Increasing Healthcare Coverage For Women of Color in the Workplace:

A Proposal for Legislative Change in Labor Law

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INTRODUCTION: GENDER, RACE, EMPLOYER-BASED HEALTHCARE COVERAGE, AND COLLECTIVE BARGAINING CONDITIONS

As the percentage of the medically uninsured continues to climb, the state of healthcare coverage in America has become a topic of volatile debate. The number of uninsured individuals reached 45.8 million in 2004, reaching a disconcerting one-sixth of the total population.[1] National unemployment rates, however, continue to hover at a far lower 5%.[2] A juxtaposition of these two figures makes readily apparent the discrepancies inherent in our current privatized, employment-based healthcare model.

Policymakers are engaged in ongoing and extensive deliberation over how to best fix these failures in our current framework. A long legislative and cultural history reifies both privatization of healthcare and primary access through employment. The most currently known reform proposals, presented by President George W. Bush in his 2006 State of the Union Address, attempt to break with this latter characteristic, but there are strong ideological impulses and

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1. Carmen DeNavas-Walt, Bernadette D. Proctor & Cheryl Hill Lee, U.S. Census Bureau, U.S. Dept. of Com., Income, Poverty, and Health Insurance Coverage in the United States: 2004 16, 60 (2005) [hereinafter Income, Poverty, and Health Insurance]. (Calculation of 1/6th was reached by dividing total population by the total number of uninsured.)
2. Regional and State Employment and Unemployment: November 2005 (Bureau of Labor Stat., U.S. Dep't of Labor, Wash., D.C.) Dec. 2005, at 1, available at http://www.bls.gov/news .releas /archives/laus_12162005.pdf.

pragmatic arguments against such action. Some of those articulated include the lack of bargaining leverage by individuals against HMOs, a power that large employers have wielded to keep costs down, the insufficient assistance allotted through tax-credits to families making under the $25,000 threshold the Bush administration recommends as a standard, the lack of assistance to families earning just over that threshold who will continue to find insurance unaffordable, and the expectation of continuing increases in premiums across the board coupled with an insistent refusal to implement HMO profit caps.[3]

Considering contemporary realities through an analysis that seeks to increase rather than decrease coverage, this paper examines our current policies vis-à-vis the employed populations with disproportionately low rates of healthcare coverage, namely women, and especially women of color.[4] With this demographic in mind, this paper offers one possible short-term solution for extending healthcare to this particular workforce while maintaining the current privatized structure: legislative reform in the field of labor. Often overlooked, labor has the potential to increase coverage for women of color, serving as a temporary solution until more significant and essential changes can be made to our healthcare system. This paper critiques currently circulating labor legislation, such as the "Employee Free Choice Act," and suggests a "percent-of-profit" based punitive damages model for unfair labor practices as a method of changing bargaining conditions over healthcare.

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3. State of the Union: Affordable and Accessible Health Care (the White House, Wash. D.C.), Jan. 2006 (discussing expansion of HSAs - private accounts in which Americans may invest tax-free monies for high-deductible policies - by affording tax-deductions for those who enroll in HSAs, and offering tax credits to offset payroll taxes. In addition, the plan seeks to allow small employers to band together and form association health plans, and invests in community organizations the ability to seek coverage for their members, ironically, to leverage bargaining power similar to large employers. The fact that such bargaining leverage would be completely eliminated for individuals with HSA plans is not addressed. The proposals also suggest a 3,000 dollar tax credit to families of four earning less than 25,000 dollars a year to spend on HSA coverage. That sum is insufficient to increase affordability as the rates continue to skyrocket as discussed below. Infra table 4), available at http://www.whitehouse.gov/news/releases/2006/01/20060131-7.html (last visited Mar. 25, 2006).

