-based solutions or buy into nongroup options.

Short of such far-reaching reform that provides universal coverage, the health care system faces tough choices. While it is expected that individuals will be covered under employment-based coverage, there is no requirement that employers provide it. Indeed, most employers—particularly those coping with smaller employee groups, rising health costs, and persistent competitive pressures—have powerful incentives to avoid this burden. Some have done so by dropping coverage, shifting more coverage costs to employees, or

shirking conventional employee-employer relationships altogether. Incremental political solutions must address each of these problems and employ bold and inventive combinations to avoid further fragmenting coverage or shuffling those already insured from one program to another. Seamless access to group-based health coverage—for nonstandard workers and others—depends on transparent employer-employee relationships, secure and portable employment-based care, and tax-subsidized access to alternative insurance pools for those left behind.

NOTES

[1] For coverage rates, see C. DeNavas-Walt, B. Proctor, and C. Hill Lee, *Income, Poverty and Health Insurance Coverage in the United States: 2004*, U.S. Census Bureau, Current Population Reports, P60-229, August 2005. For historical patterns, see J. Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (New York, 2003); and C. Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth Century America* (New York, 2003).

2 A. Dube and K. Jacobs, *Falling Apart: Declining Job-Based Health Coverage for Working Families in California and the United States*, UC–Berkeley Labor Center, Health Policy Brief , June 2005; H. Boushey and J. Wright, "Health Insurance Data Brief #3: Workers Receiving Employer-Provided Health Insurance," Center For Economic and Policy Research (April 2004) at http://www.cepr.net/health_insurance/hi_3.html.

[3] H. Boushey and J. Wright, *Improving Access to Health Insurance*, Center on Economic and Policy Research, April 2004; and The Henry J. Kaiser Family Foundation, "Employee Benefits: 2003 Annual Survey." Since 1982, the cost of employment-based health coverage has increased (in real dollars) by 260 percent; the employees' share has increased 350 percent. Between 1988 and 2003, the share covered workers are required to contribute to a family health plan grew from 66 to 92 percent, and the worker's monthly premium cost (family coverage) increased almost four times, from $52 to $201.

[4] Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2002 Data Update" (December 2003); The Henry J. Kaiser Family Foundation, "Employee Benefits: 2003 Annual Survey."

[5] The term "nonstandard" has been used to describe a wide variety of work arrangements. In this report, "nonstandard" refers to any job that is not a permanent, full-time, wage, and salaried position. The regular self-employed (i.e., small business owners) are considered neither standard nor nonstandard.

[6] The Contingent Work Supplement (CWS) is a biennial supplement to the U.S. Census Bureau's Current Population Survey (CPS). The CPS is a monthly survey of about 50,000 households, used to obtain labor force statistics, including the official unemployment rate for the nation. The CWS is a biennial supplement to the CPS, which began in 1995. Unfortunately, the survey scheduled for February 2003 was cancelled, preventing the first look at how the weak economy of the last two years has affected the prevalence of nonstandard workers in the labor market.

[7] Refer to Appendix A for a complete definition of types of work arrangements.

[8] Workers were placed into only one category based on their answers to a series of questions. See Appendix A for a more detailed description of each work arrangement.

[9] Census Bureau, Historical Health Insurance Tables from the Current Population Survey. http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html

[10] The health insurance information presented here is from a snapshot in time; survey respondents were asked about their health coverage at the time of the survey.

[11] Because of their relatively small numbers, uninsured nonstandard workers still only explain a relatively small portion of all uninsured Americans. The authors estimate that roughly 10 percent to 20 percent of uninsured Americans were nonstandard workers in 2001.

[12] The regular self-employed and self-employed independent contractors were not included in the analysis of employer-based health insurance since. Because these workers serve as their own employers, this question is not meaningful.

[13] S.R. Collins, et al., *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, March 2004).

[14] Take-up rate is coverage rates divided by eligibility rates.

[15] S.R. Collins, et al., *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, March 2004).

[16] Only workers with private health insurance were asked about the health insurance status of their spouse and children.

[17] The survey first asked individuals if they had health insurance and if so, about the source of that coverage. Then, they were asked: "Do you have a discount card allowing you to receive a discount from certain health care providers?" If the respondent answered yes, then they received a follow-up question: "Is this discount plan your only health insurance?"

[18] M. Kofman, J. Libster, and E. Bangit, *Discount Medical Cards: Innovation or Illusion?* (New York: The Commonwealth Fund: March 2005).

