# Healthy Work:

## What are the consequences of not providing health insurance on two county GOB projects?

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# Uninsured Workers on Two Miami-Dade General Obligation Bonds Projects: Costs and Consequences

## Executive Summary

Two Miami-Dade County GOB projects, the renovation of the Orange Bowl and the expansion of Jackson South Community Hospital, will create about 2,000 construction jobs for local workers. But in order for these jobs to truly be a benefit to the community, all workers must be provided with health insurance. Only about 50% of construction industry workers in Miami-Dade County have health insurance, and without insurance it is difficult to access proper health care. The uninsured have shorter life-spans than the insured because they are less likely to receive regular screenings for diseases, more likely to be diagnosed in the late stages of disease, and face more difficulties monitoring chronic conditions such as diabetes. Uninsurance also creates stress and financial crises for families, and community clinics cannot serve all those in need. The disparity in care between the insured and uninsured violates principles of democracy and equality and should not be financed by public dollars.

Lack of health insurance also generates substantial costs for society. Unhealthy workers are less productive, and the shorter life spans of the uninsured mean tens of billions in lost health capital every year. In addition the health system experiences increased costs due to emergency room visits for non-emergency conditions. **In 2004 almost 72 percent of Miami-Dade emergency room visits by the uninsured were for minor, low or moderate acuity conditions, compared with 60.6 percent of visits by the commercially insured, a difference of over $17 million per year in charges that could be avoided if the uninsured had reliable access to care for non-emergency conditions.** The Jackson Memorial health care system spent $508 million dollars in charity care in 2005, or $798 per uninsured Miami-Dade county resident. We estimate that if only half of the workers on the Orange Bowl renovation or Jackson expansion are provided with health coverage, the estimated cost in charity care will be over $800,000 for workers, and over $2.4 million for workers and their families.

Providing construction industry workers with continuous, affordable coverage is difficult because of the cyclical and seasonal nature of the jobs. However collective bargaining units have largely solved this problem by assuming the responsibility for providing coverage to members while collecting benefits payments from employers. The low rate of insurance and lack of adequate care received by the uninsured means that spending is artificially low. Requiring that all workers be enrolled in a standard commercial health care plan would likely increase project costs substantially. However by using a best value contracting method and awarding points to companies that provide health insurance to their workers the county would ensure the selection of an experienced contractor capable of producing quality work on time and on budget, which is only possible with a highly productive workforce. This is a win-win-win strategy for the community: high quality, cost control, and a healthy workforce.

## Introduction

Miami-Dade County, through its voter-approved Building Better Communities General Obligation Bonds (GOB) program, is contributing $2.9 billion over the next 15 years to the construction of over 300 neighborhood and regional capital projects. Two such projects are the renovation of the Orange Bowl and the renovation and expansion of Jackson South Community Hospital. The Orange Bowl renovation is a $150 million dollar project supported by $50 million in GOB, and the Jackson South Community Hospital renovation and expansion, a $100 million project, is supported by $52 million in GOB with the rest coming from Public Health Trust revenue bonds. The Public Health Trust was created by the county as an independent governing body for the Jackson Health System, and is funded by a half-cent sales tax approved by voters in 1991 to support public health. Ultimately, taxpayers are footing a large bill for construction projects that will enhance our community services and amenities and provide local jobs, but will these jobs provide a good living for local workers? What kind of benefits will workers and their communities reap from these projects?

Health insurance is important to the well-being of all workers and their families, and employer based health insurance is fundamental to the U.S. healthcare system. Moreover, uninsurance contradicts American values of democracy and equality of opportunity, as noted by the Institute of Medicine: "disparities in access to and the quality of health care of the kind that prevail between insured and uninsured Americans contravene widely accepted, democratic cultural and political norms of equal consideration and equal opportunity" (Committee on the Consequences of Uninsurance 2003). Local governments with vested interests in the community have a special obligation to provide living wages and benefits to workers. Many now believe that "public money… should be used to maintain or elevate living standards in the community," not to subsidize working poverty (Nissen 1998). Furthermore, insisting on the lowest possible project cost, if it means denying workers health care coverage, is ultimately not in the best interests of tax payers, as this paper will show.

