New York’s Fair Share for Health Care: No Significant Employment Impact

May 2006

David L. West, MPA
Executive Director
Center for a Changing Workforce

Seattle, WA
Center for a Changing Workforce (CFCW) is a nonprofit research and policy analysis organization focusing on issues affecting low-wage and nonstandard workers. CFCW has published research on Professional Employer Organizations (PEOs), health insurance for nonstandard workers, employee classification issues, and the use of nonstandard workers by large public employers. Center for a Changing Workforce is located in Seattle, Washington.
Executive Summary

The Fair Share for Health Care Act (FSHC) proposes a new strategy to reduce the erosion of employer-based health insurance coverage, New York’s primary insurance coverage mechanism. FSHC requires most large employers to provide affordable, comprehensive coverage, or pay into a state fund to cover the health costs of their uninsured employees.

To assess the employment impacts of the FSHC, the Center for a Changing Workforce reviewed recent economic literature on employment and health insurance, and used several methods to develop a balanced estimate of possible positive and negative employment impacts.

The report concludes that the proposed legislation will ultimately create between 7,380 and 38,744 net new jobs for New Yorkers.

Additional employment will come from new spending under the legislation on health insurance and health care, estimated at $4.6 billion to $6.5 billion per year. The impact of new health care spending on New York jobs is positive because health care spending is predominantly local, while more of the foregone consumption without the insurance requirement would go to goods or services purchased out of state. The health care industry is also labor intensive. New York State is positioned to absorb additional health care spending because the state has a well-developed health care infrastructure, with little employment leakage to other states.

At the same time, there are smaller potential negative impacts from employers choosing to cut employment rather than provide health insurance for some low-wage workers. The report uses standard economic analysis to estimate the size of this employment loss, about three percent of the affected employment.

The report summarizes the relevant economic literature on employment and health insurance as follows:

- Economists are divided on how additional health care costs are shared between employees, consumers and investors.
- Some negative impact would be expected on wages, although this is likely to happen over the long term.
- Economists are divided on the impact of additional health care costs on low-wage workers, but any impact is unlikely to affect more than three percent of workers at or near the minimum wage.
- Employers currently providing health insurance, who would receive significant savings under the proposal, are likely to increase wages and employment.

A recent report critical of the FSHC, sponsored by the fast food industry’s public relations arm, suffers from unrealistic assumptions on employment loss, and makes no attempt to measure the positive employment impacts of legislation that unquestionably will lead to a large increase in health care spending.
Introduction

The continuing erosion of America’s employer-based health care system is drawing increasing attention from policy-makers, elected officials, employers, health care providers, and affected employees.

Recent national surveys underscore the problem. In 2005, 19 percent of working adults were uninsured, up from 16 percent in 2000 (Fronstin, 2006). The percentage of employers offering insurance to their employees has dropped from 69 percent to 60 percent nationally in the past five years.¹

The erosion is also reflected in the current shift towards greater financial risk for employees, which is creating large numbers of underinsured workers, based on income and out-of-pocket expenses. Two-thirds of the 16 million underinsured Americans are in employer-provided insurance plans, and 40 percent of these are in large employer plans (Schoen, 2005).

While the majority of uninsured workers work for smaller employers, large employers are also shedding employee health insurance coverage, and at a faster rate than smaller employers (Glied, 2003)

The growth of nonstandard employment since 1990 has also impacted health insurance coverage. This category, including temporary, contract and part-time workers, now makes up almost one-third of the nation’s workforce. A recent study found 60 percent of these workers were not eligible or offered employer insurance, and only 21 percent had insurance from their own employer (Ditsler, 2005).

In addition to reduced coverage, this erosion has two other major effects. First, the costs of public benefit programs, including Medicaid, increase as employees shift from employer coverage to Medicaid coverage. This shift results in Medicaid “crowd-out,” as formerly insured employees compete for limited Medicaid coverage. Ultimately, taxpayers carry the load, with Medicaid now the top expense for state governments.²

Second, the costs of insurance for the remaining employers has climbed dramatically, with a major factor being cost shifts of hospital uncompensated care and Medicaid underpayments, and the cost of providing coverage to dependents of employers not providing insurance.