4. Income, Poverty and Health Insurance, supra note 1, at 18 (showing households with annual income under $25,000 had highest rate of uninsured at 24.3%); id. at 60-67 (showing racial delineations in coverage); U.S. Bureau of Labor Stats., U.S. Dep't of Labor, A Profile of the Working Poor, 2003 7 (2003), available at www.bls.gov/cps/ cpswp2003.pdf (giving poverty status of the employed by gender and race: women were more likely to be defined as working poor, at 6%, compared to men at 4.7%; Black, Asian, and Hispanic women were more likely than White women to be "working poor" at 12.5%, 5.1%, 10.9%, and 4.9% respectively); The Henry J. Kaiser Family Foundation, Health Insurance Coverage in America, 2004 Data Update 26 (2005) [hereinafter 2004 Data Update] (dissecting rates of the uninsured and finding that over half of the uninsured are minorities, at least 70% of the uninsured come from families with at least one full-time working member, over half of the uninsured work full-time and uninsured rates run higher for people of color), available at http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf; Women and Health Insurance Fact Sheet 2004 (New America Foundation, Wash., D.C.), Mar. 2004, at 1 [hereinafter New America Foundation] (discussing women's health insurance coverage through employment as substantially less than men's coverage), available at http://www.newamerica.net/ Download_Docs/pdfs/Pub_File_1494_1.pdf.

Part One of this paper investigates the disproportionately affected populations of employees who, despite working within the accepted definition of "market labor," have decidedly lower rates of healthcare access and participation through their employment.[5] The "selected occupations" for study in this paper are those occupations that are projected to experience the greatest growth in the upcoming decade, and from amongst those, the categories which have significant female and minority compositions. Clustered in the service-retail and healthcare industries, these selected occupations, unsurprisingly, heavily recruit female and minority labor and are notably distinguished by their relatively low wage and benefits standards.[6] Not coincidentally, these occupations, which serve as foci of female and minority employment, also have markedly low levels of union density.[7]

Part Two briefly references the history of labor and its relationship to women and minorities in this country, establishing a context for discussion of the labor movement's problems and gains in unionizing these communities. Such a discussion serves as a framework for critiquing the problematic theory and practice of labor law in the United States. This Part argues that labor law must be fundamentally altered if it is to serve as an effective tool for assisting women, and specifically women of color, in attaining higher medical insurance coverage rates through their employment.

Part Three of this paper posits that punitive damages on a proportional scale must be introduced into labor law. Such percent-based damages could at least begin the work of effectively addressing the inadequacies of the statutes governing union organizing and collective bargaining in private industry today. This Part projects how the "percent-of-profit" remedy suggested in this paper for unfair labor practices could increase health insurance coverage for women of color in the workforce, and discusses how such increased coverage could precipitate coalition building activity geared at larger structural healthcare change.

Ultimately, organized labor policies are not the final solution to the

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5. Income, Poverty and Health Insurance, supra note 1, at 4-5 (giving the median salaries by gender and race or ethnicity). Conclusion reached by combining data with information from id. at tbl.7; The Henry J. Kaiser Foundation, Racial and Ethnic Disparities in Women's Health Care Coverage and Access to Care; Findings from 2001 Kaiser Women's Health Survey, Issue Brief 2 (2004) available at http://www.kff.org/womenshealth/upload/Racial-and-Ethnic-Disparities-in-Women-s-Health-Coverage-and-Access-to-Care.pdf.

6. See Household Data Annual Averages: Table 11, Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.) [hereinafter Household Data Annual Averages], available at http://www .bls.gov/cps/cpsaat11.pdf (last visited Mar. 25, 2006); see also Bureau of Labor Stats., U.S. Dep't of Labor National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2005 1 (2005) [hereinafter Nat'l Compensation Survey], available at http://www.bls.gov/ncs/ebs/sp/ebsm0003.pdf; Occupational Employment and Wages, November 2004, (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), May 2004, at 4, available at http://www.bls.gov/news.release/pdf/ ocwage.pdf.

7. Union Members in 2004 (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), Jan. 2005, at 1-2, available at http://www.bls.gov/news.release/pdf/union2.pdf.

healthcare crisis confronting us. Rather, changes in labor policy are an attainable first step in increasing medical coverage for the populations most affected by the chasms in our current distribution model. At the same time, increasing coverage through the collective bargaining process would serve the goals of common grassroots campaigns, which have organized for either universal healthcare coverage or, alternatively, a capping of the nation's HMO profits.