Rates of uninsurance vary by industry, and the construction industry has proven to be one of the worst, due to the high percentage of low-wage workers, part-time workers, and seasonal workers. A recent study by the Research Institute for Social and Economic Policy found that about 42 percent of employees in the construction industry in Florida have no health insurance (Nissen et al. 2006), making it one of the worst industries in the state for healthcare coverage. According to the author's calculations from the Current Population Survey,[1] for Miami-Dade County close to 50 percent of workers in the construction industry lack health insurance, and only about 35.7 percent are covered through their own employer. About 6percent are covered by Medicaid and 8 percent are covered as a dependent under a family member's employer-based health insurance. This

[1] Figures on the uninsured in Miami-Dade County are two-year averages calculated from 2003 and 2004 CPS March Supplement data. Because of the small sample size, standard errors are large, and the percentages given can only be taken as approximations. Margins of error are as follows: uninsured construction workers 16.6%, coverage from own employer 13.9%, covered by Medicaid 5.2%, covered as a dependent 6.0%.

shifting of costs to the state and to other employers is a growing problem in the health care system, as noted in a 2004 report by the Commonwealth Fund, a private foundation which supports health care policy research. That report finds that employers spend an estimated $31 billion per year insuring workers employed elsewhere, and that $8 billion is spent annually on public health insurance for "full-year workers not covered by their own employer"(Collins, Davis and Ho 2004, 12).

## The Cost of Treating Uninsured Workers

The likely cost to the Jackson Health System of providing health care to uninsured workers from two major construction projects supported by County dollars is substantial. Jackson estimates it provided 577,054 patient days of "charity care" in 2005, at a cost of $508 million[2]. Charity care is defined as uncompensated care provided to those living below 200 percent of the federal poverty line. These costs are ultimately footed by state and county taxpayers through the Public Health Trust. Based on these numbers, the approximate rate for charity care at Jackson comes to $880 per patient day.[3] From an estimated 636,771[4] uninsured residents of Miami-Dade County, we calculate a rate of .9 patient days in the Jackson system per uninsured Miami-Dade County resident, or $798 of charity care cost per year at Jackson per Miami-Dade County resident. However, due to the fact that workers in the construction industry use charity care at a higher rate than the general population, 67.9 percent more according to a study of a major safety-net hospital in Nevada (Waddoups 2004), $798 per year per uninsured construction industry worker represents a conservative estimate.

For the Orange Bowl renovation, labor costs are estimated at $44.7 million[5] over two and a half years. Labor costs for the Jackson South project are estimated at $29.8 million over 5 years. From the average annual construction industry wage of $37,015[6] in Florida, we estimate 1208 full-time workers for the Orange Bowl renovation and 805 full-time workers for the Jackson South expansion.[7] If we assume that an average percentage of project workers have health insurance, about 50 percent for the construction industry in Miami, the cost to Jackson for treating uninsured workers from both projects will be

[2] Figures supplied by the budget office at Jackson Memorial Hospital.
[3] This figure is lower than that arrived at by the Institute of Medicine in the study *Hidden Costs, Value Lost: Uninsurance in America* of $923 per capita spending per year on health care for the uninsured.
[4] Number is based on 26.8% uninsured rate in Miami-Dade County (Nissen 2006) and U.S. Census Bureau 2005 population estimate for Miami-Dade County of 2,376,014.
[5] Construction industry labor costs are estimated at 29.8% of the total project cost. This is based on calculations of figures from the 2002 Economic Census. We take the Total Payroll for Commercial and Institutional Building Construction plus the Total Payroll for Specialty Trade Contractors, and divide by the Net Value of Construction Work for these two industries.
[6] Calculated from Quarterly Census of Employment and Wages. Wages averaged from first three quarters of 2005.
[7] Since much construction industry work is part-time and of limited duration on any one project, these estimates of the number of workers do not reflect the number of unique workers associated with each project, but rather the number of full-time equivalent workers.