These trends have not escaped the attention of policy makers and elected officials. Proposals aimed at addressing the erosion of employer-based insurance are surfacing in legislatures across the country. More than 20 states are considering “fair share” employer responsibility legislation, following the passage of fair share proposals in Maryland, New York City and Suffolk County on Long Island.
These proposals all have one thing in common—they are aimed at reducing erosion of employer-based health care coverage and reducing the shift of employees from employer coverage to public coverage.

State legislators in New York have developed one of the more far-reaching proposals in the nation. The New York proposal, the Fair Share for Health Care Act (FSHC), would give large employers a choice of providing health insurance or paying into a state fund to provide such insurance. The New York proposal is raising policy questions—what will the impact be on employment? Will proposals lead to a less-friendly business climate? This paper reviews the economics literature on the employment impact of legislation regulating employer health insurance benefits, and provides an initial estimate of the net jobs impact of the Fair Share for Health Care legislation in New York.

Description of New York legislation

The Fair Share for Health Care Act (FSHC) was introduced into the New York Assembly and Senate in March 2006. This legislation follows employer fair share legislation recently passed in Maryland, although the details differ considerably from Maryland’s law.

FSHC places an assessment of $3.00 per hour on most large employers (defined as 100 employees or more) to cover the costs to the public health care system of providing health insurance for uninsured workers. Large employers who are currently paying for employee health insurance will be allowed to deduct their current payments from the assessment. Two sectors of the economy—manufacturers and agriculture—will not be subject to the assessment. Employers of building service workers in buildings with 100,000 square feet of office space or fifty residential units are also covered. The assessment does not count hours worked in the first 30 days of employment.

The FSHC will have the following general impacts on the incidence of employee health care costs:

- Health insurance costs will increase for employers whose average health insurance costs are less than $3.00 per hour per employee. These employers do not currently provide comprehensive health insurance to most employees.
- Health insurance costs may fall for employers whose average health insurance costs are more than $3.00 per hour per employee, depending on the competitiveness of the market for insurance and health care providers. These employers currently provide comprehensive health insurance to most employees and spouses/dependents.
- Employees will probably pay less for health insurance across the board, since large employers who currently pay a small portion of employee health care costs will be required to pay more under the legislation. Workers’ salaries may be adjusted downward in the short or long run to maintain overall employee compensation levels, depending on the competitiveness of the labor market.
**Review of Economic Literature on Employment and Health Insurance**

In standard economic theory, employers react to an increase in one component of employee compensation (i.e. health insurance) in several ways. The employers can reduce wages or other benefits so overall employee compensation stays the same, increase prices, reduce other input costs, reduce profits, or reduce employment levels. All of these options depend on supply and demand factors facing the firm for labor inputs and product outputs. Table 1 presents some of the likely options for a typical firm.

<table>
<thead>
<tr>
<th>Demand for Products</th>
<th>Labor Markets Conditions</th>
<th>Tight Labor Market</th>
<th>Slack Labor Market</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (Inelastic) Demand</td>
<td>Raise prices</td>
<td>Reduce wages or raise prices</td>
<td></td>
</tr>
<tr>
<td>Low (Elastic) Demand</td>
<td>Reduce profits</td>
<td>Reduce wages</td>
<td></td>
</tr>
</tbody>
</table>

In this model, given fixed product demand, lower demand for employees (wages elastic) would mean a greater possibility of wage or job cuts, whereas steep demand for workers (wages inelastic) lessens the ability of employers to reduce wages or employment. On the product side, given fixed demand for labor, low product demand (price elastic) means profits or wages must be cut because prices cannot be raised, while high product demand (price inelastic), means prices could be raised.

Most economists support the theoretical view that at least some of an increase in employee health care costs would be passed on to employees in the form of lower wages. However, there is little consensus on how much of the added cost is passed on to employees, or whether this wage reduction happens in the short or long run.

Some economists believe the question is more complicated. Karen Davis, President of the Commonwealth Fund, concludes “empirical evidence on whether health care costs are shifted forward to consumers or backwards to workers is largely inconclusive (Davis, 1994).” The main problem is that there is no data available that directly correlates employer health insurance costs for an entire workforce with employment at the firm level. As a result, researchers are forced to look at other data sets and infer conclusions.