[19] See A. Miller, "Wal-Mart Stands Out on the Rolls of PeachCare," *Atlanta Journal-Constitution,* February 27, 2004; Arindrajit Dube and Ken Jacobs, "Hidden Costs of Wal-Mart Jobs: Use of Safety Net Programs by Walmart Workers in California" (UC Berkeley Labor Center: August 2004), http://laborcenter.berkeley.edu/lowwage/walmart.pdf. In just the last five years the, number of households claiming both employer-provided insurance and Medicaid has increased steadily, from 4.4 percent of low-wage workers in 1992 to 8.7 percent in 2002. Between 1999 and 2002, the share of child Medicaid beneficiaries living in families where other members had employer-provided health insurance more than doubled to 11.1 percent. See H. Boushey and J. Wright, "Health Insurance Data Briefs #5: Public Versus Private Health Insurance" (Center for Economic and Policy Research: April 2004) at http://www.cepr.net/health_insurance/hi_5.html.

[20] See D. Ross and L. Cox, *Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children* (Center on Budget and Policy Priorities: January 15, 2004); Academy Health, *State of the States: Cultivating Hope in Rough Terrain* (State Coverage Initiatives: January 2004). At the end of 2003, state waivers were responsible for a paltry coverage gain of about 200,000 persons, a total that included an increase of 300,000 in New York and a loss of nearly 200,000 as a result of budget-anxious adjustments to Tennessee's TennCare program. A few states, like Illinois and Idaho, expanded coverage by raising the poverty threshold for SCHIP or Medicaid, but more, facing a combination of higher health costs and higher demand in need-based programs, cut back. In 2003 alone, 18 states reduced the benefits available under Medicaid and another 25 lowered income ceilings for eligibility—the latter most directly affecting the coverage of parents whose children remained eligible. See C. Mann, S. Artiga, and J. Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage* (Kaiser Commission on Medicaid and the Uninsured: December 2003).

[21] B. Garrett, L. Nichols, and E. Greenman, "Workers Without Health Insurance: Who Are They And How Can Policy Reach Them?" (Urban Institute, 2001): 22–23; Danielle Ferry et al, "Health Insurance Expansions For Working Families: A Comparison of Targeting Strategies," *Health Affairs* 21:4 (2002), 246–54.

[22] See T. Oliver, "State Employer Health Insurance Mandates: A Brief History" (California Health Insurance Foundation, March 2004).

[23] For more information on the California bill, see A. Dube, *Impact of SB 2 on Health Coverage* (Berkeley, Calif: Institute for Labor and Employment, September 9, 2003); and California Health Insurance Foundation, *The Health Insurance Act of 2003: An Overview of SB 2*, November 2003. While the California mandate was rejected by voters in 2002, other state and local initiatives have followed. See (on New York City) For information on the New York City Health Care Security Act, see J. Murphy, "Rad Medicine: City Council Wades into the Middle of the Nation's Health Care Crisis," *Village Voice,* May 10, 2005; on Wisconsin see, The Lewin Group, "The Wisconsin Health Care Plan for Workers and Dependents in Wisconsin: Cost and Coverage Impacts," September 2003.

[24] For information on ERISA, see P. Butler, *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints* (Portland, Maine: National Academy for State Health Policy, May 2002); P. Butler, *ERISA Update: The Supreme Court Texas Decision and Other Recent Developments* (Portland, Maine: National Academy for State Health Policy, August 2004); and http://www.brennancenter.org/programs/living_wage/index.html#Reports, for information ERISA implications for local living wage laws.

[25] Maryland's "Walmart" bill, for example, imposes an 8 percent payroll tax on large employers (i.e., those who have over 10,000 employees in the state) who do not spend at least that amount on private health coverage. See J. Wagner and M. Barbaro "Maryland Passes Rules on Wal-Mart Insurance," *Washington Post* (April 6 2005); D. Nitkin, "Health Care Tax to Target Big Employers," *Baltimore Sun,* April 6, 2005. At this writing, the legislature expects to have enough votes to override an expected veto by the governor. For information on other state-level efforts, see http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=30128.

[26] K. Davis and C. Schoen, "Creating Consensus On Coverage Choices," *Health Affairs* Web Exclusive, April 23, 2003; For details on Kerry plan, see S. R. Collins, K. Davis and J. Lambrew, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals* (New York: The Commonwealth Fund, October 2004).

[27] See J. Rosenthal and C. Pernice, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine* (Portland, Maine: National Academy for State Policy Research, June 2004).

[28] Report on Multiple Employer Welfare Arrangements (California Department of Insurance; December, 2001) M. Kofman, E. Bangit, and K. Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (New York: The Commonwealth Fund, March 2004).

[29] S. Schneider, "Home Health Care Workers: Organizing Victories in California, Oregon, and Washington," *Dollars & Sense* 49 (September/October 2003): 25–28; and Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services' Office of Long Term Care, *Results of the 2003 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce,* March 2004.

[30] J. Gabel, *Are Tax Credits Alone the Solution to Affordable Health Insurance?: Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund, May 2002); J. Reschovsky and J. Hadley, "The Effect of Tax Credits for Nongroup Insurance on Health Spending by the Uninsured" *Health Affairs* Web Exclusive, February 2004.