$803,000 for workers only, or $2.4 million for workers and their families[8]. **If none of the workers on the Orange Bowl renovation or Jackson expansion are provided health coverage, the estimated cost in charity care will be over $1.6 million for workers, and over $4.8 million for workers and their families.**

**Table 1**

**Estimated Costs of Charity Care to Jackson Health System for Uninsured Workers on the Orange Bowl Renovation and Jackson South Expansion Projects**

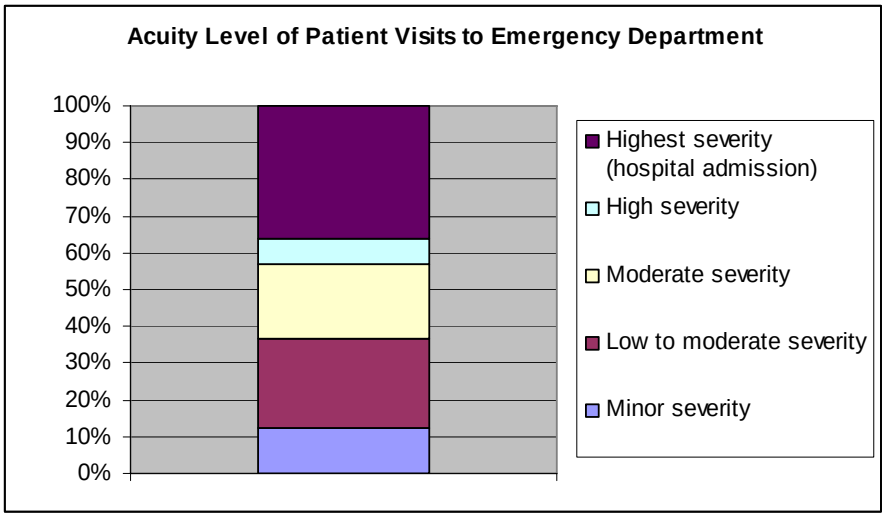
| | Orange Bowl | Jackson South | Total |
|---|---|---|---|
| *If 50 percent of workers have health coverage* | | | |
| Total Cost, Individual | $482,000 | $321,000 | $803,000 |
| Total Cost, Family | $1,446,000 | $964,000 | $2,409,000 |
| | | | |
| *If no workers have health coverage* | | | |
| Total Cost, Individual | $964,000 | $643,000 | $1,606,000 |
| Total Cost, Family | $2,891,000 | $1,927,000 | $4,818,000 |

## The Emergency Room: Source of Routine Care?

One reason why the cost of treating the uninsured is so high is because those without health insurance tend to forgo routine care and resort to expensive emergency room treatment when problems arise, or to seek routine care in the emergency room because they do not have access to or are not aware of other routine care options. A study of New York City emergency rooms found that 42 percent of emergency room visits in 1998 were for non-emergency conditions, and that the uninsured and those on Medicaid were much more likely than those with commercial insurance to visit the emergency room for a non-emergency or for a condition that was an emergency but could have been prevented with routine care (Billings et al. 2000). Analysis of Miami-Dade hospital data from the first quarter of 2005 shows that 57.2 percent of emergency room visits were by minor, low, or moderate acuity patients. (Figure 1). In addition, the average acuity level for self-pay, underinsured, or charity care patients was moderate, while the average acuity level for the privately insured was high, indicating that the underinsured are more likely to visit the emergency room for non-emergency conditions. (Table 2).

[8] The average family size in Miami-Dade County is 3.35 persons according to the 2000 U.S. Census. For construction workers, the average family size for Miami-Dade County is 3.1 according to the Current Population Survey.

**Figure 1**




Source: Author's analysis of 2005 AHCA Emergency Department and Hospital Inpatient Data for Miami-Dade facilities.