---

1 See Gruber and Krueger, 1991; Summers, 1989; Heckman, 1993; and Gruber, 1994
2 One estimate based on a review of literature concluded that 88 percent of the change in employer costs would be passed on to employees in the form of lower wages. (Lewin Group, 2003). Others (Baicker and Chandra, 2005), have found evidence of incomplete tradeoffs between wages and health benefits.
3 “Although over the long term employer-paid premium costs may reduce total wage income through the impact of higher prices or reduced wage increases overall, this impact is unlikely to be distributed dollar for dollar per employee based on that employee’s health costs.” (Davis, 1994) Also (Krueger and Reinhardt 1994) “…In other words, in the longer run the cost of the employer mandate most likely will be shifted backward to employees in a gradual manner that many of them may not even notice.”

---

*Center for a Changing Workforce*
One example is a study on maternity benefits (Gruber 1994), which found that mandatory maternity benefits resulted in reduced wages for married women. Since this mandate effectively applies to less than half the workforce, and employers could single out married women for wage cuts, it may not reflect broader dynamics of health insurance and employment.

The only existing example of a health insurance employer mandate is Hawaii, which requires employers to provide health insurance to all full-time workers. Here the evidence is mixed—the most well-known study (Thurston, 1997) found industries most affected by the mandate had slower wage growth than other island industries, but more rapid wage growth than the same industries on the mainland. Thurston speculated that other unmeasured factors were having a larger effect on employment than the health insurance mandate. Thurston also found that for each 10 percent increase in employment in workers covered by the mandate, one percent of the jobs were shifted to exempt workers (i.e. part-time), suggesting that rising health insurance costs will lead to more part-time workers who can be excluded under current law (ERISA) from benefit plans. In contrast to Hawaii and ERISA, the language of the FSHC legislation covers part-time workers.

Among the most recent studies, Baicker and Chandra (2005) looked at census data and medical malpractice costs (as a surrogate for health insurance costs), and predicted that rising health insurance premiums would have a negative effect on employment, wages and full-time work, with a major impact on manufacturing workers, who compete in worldwide markets. The FSHC strategy of exempting New York’s manufacturing sector addresses this analysis, as does the bill’s coverage of part-time workers.

Other researchers note that cutting employee wages can be difficult, even in a recessionary economy. Truman Bewley, in Why Wages Don’t Fall During A Recession, reports on interviews with personnel managers on reasons employers will not cut wages. Bewley concluded the main reason was the fear that wage cuts would hit workers' standard of living and lower self-esteem, causing morale problems, which in turn would undermine employee productivity and cause staff turnover, costing the employer more than any savings from wage cuts.

Challenges to Standard Theory on Health Insurance and Employment

Another challenge to the conventional theory that there is a tradeoff between wages and health insurance comes from a variety of studies showing a positive correlation between health insurance and wages—in other words, higher wages are correlated with the presence of health insurance and vice-versa. In a review of 11 studies on health insurance and labor market outcomes, Currie and Madrian (1999) found five studies showing a positive relation between wages and benefits, three studies with a negative relationship, and three inconclusive studies.

The biggest puzzle in this literature is the dearth of evidence supporting a negative relationship between health insurance and wages in spite of a strong (and uncontroversial) presumption that such a tradeoff should exist. The conflicting evidence
on this front underscores the difficult identification issues associated with isolating the impact of health insurance, as separate from other factors, on labor market outcomes.

Ellen O’Brien (2003) comes to the same conclusion, and suggests that economists who support the wage/health insurance tradeoff theory should look in other places.

Despite decades of efforts to demonstrate its validity, the empirical basis for the theory (on wages and health insurance) remains weak. But rather than reassess the theory, economists have focused on why the empirical research fails to produce the expected result. A key flaw in the standard theory is that it ignores the benefits accruing to employers from offering health benefits. The alternative view…posits a business case for employment-based health coverage because offering a compensation package composed of both wages and health insurance is more profitable than providing wages alone.

O’Brien makes a case that employers would want to offer health insurance, regardless of what employees want, because it improves productivity, allowed them to attract and retain high-skilled workers, and reduce absenteeism and turnover.