PART I: DEMOGRAPHICS AND HEALTHCARE COVERAGE WITHIN THE WORKFORCE

Employment serves as the largest single method by which persons receive healthcare coverage in the United States today.[8] Unfortunately, both access to and participation in these plans are declining.[9] For all private employers, the rate of offer has fallen from 69% to 60% over the past five years.[10] This decline is largely attributed to the drop in access through small, private employers (3-199 employees), which has dropped from 68%-59% in the same time period.[11] On average, small firms hire greater numbers of female workers and hire twice as many Hispanic employees.[12] However, for several decades, a small fraction of large, conglomerate employers have controlled upwards of 70% of all private economic activity, so market conditions result primarily from their actions.[13]

Employees who did not participate in available workplace plans and employers who did not offer plans both cited costs as the largest deterrent.[14] Premiums for coverage have risen approximately 125% since 1988, while wage earnings have risen on average only 40%; these wage increases have barely kept up with inflation, which has increased 38% in the same time period.[15] In addition, industries that historically served as the nation's economic backbone, such as manufacturing, are on the decline. Meanwhile, the emerging economic forces of service retail and health services are far less likely to offer health insurance, or pay the higher wages that tend to boost employee participation.[16] Service occupation employees have access to medical care only 44% of the time, while both blue- and white-collar workers in other industries have access 77% of

8. Income, Poverty, and Health Insurance, supra note 1, at 60.
9. Employer Health Benefits 2005 Summary of Findings (The Kaiser Family Found. & Health Research and Educ. Trust, Wash. D.C.), 2005, at 4 [hereinafter Employer Health Benefits], available at http://www.kff.org/insurance/7315/sections/upload/7316.pdf.
10. Id.
11. Id.
12. Dawn M. Gencarelli, Health Insurance Coverage for Small Employers, Nat'l Health Pol'y Forum, George Wash. U. 5 (2005) available at http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.
13. Fran Ansley, Standing Rusty and Rolling Empty: Law, Poverty, and America's Eroding Industrial Base, 81 Geo. L.J. 1757, 1764 (1993).
14. Gencarelli, supra note 12, at 7-8; 2004 Data Update, supra note 4, at 14.
15. Employer Health Benefits, supra note 9, at 1.
16. Nat'l Compensation Survey, supra note 6, at 5 tbl.1 (depicting access distribution).

the time.[17] Participation rates reach as low as 39% for employees with a mean hourly wage of less than fifteen dollars per hour.[18]

According to a recent Bureau of Labor Statistics forecast for the upcoming decade, the occupations within these emerging powerhouse sectors will continue to experience the largest job growth.[19] These occupations have been identified as retail salespersons, customer service representatives, janitors, waiters, combined food preparation and servers, home health aides, teachers, nurses, general operations mangers, and nursing aides.[20] As Table 1 below illustrates, seven of these occupations have noticeably high female and minority compositions.[21] In fact, the top nine of the fastest-growing occupations rely heavily upon female labor. The only exception to this trend is the janitors and cleaners occupation, which, due to a separate category for maids and housekeepers who are predominantly female, tends to be primarily male.[22] Many of these occupations employ a large percentage of the total number of employed women of color in the national workforce.[23] Their rates of unionization are often lower than the national average for private industry, and are far lower than the rates for the public sector, which is governed by its own set of union/management relation policies, rather than the National Labor Relations Act (NLRA).[24] The overall national unionization rates for the private and public sectors are 8% and 36% respectively.[25] Table 1 below calculates an even lower cumulative rate of 6% unionization for the occupations selected for study in this paper.[26]

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17. Id.
18. Id.
19. BLS Releases 2004-2014 Employment Projections (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), Dec. 2005, at 7 [hereinafter Employment Projections], available at http://www.bls.gov/news.release/pdf/ecopro.pdf..
20. Id.
21. The occupations for this article were selected from amongst those projected to grow most in the upcoming decade and then chosen for their relationship to the private sector (eliminating post-secondary teachers), below the 15 dollar median hourly salary (eliminating registered nurses) and high women and minority ratios (eliminating general operations managers). Estimates for demographic distribution in the occupations above were calculated by selecting from the National Employment Matrix, the one sub-occupation, regardless of industry, which accounted for over 80% of the total occupation, and then cross-referencing the choice with the Household Data Annual Averages, supra note 6, to get the demographic breakdown. Those numbers were then applied to the total numbers in the workforce. Otherwise, a combination of several of the sub-occupation breakdowns within industries was used to reach above the 80% percentile within the total occupation. See National Employment Matrix, employment by occupation, industry, and percent distribution, 2004 and projected 2014 (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), 2005, available at http://www.bls.gov/emp/empoils.htm
22. Household Data Annual Averages, supra note 6, at 210-213.
23. See Table 2, infra Part I.
24. Union Members in 2004, supra note 7, at 1.
25. Id. (giving averages for the private and public sector).
26. See Table 1, infra Part I (depicting percentages of union members in the selected occupations discussed in this article).