**Table 2**

| Average Acuity Level of Patient Upon Arrival by Insurance Type | |
|---|---|
| Medicare | 4.44 |
| Commercial | 3.98 |
| Other | 3.53 |
| Medicaid/public | 3.43 |
| Self-pay/uninsured/charity | 3.23 |

Acuity level: 1=minor, 2=low, 3=moderate, 4=high, and 5=highest.
Source: Author's analysis of 2005 AHCA Emergency Department and Hospital Inpatient Data for Miami-Dade facilities.

The high cost of medical care is prohibitive for the uninsured, and more affordable community clinics are often overcrowded and understaffed, making routine care unfeasible. A Kaiser Commission on Medicaid and the Uninsured survey found that over 40 percent of the uninsured do not have a regular source of care and about 20 percent, compared with 3 percent of those who have coverage, use the emergency room as their usual source of care (Kaiser Commission on Medicaid and the Uninsured 2003). Persons with regular access to health care services and affordable prescription medication are better able to receive preventive care and to manage chronic conditions such as diabetes and hypertension, which can become quite serious and costly if left untreated. The American College of Physicians reports that Americans without health insurance were 3.6 times more likely to delay seeking care than the insured, and 66 percent less likely to have had a recent physician visit (American College of Physicians 2000).

The excess of non-emergency patients impedes the ability of emergency rooms to function efficiently, and to serve those truly in need of immediate care. Moreover, the cost of emergency room care is much higher than in primary care settings, even for minor conditions. In Miami-Dade County, the average charge for a visit to the emergency room

for a minor acuity condition was $539.93 in the first quarter of 2005, according to Florida Agency for Health Care Administration data, and $1170.38 for a low-to-moderate acuity condition. (Table 3)

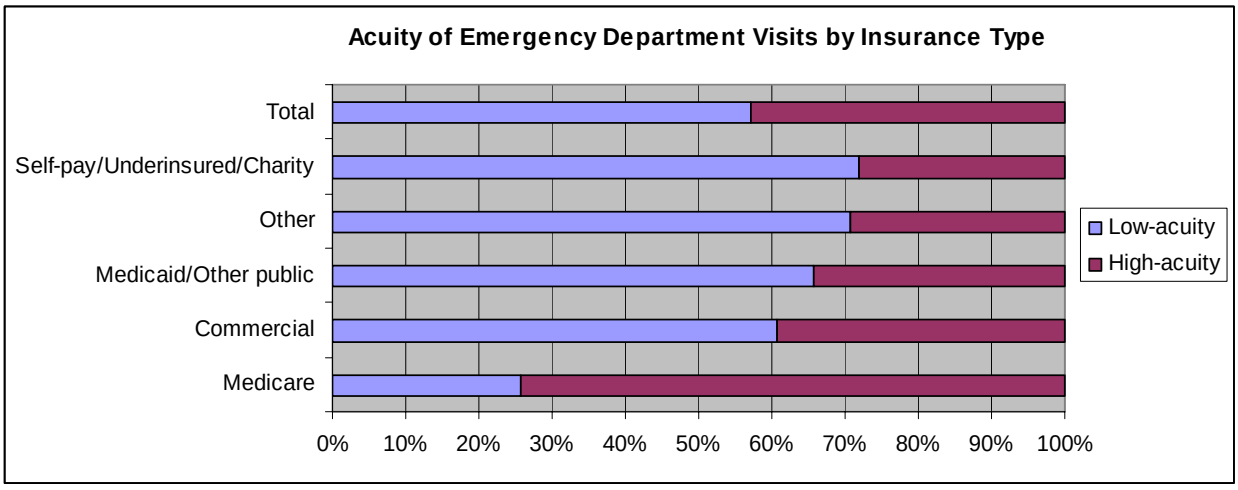
**Table 3**

| Average Charge for Emergency Department Visit by Patient Acuity Level | |
|---|---|
| Minor severity | $539.93 |
| Low to moderate severity | $1,170.38 |
| Moderate severity | $1,870.42 |
| High severity | $3,503.67 |
| Highest severity | $31,541.89 |

Source: Author's analysis of 2005 AHCA Emergency Department and Hospital Inpatient Data for Miami-Dade facilities.