[31] B. Garrett, L. Nichols, and E. Greenman, "Workers Without Health Insurance: Who Are They And How Can Policy Reach Them?" (Urban Institute, 2001).

[32] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive, April 23, 2003.

[33] S. Houseman and A. E. Polivka. 2000. "The Implications of Flexible Staffing Arrangements for Job Stability." In David Newmark, ed., *On the Job: Is Long-Term Employment a Thing of the Past?* New York: Russell Sage Foundation.

[34] Ibid.

APPENDIX A. THE CONTINGENT WORK SUPPLEMENT (FIGURES 1–3)

The authors analyzed data from the 1995, 1997, 1999, and 2001 Contingent Work Supplement (CWS). CWS data are collected through a February supplement to the U.S. Census Bureau's Current Population Survey (CPS), a monthly survey of approximately 50,000 households. All employed persons, except unpaid family workers, are included. Only data from the 2001 CWS is included in this report. Health insurance status is determined based on workers' coverage during the reference week (i.e., the week before the survey).

Table A-1. Categories of Nonstandard Workers (numbers in thousands)

All temporary workers		6,566
Temporary agency workers	1,198	
On-call workers	2,395	
Direct-hire temporaries	2,973	
Independent contractors—wage and salaried		1,184
Independent contractors—self-employed		7,598
Contract company workers		606
Part-time workers		18,335
All nonstandard workers		**34,288**
Standard workers		97,386

Note: The regular self-employed, who make up 5.9 million workers, are considered neither standard nor nonstandard.
Source: Authors' analysis of the 2001 Contingent Work Supplement.

DEFINITIONS

All persons who worked during the reference week and were at least 16 years old were classified into one of nine worker categories. Regular full-time workers are the only group of "standard" workers. All other workers, except the regular self-employed, are considered to be in "nonstandard work arrangements." The definitions constructed in this report follow those developed by Houseman and Polivka (2000), except that independent contractors were separated into two distinct categories depending on whether they described themselves as employees of another company or as self-employed.[33]

Nonstandard work differs from regular full-time work in at least one of the following ways:

1. the temporary nature of the job;
2. the employer is distinct from the company for whom the person actually works (i.e., worker is placed by a staffing firm);

3. lack of an employer (i.e., independent contracting, self-employed status)
4. hours worked per week are usually less than 35 hours.

Persons with two or more jobs are classified in the job at which they worked the most hours during the reference week. The definitions for each type of work arrangement are described below:

Standard workers

Regular full-time workers: Regular full-time workers are wage and salary workers who do not fall into any of the "nonstandard job" categories and who usually work 35 or more hours per week.

Nonstandard workers

Temporary help agency workers or agency temporaries: Temporary help agency workers are wage and salary workers who were paid by a temporary help agency, whether or not they indicated that their job was temporary. It is estimated that about 3.2 percent of the workers are actually the permanent full-time staff of these agencies.[34] The CWS defines a temporary help agency as a business that "supplies workers to other companies on an as-needed basis or supplies workers to other companies primarily for short-term assignments."

On-call/day laborers: On-call workers are wage and salary workers who are called to work only as needed, although they can be scheduled to work for several days or weeks in a row. Workers who called themselves both "on-call" and "provided by contract firms" were classified as on-call. Day laborers are workers who wait at a place where employers pick up people to work for a day. Persons who work a regular schedule, but are also on-call—such as doctors, electricians, and plumbers—are not included in this category.

Independent contractors—wage and salary: These workers identified themselves as employees of a government, private company, or nonprofit organization in the basic CPS. In the supplement, they affirmatively answered the question: "Were you working as an independent contractor, an independent consultant, or a freelance worker?" The CWS defines an independent contractor as "someone who obtains customers on their own to provide a product or service. Independent contractors can have other employees working for them."

Independent contractors—self-employed: Workers identified as self-employed in the basic CPS who answered affirmatively to the question in the supplement, "Are you self-employed as an independent contractor, independent consultant, or freelance worker?" An independent contractor is defined as "someone who obtains customers on their own to provide a product or service. Independent contractors can have other employees working for them."

Contract company workers: Contract company workers are wage and salary workers who are employed by a contract company that provides them or their services to others under contract and who are usually assigned to only one customer and usually work at the customer's work site.

Direct-hire temporaries: Direct-hire temporaries are wage and salary workers who are hired directly by the company for whom they work, and are in a temporary work arrangement only because they cannot find permanent positions. Specifically, workers were classified as direct-hire temporaries if their job was temporary or they could not stay in their job as long as they wished because of any of the following reasons: they were working only until a specific project was completed, they were hired for a fixed period of time, they were temporarily replacing another worker, their job was seasonal, or they expected to work for less than one year because their job was temporary.