Table 1: "Selected Occupations" from DOL Largest Projected Job Growth Through 2014[27]

Occupation[28]	Rank[29]	Workforce 2004[30]	Workforce 2014[31]	Median Hourly Wage[32]	Percent Women[33]	Percent Women of Color[34]	Percent Black[35]	Percent Asian[36]	Percent Hispanic[37]	Percent Union Members[38]
Retail Salesperson	1	4,256,000	4,992,000	9.03	50.8	13.0	10.9	3.8	10.9	3.6
Customer Service Representative	4	2,063,000	2,534,000	13.08	71.1	22.54	16.4	2.9	12.4	10.7
Janitors and Cleaners, Except Maids and Hskp.	5	2,374,000	2,813,000	9.19	33.2	15.90	17.8	3.3	16.8	10.7
Waiters and Waitress	6	2,252,000	2,627,000	6.78	73.1	17.91	7.0	4.8	12.7	1.2

27. Employment Projections, supra note 19; See National Employment Matrix, employment by occupation, industry, and percent distribution, 2004 and projected 2014 (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), (2005) (for occupation cross-reference discussed in note 21), see http://www.bls.gov/emp/empoils.htm.
28. Employment Projections, supra note 19, at tbl.3.
29. Id.
30. Id.
31. Id.
32. Occupational Employment and Wages, November 2004 (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), Nov. 9, 2005, at tbl. 1.
33. Household Data Annual Averages, supra note 6, at 210-213.
34. Estimates were reached by applying the percentage of women in each occupation to population by race or ethnicity. The three estimated percentages of minority women in each occupation were then averaged together in a weighted calculation. For purposes of this calculation it is assumed that the initial gendered composition of the total occupation is identical to the gendered composition of each race category within the occupation.
35. Household Data Annual Averages, supra note 6, at 210-213.
36. Id.
37. Id.
38. Union Members in 2004, supra note 7, at tbl. 3.

Occupation[28]	Rank[29]	Workforce 2004[30]	Workforce 2014[31]	Median Hourly Wage[32]	Percent Women[33]	Percent Women of Color[34]	Percent Black[35]	Percent Asian[36]	Percent Hispanic[37]	Percent Union Members[38]
Combined Food Preparation and Serving, Including Fast Food	7	2,150,000	2,516,000	7.09	58.72	22.63[39]	13.25	5.56	19.72	4.10
Home Health Aids	8	624,000	974,000	8.92	87.60	38.54	21.80	6.10	16.10	7.10
Nursing Aids, Orderlies and Attendants	9	1,455,000	1,781,000	10.20	89.30	46.17	34.60	3.70	13.40	7.20
Total Number of Workers in Selected Workforces		15,174,000	18,237,000	9.18 (average)	60.94	21.41	15.39	4.10	14.02	5.94

The demographics of these fast-growing occupations have significant implications not only for the coverage issues that arise directly in these heavily minority and female workforces, but also for the health insurance access of the communities attached to these women. The relatively high percentage of women, especially women of color, employed in these occupations influences the means by which entire families gain access to healthcare. Table 2 indicates that as high as 22% of all employed Hispanic and Black women in the total population depend on health insurance coverage through work in the seven selected job occupations chosen for this study. Approximately 7,175,000 families within the Unites States depend on female employment as the sole source of labor.[40] Table

39. Due to a discrepancy in U.S. Bureau of Labor studies, I calculated gender and race demographics for this occupation by averaging the percentage of "food preparation workers," "combined food preparation and serving workers, including fast food workers," "counter attendants, cafeteria, food concession, and coffee shop," "food servers, non-restaurant," and "dining room and cafeteria attendants and bartenders helpers." The discrepancy occurred between the identically defined major occupation numbers used to project the current and future numbers in Employment Projections, supra note 19, based off the information in Occupational Employment and Wages, November 2004, supra note 6, and the numbers found in the Household Data Annual Averages, supra note 6. The first two studies concluded that the category employed 2,223,820 workers, while the last study concluded that the category only included 296,000 workers. This was the only major job occupation with such a large discrepancy.