**Almost 72 percent of emergency room visits by the uninsured were for minor, low or moderate acuity conditions**, compared with 60.6 percent of visits by the commercially insured, (Figure 2) a difference of over $17 million per year in charges that could be avoided if the uninsured had reliable access to care for non-emergency conditions.[9] Medicare, the plan that most resembles universal coverage (although it is not directly comparable because of age restrictions) appears to be the best at keeping away unnecessary visits to the emergency room – only 25.7 percent of visits by Medicare recipients were for minor, low, or moderate acuity conditions, a yearly difference of over $70 million compared with the uninsured.

**Figure 2**




[9] The mean charge for a low-acuity visit to the emergency room for a self-pay/uninsured/charity patient was $1369.42 in the first quarter of 2005. If the rate of low-acuity visits by the uninsured matched that of the commercially insured the total spending on low-acuity visits by the uninsured would be $23,325,114.49, a difference of $4,312,474.51 per quarter, or $17,249,898.03 per year. For a rate comparable to that of Medicare patients, spending would be $9,892,004, a difference of $17,745,585 per quarter, or $70,982,340 per year.

**Table 4**

**Acuity of Emergency Department Visits by Insurance Type**

| | *Low-acuity* | *High-acuity* |
|---|---|---|
| Medicare | **25.7%** | 74.3% |
| Commercial | 60.6% | 39.4% |
| Medicaid/Other public | 65.8% | 34.2% |
| Other | 70.7% | 29.3% |
| Self-pay/Underinsured/Charity | **71.8%** | 28.2% |
| Total | 57.2% | 42.8% |

Source: Author's analysis of 2005 AHCA Emergency Department and Hospital Inpatient Data for Miami-Dade facilities.

## Negative consequences for families and society

Lack of insurance leads to reduced economic resources for a family and society. **The uninsured have a 25 percent higher mortality rate** according to the Institute of Medicine, which estimates that the value of "health capital" lost each year due to decreased life spans of the uninsured with chronic diseases amounts to between $65 and $130 billion (Committee on the Consequences of Uninsurance 2003). The Committee performed a cost-benefit analysis of "the economic value of the healthier and longer life that an uninsured child or adult forgoes because he or she lacks health insurance" (Committee 2003, 3) versus the cost of additional years of health insurance, and found that **the benefits to society of having more healthy individuals did indeed outweigh the costs of providing health insurance, both public and private.**

Lack of health insurance places strains on families in a number of ways. Out-of-pocket spending on health care services can consume a substantial portion of a low-income family's resources, leading to financial insecurity and stress. Thirty six percent of the uninsured report having problems paying a medical bill, compared with 16 percent of those with coverage, and 23 percent have changed their way of life significantly to pay medical bills, compared with 9 percent of the insured (Kaiser 2003). The Kaiser Commission on Medicaid and the Uninsured notes that "Insurance helps reduce the financial uncertainty associated with health care, as illness and health care needs are not always predictable and care can be very expensive. Therefore, those lacking coverage are more financially vulnerable to the high cost of care, are exposed to higher out-of-pocket costs compared to the insured, and are more often burdened by medical bills" (Kaiser 2006, 1).

Also, the uninsured are less likely to receive preventive screenings; left untreated or undetected, serious medical conditions can develop which present a huge burden to a family when one or more members must leave a paying job to care for the sick member. The uninsured are 50 percent more likely to be hospitalized for a preventable condition, and "up to two and a half times more likely to be diagnosed in the late stages of cancer than those with health insurance" (Kaiser 2003, 7).

Finally, workers who do not have access to health insurance for their families risk negatively impacting the growth and development of their children. Poor health leads to excesses of missed school days and diminished academic performance, which decreases later earning potential and quality of life.

A health crisis intensifies the variety of hardships faced by the uninsured, and can be enough to push a family that has been squeezing by with minimal health care over the edge. Anibal Mendoza, his wife and their four children have been U.S. residents for six years. They own their home in North Miami-Dade, which Anibal bought with workers' compensation money he received after suffering an injury on the job at a construction site. Since they arrived in the U.S. he has been looking for health insurance, but because he has diabetes, he is either denied coverage or offered only extremely expensive coverage. After his injury he could no longer find construction work, and instead finished his studies in theology and became pastor of a small evangelical church. He teaches religion classes and ministers to alcoholics, domestic abusers, and youth gangs, but has no steady salary.