Health care costs also affect the way employers organize the workplace. Since health insurance is a fixed, not a variable cost, employers try to amortize the cost over as few insured workers as possible, and employ higher productivity workers. This is consistent with the findings above that health insurance is correlated with higher wages. There is evidence that employers respond to higher insurance costs by increasing hours for existing insured workers and reducing hours for uninsured workers (Cutler and Madrian, 1998), or by requiring more overtime hours for insured workers.

Employers have also responded to higher costs by using more temporary, part-time and seasonal workers. The FSHC proposal would probably be a disincentive for such practices, since nearly all employees working for a covered employer would be included.

Some economists (Krueger and Reinhardt, 1994; Davis, 1994) conclude that some unemployment may result from rising health insurance costs, but other outcomes are just as likely, including increases in prices, reduced profits, or changes in other inputs (see discussion above), depending on the demand for labor and products.

Another issue often ignored in studies on employer health insurance is the impact on employment with employers who do provide health insurance. The theory is straightforward:

For firms or industries experiencing major reductions in health insurance cost per FTE, the demand curve for labor should shift up…one would see both take-home pay and employment rise as a result of these labor cost reductions. (Krueger and Reinhardt, 1994)

The Minimum Wage Argument

According to standard economic theory, when employers are faced with added benefit costs, they will reduce wages. If the employee is paid at or near the minimum wage,
wages cannot be reduced any further and unemployment will result. This argument has been used recently in studies sponsored by the restaurant industry and other low-wage employers. The theory posits that wages and benefits are interchangeable, and the effects of an increase in health care costs are the same as an increase in the minimum wage. Researchers supporting this view theorize that they can predict the number of jobs lost using estimates of wage elasticity. There is no agreement, however, on the size of the elasticity employment effect, something even the theory’s supporters acknowledge.

Opponents of raising the minimum wage, led by the restaurant and retail industry, have argued that raising the minimum wage leads to job loss, especially for teen-age workers. Studies using national data from the 1960’s and 1970’s did find a very small negative employment elasticity figure (-.01), which would mean a 1 percent teen job loss, however studies using more recent national data have concluded that the employment effect from raising the minimum wage is very close to zero.

A 1995 book by David Card and Alan Krueger, *Myth and Measurement: the New Economics of Minimum Wage*, reviewed previous studies and conducted new research in fast food restaurants in Pennsylvania and New Jersey to conclude there is “reasonably strong evidence against the prediction that a rise in the minimum wage invariably leads to a fall in employment” (Card, p. 389). Card and Krueger found evidence that in some situations, minimum wage increases may sometimes actually increase employment. Their theory, which a number of economists agree with, is that the minimum wage can sometimes be an efficiency wage—employees work harder with higher wages, thus increasing productivity, because the costs of losing one’s job are higher.i

An overview of these minimum wage studies by Charles Brown in the standard textbook *Handbook of Labor Economics* (1999, p. 2154) finds “there is no credible evidence of long-term impact on employment.” Looking at studies on state minimum wage increases and employment, Brown concluded that a finding of “zero (impact) is often hard to reject.”

A recent letter to Congress and the President signed by over 500 economists agreed with the 1999 statement by the Council of Economic Advisors that solid economic research proves that past increases have had “very little or no effect on employment.”ii

**Real World Evidence on Jobs Impact**

The real world evidence on recent minimum wage increases, even large ones, indicate that none of the changes to date have resulted in measurable job loss. A review of statewide increases in Washington, Alaska and Oregon (Chapman 2004) found no

---

i Also see “The Consequences of Minimum Wage Laws: Some New Theoretical Ideas, (Rebitzer and Taylor 1991)

ii The signers included four winners of the Nobel Prize in Economics and seven past presidents of the American Economic Association. As Nobel economist Robert Solow said, "the focus on jobs is pure political rhetoric - employment has risen even after minimum wage increases. The research evidence of job loss is weak, which suggests that the impact is small" (NYT 1/12/95)
evidence that relatively large minimum wage increases (26 percent) negatively impacted employment. A recent study of a 26 percent increase in the minimum wage in Santa Fe in 2004 by the New Mexico Bureau of Business and Economic Research, found local employment rising in all six quarters since passage, while the number of families in need of temporary financial assistance was dropping.