Regular part-time workers: Regular part-time workers are wage and salary workers who do not fall into any of the other nonstandard job categories and who usually work less than 35 hours per week.

APPENDIX B. THE IPP SURVEY OF FRINGE BENEFITS AND NONSTANDARD WORK (FIGURES 4–6)

The Iowa Policy Project Survey of Fringe Benefits and Nonstandard Work was made possible with generous support from The Commonwealth Fund and is the basis for this updated report on nonstandard workers. The survey was fielded in October and November of 2003, and in February of 2004. December 2003 and January 2004 were not included to avoid bias due to the high levels of seasonal employment over the holidays. This survey was conducted by Lake, Snell, Perry & Associates and consisted of 20-minute telephone interviews among a random, nationally representative sample of 4,573 workers living in the United States. Researchers at the Iowa Policy Project designed the survey and analyzed the findings.

Statistical results are weighted to correct for the oversample of nonstandard workers. The resulting weighted sample is representative of the approximately 130.1 million workers in the United States during the survey period. The response rate was 25 percent for the original sample and 26 percent for the oversample.

The survey procedure avoided problems of underrepresentation among males by interviewing only the employed person in the household with the nearest or farthest birthday from the date of the phone call. As a result, the person was randomly selected for the interview and not simply because of the fact that he or she was more likely to be home or to answer the phone. In the IPP survey, 52.6 percent of respondents were female compared with 51.9 percent in the CWS. Minorities, however, were underrepresented in the IPP survey. Only 23.6 percent of respondents in the IPP survey did not identify themselves as white compared with 27.2 percent of respondents in the CWS.

The survey has an overall margin of sampling error of 1.5 percentage points at the 95 percent confidence level. For nonstandard workers, the margin of error is 2.5 percentage points.

Workers were divided into five categories based on a series of survey questions: temporary workers, independent contractors, regular part-time workers, small business owners and regular full-time workers. A nonstandard worker was defined as being a member of one of the first three categories. Temporary workers described themselves as temporary agency workers, contract company workers, leased employees, on-call workers, day laborers, or direct-hire temporary workers. Independent contractors were workers

whose main job was not as a small business owner and who labeled themselves as independent contractors. Independent contractors who later said that they were paid by the job, had multiple customers, and worked at their own place of business were re-classified as small business owners. Regular part-time workers were people who usually worked less than 35 hours per week in an otherwise traditional employer-employee relationship.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

Limited Take-Up of Health Coverage Tax Credits: A Challenge to Future Tax Credit Design (October 2005). Stan Dorn, Janet Varon, and Fouad Pervez. The latest enrollment figures for Trade Act tax credits again show disappointingly low take-up rates, with high insurance premium costs, a complex application process, and inadequate outreach the prime causes.

A Need to Transform the U.S. Health Care System: Improving Access, Quality, and Efficiency (October 2005). Anne Gauthier and Michelle Serber. The fragmented U.S. health system is fraught with waste and inefficiency, as documented by this chartbook from the Fund's Commission on a High Performance Health System.

Entrances and Exits: Health Insurance Churning, 1998–2000 (September 2005). Kathryn Klein, Sherry Glied, and Danielle Ferry. This issue brief reveals that 22 percent of the U.S. population experienced at least one spell without any health coverage over a two-year period, in addition to the 9 percent who were uninsured for the full two years. Those with private, nongroup insurance were among the most likely to have unstable coverage.

"Choice" in Health Care: What Do People Really Want? (September 2005). Jeanne M. Lambrew. People value a choice of health care providers over a choice of health plans, according to this analysis of Fund survey data. Dissatisfaction among adults who have no choice of provider was more than twice as high compared to adults with no choice of plan.

Health and Productivity Among U.S. Workers (September 2005). Karen Davis, Sara R. Collins, Michelle M. Doty, Alice Ho, and Alyssa L. Holmgren. Health problems among working-age Americans and their families carry an estimated price tag of $260 billion in lost productivity each year, according to this study.

Seeing Red: Americans Driven into Debt by Medical Bills (August 2005). Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren. The researchers report that while medical bill problems and debt are experienced most often by the uninsured, even many working-age adults who are continually insured have problems paying their medical bills and have medical debt.

Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers (July 2005). Katherine Swartz. The author reports that state-provided reinsurance—in essence, insurance for insurance companies—can allow insurers to lower premiums significantly by relieving them of the risk of enrolling large numbers of people with catastrophic medical costs, but that only two states, New York and Arizona, have reinsurance programs in place.

Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan (July 2005). Bill J. Wright, Matthew J. Carlson, Jeanene Smith et al. In 2003, Oregon raised premiums, required copays for the first time, and imposed a six-month lockout for individuals missing premium payments. This study reports that nearly two-thirds of surveyed individuals lost their coverage after the initial premium and cost-sharing increases, many directly resulting from increased costs.