Not yet forty years old, Anibal's health began to worsen eight months ago, and was interfering with his work. He went to a community clinic to see the doctor, but was prescribed medicines that cost almost $400 per month. He tried to have medicine sent from Nicaragua, but felt that taking medicine without a doctor's care was unwise. Unable to continue buying his prescribed medicine, he suffered a heart attack in March and spent three weeks at Jackson Memorial Hospital. He praises the care he received, but is worried about his bill – over $100,000. As a pastor, he says, he must be an upstanding member of the community, and his inability to pay his bills weighs on his conscience. He has been repeatedly told he is ineligible for Medicaid because of the value of his house. He could apply for disability, he says, but he is not willing to lie by claiming that he is completely unable to work. "A person like me has to be right with society because this is what I teach, but with the circumstances how do you do it? If I had had medical insurance, I wouldn't have had all these problems. It's not that I didn't want it, but I couldn't get it. I would have to dedicate two weeks of work a month to pay for medical insurance just for me."

After his stay in the hospital, Anibal received a Public Health Trust card that allows him to buy his medicines at a lower cost, but it expires in August and he is not sure if he will be able to renew it. He receives bills from many different doctors, but if he offers to pay each one $50 per month, he would spend at least $500. The difficulty of juggling bills and the sacrificing causes more stress for the family, and Anibal is worried about his family's health as well – his wife has a family history of breast cancer, and his children are growing up without regular check-ups, but without employer based health insurance and being ineligible for public insurance, he does not know where to turn for affordable health care.

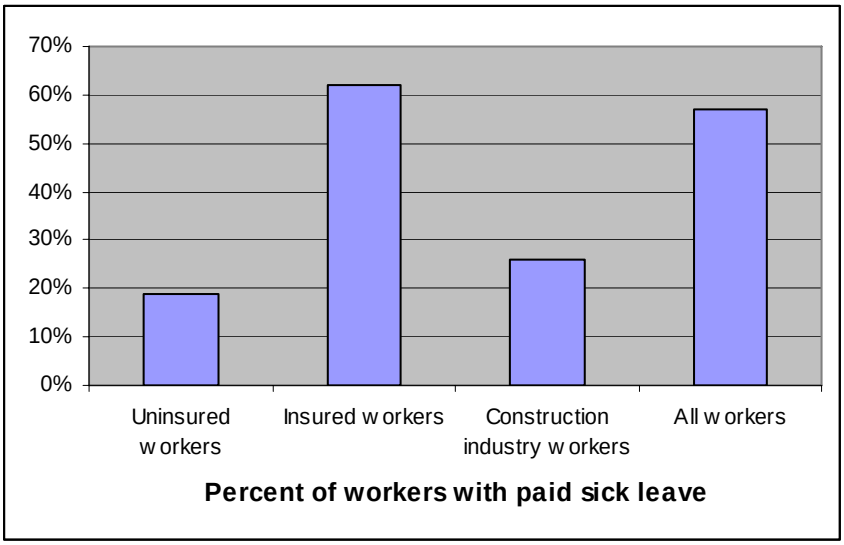
## Decreased productivity on the job

It is now widely understood that uninsurance causes significant economic losses due to decreased productivity of unhealthy employees. Lack of health insurance is related to reduced access to health care and poorer health, and unhealthy workers have lower productivity. The American College of Physicians (2000) reports that a review of 1987 National Medical Expenditure Survey data found that "Uninsured individuals had significantly lower levels of self-reported health status than did the insured. These results held even when adjustments were made for the effects of age, sex, race, income, attitude toward the value of medical care and health insurance, and medical conditions" (9). The uninsured are less likely to receive regular screenings for diseases such as colon and breast cancer, and hence are more likely to be diagnosed in the late stages of these diseases and to die from them. Such disparities in health care are increasingly an issue of national concern and present a strong moral argument for universal health coverage.