One reason impacts have been minimal is that few of the employees affected by increases are actually at the minimum wage, because many employers pay $1.00 or more above the minimum wage to attract and retain better workers. As a result, few employers actually face the full predicted percentage cost increase for their workforce.

Another way to look at the impact of minimum wage increases is to look the impact on overall costs and prices charged by minimum wage employers. Recent studies and business surveys in cities that have passed local minimum wage increases indicates that impact on prices is minimal, which is consistent with a minimal employment impact. For instance, in San Francisco, a study commissioned for the City concluded that 82 percent of employers would face cost increases of less than one percent, and only five percent of employers would see cost increases of five percent or more (Reich and Laitinen, 2003). In Santa Fe, a typical (median) employer would need to raise prices 1 percent, and the most heavily affected restaurant industry would need to raise prices by 3.4 percent (Pollin, 2004).

On a practical level, large retail stores and fast-food restaurants are already staffed at the lowest possible level, the result of years of work by efficiency experts. Any significant staffing reductions would threaten the stores’ ability to maintain market share or stay in business. Job losses are also unlikely because in many markets, large stores and restaurants will all face the same requirements, with no large employers gaining an advantage. Instead, smaller, primarily local stores, and large competitors offering health insurance will benefit, and may see employment increases.

**Reviewing EmPI’s New York Fair Share for Health Care Projections**

The Employment Policies Institute (EmPI), a public relations office run by the restaurant industry, recently released a report by Aaron Yelowitz (2006) concluding that the FSHC proposal would result in the loss of 69,000 to nearly 100,000 jobs in New York. The author has written numerous reports for EmPI predicting job losses from health care and minimum wage measures.¹

The EmPI report is based on the standard theory that increased employer health care costs will result in wage cuts and jobs losses for low-wage workers. The report does not attempt to estimate the additional employment from increased health care spending or increased hiring by firms who will see health care spending reductions. The report cites a study (Gruber, 1994) correlating employer mandates with wage cuts, but doesn’t address other studies in the literature correlating wage gains with health insurance. Finally, the

¹ In the unsuccessful court case challenging the Santa Fe minimum wage ordinance, Yelowitz served as a paid expert witness for the plaintiff employer group, New Mexicans for Free Enterprise.
report acknowledges that employers may pass on a percentage of increased costs to consumers or absorb costs in reduced earnings rather than reduce wages, but does not attempt quantify these effects.

The EmPI report estimates a range of costs from the FSHC, from $9.2 billion to $5.7 billion, and a per employee cost range of $19,617 to $12,000. The upper estimate is entirely theoretical, as it doesn’t include cost offsets to employers and public programs whose costs would be reduced under FSHC. The report leaves the casual reader with the impression that employers must pay all costs, when in reality the costs are also born by other payers, including individuals and taxpayers.

Rejecting the available evidence that the minimum wage employment impact is too small to be measured, the EmPI report uses a high negative elasticity estimate (-.22), citing one study (Neumark and Waschler, 2000), even though these authors concluded that they could only say for sure that minimum wage does not lead to employment increases.

Given the lack of consensus by economists on the impact of health insurance coverage on wages, using minimum wage elasticity estimates under any circumstances to make inferred predictions in the more complicated area of employment health care coverage is speculative at best.

As part of EmPI’s job loss prediction, the report theorizes a negative employment “notch” effect from the FSHC proposal’s 100 employee threshold that would cost 40,000 jobs, yet admits there is no empirical evidence for such a claim. In fact, many state and national employment laws have such a threshold feature, including family/parental leave laws and discrimination laws, and our research could find no evidence that any of these laws, some dating back to the 1970’s, have a negative “notch” employment effect at the threshold.

It’s important to note that many employers who are covered under the FSHC legislation will not experience the full impact because they already make contributions to employee health care costs, but at lower levels, because either the employees are paying a significant share of the costs, or the coverage is less than comprehensive coverage. Analysis of Medical Expenditure Panel Survey (MEPS) data indicates that the average amount paid by covered employers in 2003 was $2.30 per hour. The increase required of the average employer covered under the FSHC is about $.70 per hour, well within the size of previous increases in state or federal minimum wage levels.