The disparity in health status between the insured and uninsured also presents an economic argument about the value to be gained by offering health insurance to employees. Researchers from the Commonwealth Fund found that **the sicker the worker, the more likely the worker was to report reduced productivity**, defined as inability to concentrate at work due to health problems. The report argues that "ensuring that all workers have health insurance coverage would also improve health and productivity by increasing the use of preventive care and helping to ensure early treatment of acute illnesses as well as ongoing management of chronic conditions"(Davis et al. 2005).

A variety of evidence also points to the vicious cycle comprising low-wage jobs with no benefits, poor health, and low productivity. Data from the National Health Insurance Survey indicate that uninsured workers may not miss more days of work due to illness or injury than insured workers. But the uninsured are much less likely to have paid sick leave. Only 19 percent of the uninsured have paid sick leave, versus 62 percent of the insured. Construction workers are also less likely than workers in other industries to have paid sick leave. Only 26 percent of construction industry workers have paid sick leave, compared with 57 percent of the general population (Figure 3).

**Figure 3**




Source: National Health Interview Survey, 2003

Jobs without paid sick leave are typically low-wage jobs, as are some construction industry jobs, and low-wage workers are reluctant to miss work even if sick. Workers with lower hourly wages of $10 to $15 dollars per hour are more likely to have low-productivity days than workers with higher hourly wages of above $15 dollars per hour, even after adjusting for health status, sick leave benefits, and other factors (Davis et al. 2005, 3). To improve the health of workers however, simply offering coverage is not enough. Many low-wage workers, especially part-time workers, are offered employer based coverage but at extremely high rates that are simply unaffordable. Low-wage workers squeezed by health must often forgo certain treatments or medications, at the expense of their health, as Anibal Mendez's story above illustrates.

## The Cost of Covering Uninsured Workers

Providing workers with health insurance would increase accessibility to routine care, reducing emergency room costs and more importantly increasing health and life for workers and their families. Two barriers to extending coverage to all workers on the Orange Bowl renovation and Jackson South expansion projects are logistics and cost. One of the difficulties with insuring the construction workforce is the fluidity and the cyclical nature of the jobs. Workers can be employed by several different construction firms in a year working on different projects, which makes obtaining continuous employer-based health coverage difficult if not impossible. The seasonal and cyclical nature of construction work often means spells of unemployment. Even if a worker managed to stay employed with a firm long enough to qualify for coverage, if the worker became sick or was injured while on one employer's health plan, the worker might not be eligible for coverage from another employer. However collective bargaining associations

such as unions have largely solved this problem by offering continuous health coverage to members according to trade, while the employer pays the union for the cost of benefits for each worker. Members must have a certain amount of work hours per year, and then are eligible for continuous coverage even if unemployed for a period of time. The larger risk-pool lowers risk and administrative costs, making the plans affordable (Waddoups 2004).

What would be the cost of insuring all workers? Since the uninsured do not receive adequate care, current spending is artificially low and extending health insurance coverage to all would likely result in some cost increase. How much costs would increase is a matter of debate and depends on many factors such as whether the uninsured are provided with public or private health insurance, and how much more care they will consume. Health care usage is impacted by demographics, lifestyle, and personal history, and is therefore difficult to quantify. But even though decreased emergency room spending and increased efficiency in the system as well as improved worker productivity would offset cost increases, it is fairly certain that requiring that uninsured workers be enrolled in a standard commercial health insurance plan would add significant costs to a project.

However using a best value contracting method[10] that awards points to bidders that provide health insurance to their workers would ensure that the county is getting a good deal. The best value contracting method saves money by ensuring the selection of a contractor who has a proven record of producing quality work on time and on budget. Many such contractors already offer health insurance to their workers because they understand the positive effect this has on the turnover of their workforce.[11] With the current shortage of workers, a contractor who does not offer health insurance is unlikely to retain the best workers and therefore will have more difficulty producing the highest quality product. Using a performance based method of selecting contractors and awarding points for provision of health care coverage would meet the county's goals of high quality, reasonable cost and good jobs for local workers.