**Economic Impact Analysis of Fair Share for Health Care**

Given the number of variables impacting hiring decisions, estimating the employment impact of proposed legislation is difficult, as the above literature confirms. An estimate must take into account not only possible negative factors, but positive factors as well. Our analysis here attempts to make conservative estimates of both negative and positive factors and develop a net employment estimate.

*Center for a Changing Workforce*
Section 1 - Estimate of Employment – Positive Effects

“One American’s rising medical spending is another American’s rising income.”
--Economist Mark Pauly

While health care spending takes its toll from both employers and employees, health care spending also has a positive impact on the economy, resulting in employment growth and profits for mostly American companies. This employment growth needs to be addressed in any complete analysis. Under the FSHC legislation, employers currently paying less than $3.00 per hour for employee health insurance, must increase their spending to the meet the $3.00 threshold, or pay the difference into a state fund. Health care spending is primarily local—this new spending will create additional health care jobs in New York State, and will replace foregone spending by employers, who, lacking a health care requirement, would spend a higher percentage on out-of-state goods and services.

We first estimated new health care spending under the FSHC legislation, and developed a range of estimates, from $4.6 billion to $6.5 billion per year. For the low estimate, we estimated the cost of providing coverage for 466,000 uninsured covered workers at $3.00 per hour and 1,840 hours per year at $2.9 billion. We then added the cost of providing basic coverage to an estimated 549,000 covered underinsured workers. To approximate current spending on underinsured workers, we used average employer spending at the 25th percentile ($1.04 per hour) from MEPS data, subtracted from the $3.00 threshold, resulting in additional spending of $1.96 per hour. The total of new spending needed to cover the underinsured is estimated at $2 billion. We subtracted $300 million for estimated savings to Medicaid from reduced employee participation, for a total net spending estimate of $4.6 billion.

For the high estimate, we estimated the additional cost to employers for all 4,156,508 covered employees, using 2003 MEPS data on employer health care expenditures, inflated to 2006. The MEPS data allows us to estimate the average hourly cost for each decile group of employers (based on number of workers). For each decile group, we subtracted current spending from the $3.00 threshold, and totaled new spending only up to the 60th decile, where current spending meets the $3.00 threshold. We assumed an average 38 hour week for 46 weeks, totaling 1,748 hours per year, totaling $6.8 billion in new spending as shown in Table 2. As with the low estimate, we subtracted $300 million in Medicaid savings, creating a net estimate of $6.5 billion.

In neither estimate did we adjust for reduced employer spending for insured employers due to reduced cost-shifting, nor did we attempt to estimate any additional non-health care employment that would result from such savings on the positive side.

---

1 Based on Baicker and Levy (2005) tabulations of Current Population Survey (CPS) data for uninsured workers, p. 9

2 The Commonwealth Fund estimates that there are 16 million underinsured people in the U.S, or approximately .53 underinsured for every uninsured person. Approximately 64 percent of those are employed, and approximately 60 percent of those are at large firms (Schoen, 2005). Applying this formula to New York’s 2.7 million uninsured, we estimate covered 549,000 underinsured workers.

3 Based on the uninsured cost analysis by Kenneth Thorpe for Families USA (2005).
The New York State Department of Labor estimates that state health care wages were $43 billion in 2004.5 New Yorkers spent a total of $124 billion on health care in New York in 2004, for a wage-to-spending ratio of 35%.6 New York has a higher percentage of health care jobs than the national average, which is true in all regions of the state. The average New York health care wage is $42,400 (2005).

To arrive at estimates of additional employment based on new health care spending, we applied the wage-to-spending ratio to the range of health care spending on wages, and divided by the average New York health care wage. See Table 3. The resulting estimates project 31,000 to 55,000 new health care jobs at the average wage.

This does not count any additional employment by employers spending less on health care costs for current employees, a very likely possibility. New health care spending will also result in additional jobs through a multiplier effect. The New York health care multiplier is 1.78 for every new job created.7 Possible job loss (see analysis below) is concentrated in sectors with lower job multipliers, including retail and hospitality, ranging from 1.5 to 1.7.

EmPI estimated a net cost of $5.7 billion for the FSHC. Using their cost analysis and our health care spending analysis, would result in a new jobs estimate of 47,169, between our low and high estimates.

In some states, researchers have developed complex regional econometric input/output models to simulate how sectors of the economy interact, including the flow of labor between sectors depending on changes in demand. In 2005, the Blue Cross Blue Shield Foundation of Massachusetts (BCBS) utilized such a model, the Regional Economic Models Incorporated (REMI) Policy Insight model, to estimate the impacts of health care mandate proposals in Massachusetts. While the Massachusetts proposal under discussion differed by including individual and employer mandates, the simulation is valuable for us by predicting employment outcomes for given levels of new health care spending.

The Massachusetts BCBS simulation (Blumberg, 2005) was based on an increase of health care spending of $1.4 billion. The study predicts a range of net increases of 7,900 to 31,100 jobs in Massachusetts, with the following reasoning:

<table>
<thead>
<tr>
<th>Employment Decile</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Cost Per Hour</td>
<td>0.15</td>
<td>0.72</td>
<td>1.40</td>
<td>1.87</td>
<td>2.37</td>
<td>2.94</td>
<td></td>
</tr>
<tr>
<td>Additional Cost ($)</td>
<td>2,277,242,451</td>
<td>1,824,293,92</td>
<td>1,281,777,956</td>
<td>906,389,101</td>
<td>503,778,497</td>
<td>50,309,096</td>
<td>$6,843,791,022</td>
</tr>
</tbody>
</table>

Source: Medical Expenditure Panel Survey (MEPS) Data, 2003
One reason for the mildly positive economic impacts is that new health spending will largely stay in the state, while more of the foregone consumption due to higher taxes would be goods or services that are purchased out of state.

Applying the same formulas to our estimates of new health care spending in New York, we find a range of 19,000 to 106,000 net new jobs created. While there are many differences between the two state economies, there are also similarities based on the importance of health care to both state economies. The Massachusetts analysis provides a useful check and demonstrates that our new employment projections above are probably conservative.

Section 2 - Estimate of Employment – Negative Effects

While there is no evidence of job loss from higher minimum wage requirements, there is no clear evidence on the employment impact of health care proposals like the FSHC. Because the empirical evidence reviewed in the literature is mixed on whether there is a positive or negative relationship between wages and health insurance, and because the evidence on the minimum wage concludes there is zero employment impact, we anticipate that the effect of the FSHC proposal on employment will be small. Thus we have chosen the low end of the accepted range of labor demand elasticity for low wage jobs (-.01). That is, for every 10 percent increase in the cost of health care, there would theoretically be a one percent job reduction.

If there is job loss, it would be focused among uninsured workers covered by the FSHC, since those employers would be required to spend the most under the legislation. Low-wage employers (paying an average of $9.50 per hour) are currently spending $.84 per hour on health care, according to MEPS data. The FSHC proposal would require an increase in current spending to $3.00 per hour, or a $2.16 increase, which is 32% of the current New York minimum wage of $6.75.

Our elasticity estimate predicts a 10% increase in minimum wage will create a 1% reduction in employment. Thus, 32% increase in the minimum wage would result in a 3.2% employment reduction for low-wage New York uninsured workers. There are currently 466,000 uninsured covered workers, most of whom are low-wage, resulting in a low-end theoretical reduction of 14,912 jobs. Our net jobs estimate is shown in Table 3.

Job loss could theoretically affect a percentage of all covered low-wage workers. An estimated 23 percent of the 4.1 million covered employees are within $3.00 of the New York minimum wage. We apply the methodology from the estimate above, again assuming a (-.1) wage elasticity. Low-wage employers would face a $2.16 average hourly cost increase to reach the $3.00 threshold, a 32 percent increase, which translates into a 3.2 percent theoretical job loss, creating a high-end potential estimate of 30,592 lost jobs.
Other Impacts

Because there is no accepted theory or empirical evidence of the jobs impact of what EmPI describes as a “jobs notch” (the 100 employee threshold) under the FSHC proposal we cannot estimate any jobs impact from this provision.