## Conclusion

Health insurance coverage is extremely important for promoting the health of our community and workers. Those with health insurance have more access to care, are more likely to get care, and have longer life spans. **Those without health insurance are less likely to receive routine care, more likely to seek non-urgent care in the emergency room, and often face heavy financial burdens when serious health problems arise.** The disparities in care between the insured and the uninsured are unacceptable for a society that professes equality of opportunity.

[10] See the companion report by Marcos Feldman, *Best value in publicly funded projects: Contractor selection in two county GOB projects*, July 2006.
[11] Boodhoo, Niala. 2006. "See jobs grow; See care shrink," The Miami Herald, June 14, 2006.

The high cost of medical care places an enormous burden on families without health insurance. Many of the uninsured with chronic conditions such as diabetes are unable to afford needed medicine and supplies, and must make choices between buying medication and other life necessities. Even when a worker has health insurance from an employer, the cost of buying coverage for dependents is often prohibitively high, especially for low-wage workers. Public programs, including Medicaid, do not cover all of those in need, and community clinics that cannot provide low-cost prescription medication are not the whole solution.

For two major projects funded in part by county taxpayer dollars, we estimated the cost to the Jackson system that would be accrued by uninsured workers. Those costs approach $5 million if none of the workers and their families have health insurance, and $2.5 million if only half of the workers have health insurance, the average rate in Miami-Dade County. Providing workers with health insurance would eliminate these costs and result in additional savings through improved efficiency in the health care system as well as increased worker productivity. It would also provide enormous benefit for workers and their families in terms of increased life, health, and financial security.

The logistical difficulty of providing continuous, affordable health insurance for workers is a significant barrier in the non-union sector, and the additional cost of requiring all uninsured workers to be enrolled in standard commercial health insurance would likely increase project costs substantially. However if the county used a best value contracting method and awarded points to companies that provide health coverage to workers, the county would get a higher quality of work at a lower cost and the community would benefit from a healthy and productive workforce.

**References**

American College of Physicians. 2000. No health insurance? It's enough to make you sick. Philadelphia: American College of Physicians-American Society of Internal Medicine.

Billings, J., N. Parikh, et al. 2000. Emergency department use: The New York story. New York: Commonwealth Fund.

Collins, Sara R., Karen Davis, and Alice Ho. 2004. A shared responsibility: U.S. employers and the provision of health insurance to employees. *Inquiry* Vol. 42 (No. 1):pp. 6–15.

Committee on the Consequences of Uninsurance. 2003. Hidden costs, value lost: Uninsurance in America. Washington, D.C.: Institute of Medicine of the National Academies.

Davis, Karen, Sara R. Collins, Michelle M. Doty, Alice Ho, and Alyssa L. Holmgren. 2005. Health and productivity among U.S. workers. Washington, D.C.: The Commonwealth Fund.

Kaiser Commission on Medicaid and the Uninsured. 2003. Access to care for the uninsured: An update. Washington, D.C.: The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured 2006. The uninsured: A primer. Washington, D.C., Henry J. Kaiser Family Foundation.

Miller, Edward, Jessica S. Banthin, and John F. Moeller. 2003. *Covering the uninsured: Estimates of the impact on total health expenditures for 2002*. Rockville, MD: Agency for Healthcare Research and Quality.

Nissen, Bruce, Emily Eisenhauer and Yue Zhang. 2006. Healthcare Coverage and Employment Status: A Report. Miami, FL: Research Institute for Social and Economic Policy.

Nissen, Bruce. 1998. The Impact of a Living Wage Ordinance on Miami-Dade County. Miami, FL: Florida International University.

Waddoups, C. Jeffrey. 2004. Health care subsidies in construction: Does the public sector subsidize low-wage contractors? In *The economics of prevailing wage laws*, edited by H. Azari-Rad, P. Philips and M. J. Prus. Hampshire, UK: Ashgate Publishing Limited.