Based on our previous research with nonstandard employment, we believe the FSHC will address several distortions in the current labor market. Since the late 1980’s the percentage of temporary, part-time, seasonal and other nonstandard workers has grown as employers seek to cut costs by removing employees from benefit plans. The FSHC proposal would be a disincentive for such practices, since nearly all employees working for a covered employer would be included, and most third-party staffing firms would be covered under the proposal.

The proposal is also unique in addressing the growing problem of misclassification of employees in the building maintenance industry. Some large building maintenance contractors misclassify employees who clean individual floors of large buildings as “independent contractors” or “franchisees.” These employers do not provide health insurance, retirement, workers' compensation, unemployment insurance or paid leave. These employees are also not covered by any employment laws, including minimum wage, overtime, discrimination laws, etc. The savings from this misclassification scheme are passed on to the building owners. By properly identifying the large building owner as the real employer, and providing coverage, the proposal removes a major incentive for such misclassification.

| Table 3. Estimate of Net Employment Impact of New York Fair Share Legislation |
|--------------------------------------------------|----------------|----------------|
| **Possible Employment Increases**               | **Low**        | **High**       |
| Estimates of increased health care spending     | $ 4,600,000,000 | $ 6,500,000,000 |
| Estimate of new health care wages               | $ 1,610,000,000 | $ 2,275,000,000 |
| Additional new jobs                             | 37,972         | 53,656         |
| **Possible Employment Reductions**             |                |                |
| Total number of covered workers (uninsured in High estimate) | 4,156,508 | 466,000 |
| Number of workers within $3.00 of New York min. wage (23 percent of total) | 955,997 | NA |
| Additional hourly cost to employers             | 2.16           | 2.16           |
| Additional hourly cost as percent of minimum wage | 0.32          | 0.32          |
| Employment reduction factor using 1% elasticity | 0.032         | 0.032         |
| Potential jobs lost                             | 30,592         | 14,912         |
| **Net New Jobs**                                | 7,380          | 38,744         |
Conclusion

We conclude that the FSHC proposal will have a minimal employment impact on the New York State economy. We find that additional employment created by the proposal is about half of one percent of total New York employment. Many other factors affecting the New York economy would have a greater impact, including, for example, oil price increases, federal or state tax changes, or changes in the international economy. The FSHC proposal also exempts manufacturing, the employment sector most likely to be negatively affected by out-of-state or international competition.

During the 2005 debate in Maryland over fair share legislation, Wal-Mart told state legislators that such legislation would make the company “reconsider” its plans to build a large distribution facility on the Eastern Shore, a statement that influenced the debate over the legislation. Recently Wal-Mart announced that in spite of the new law, it was going ahead with building the Maryland distribution center. The reality is that hiring and employment decisions are based on many factors, a concept that state policymakers need to keep in mind in analyzing the FSHC proposal and similar policy proposals.
Sources


Bewley, Truman, *Why Wages Don’t Fall During a Recession*, Harvard University Press, 2002

Blumberg, Linda, John Holahan, Alan Weil, Lisa Clemons-Cope, Matthew Buettgens, Fredric Blavin, Stephen Zuckerman, “Building the Road Map to Coverage: Policy Choices and the Cost and Coverage Implications,” Blue Cross Blue Shield Foundation of Massachusetts, June 2005


Reich, Michael, and Amy Laitinen, “Raising Low Pay in a High Wage Economy,” Univ. of California Institute for Labor and Employment, [www.iir.berkeley.edu/livingwage](http://www.iir.berkeley.edu/livingwage)

Schoen, Cathy, Michelle Doty, Sara Collins, and Alyssa Holmgren, “Insured but not protected: How many adults are underinsured?” *Health Affairs*, June 2005


Thorpe, Kenneth and Families USA, “Paying a Premium, the Added Cost of Care for the Uninsured, Families USA Foundation, 2005, [www.familiesusa.org](http://www.familiesusa.org)


**Endnotes**

1 Kaiser Family Foundation and Health Research and Education Trust (HRET), Employer Health Benefits 2005 Summary of Findings.


3 Mark V. Pauly, Should We Be Worried About High Real Medical Spending Growth In The United States? Health Affairs Web Exclusive, January 8, 2003


7 New York State Department of Labor, “Understanding the Multiplier Effect,” *Employment in New York State*, April 2005