40. Table 4, Families with own children: Employment status of parents by age of youngest child

5, in Part III below, illustrates that a potential 2,543,641 families who depend on female employment for coverage lie within these occupational groups.

Table 2: Percentage Employment by Population of Women and Women of Color[41]

Women by Race/Ethnicity in Selected Job Occupations 2004	Total in Population[42]	Total in Workforce[43]	Employment Rates[44]	Total in Selected Occupations[45]	Percentage of Respective Workforce[46]
All Women	115,647,000	64,728,000	55.97%	11,112,915	17.17%
White Women	93,599,000	52,527,000	56.12%	8,734,751	16.63%
Black Women	14,409,000	7,997,000	55.50%	1,710,010	21.38%
Asian Women	4,990,000	2,751,000	55.13%	455,380	16.55%
Hispanic Women	13,692,000	7,098,000	51.84%	1,557,636	21.94%

Despite their central roles, employers in these occupations do not sufficiently fulfill their obligations in distribution of health insurance access; whether by discontinuing access, or by offering coverage too expensive for the low-wage worker to afford, employers effectively deny coverage to a large fraction of employed women, particularly Black and Hispanic women.

On the other hand, when employees are unionized, the percentage of employees offered coverage through employment increases dramatically from 68% to 92%.[47] Employee participation rates also increase, from 49% to 83%.[48] This occurs for two reasons. First, union employees are not compelled to make contributions to their coverage at the same rate as non-union employees: 22% fewer unionized workers must contribute to their single plan, and 27% fewer

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and family type, 2003-04 annual averages (Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), Jun. 2005, at tbl. 1. [hereinafter Families with own children], available at http://www.bls.gov/news.release/famee.t04.htm.

41. See infra notes 44-46 (providing equations used for each estimate).
42. U.S. Dep't of Labor, U.S. Bureau of Labor Statistics, Women in the Labor Force: A Databook 10-11 tbl. 3 (2005) (providing the 2004 annual averages of employment status by race, sex, and Hispanic or Latino ethnicity).
43. Id.
44. Estimates reached by dividing total in workforce by the total in respective population.
45. Estimates reached by multiplying total workforce numbers for each occupation, Table I, infra Part I, by the percentage female and race/ethnicity. It is assumed that women within a certain racial demographic are hired at the same rate as the total gender composition indicates.
46. Totals reached by dividing number of employees in selected occupations by number in total population.
47. Nat'l Compensation Survey, supra note 6, at 5 tbl.1.
48. Id. at 6 tbl.2.

must contribute to their family plan.[49] Second, for those employees who must contribute, they contribute a significantly lower percentage of the premium.[50] For union members who must contribute, single-coverage payments average fifty-six dollars per month, while for non-union members, the payment average reaches seventy-one dollars per month.[51] For family coverage the disparity becomes even more pronounced, with union members on average paying 198 dollars per month and non-union workers paying 283 dollars per month.[52] Median wages are also higher for union workers than their non-union counterparts, further addressing the factor of affordability.[53]

Table 3 focuses on the access and participation rates of union and non-union workers, as well as employees with a median hourly salary of fifteen dollars an hour or more. A median wage level above fifteen dollars an hour, which is higher than the median wage level of the occupations selected for this paper, is tied to significantly higher healthcare coverage than lower median wages.

Table 3: Health Care Access and Participation, Union, Non-Union, and Low-Wage.[54]

HEALTH INSURANCE COVERAGE FOR PRIVATE INDUSTRY POPULATION	ACCESS RATES 2004	PARTICIPATION RATES 2004	NO ACCESS RATE 2004	NON-PARTICIPATION RATE 2004
UNION	92.00%	83.00%	8.00%	9.00%
NON-UNION	68.00%	49.00%	32.00%	19.00%
UNDER 15$/ HR MEDIAN WAGE	58.00%	39.00%	42.00%	19.00%

As Table 4 demonstrates, the cost of family coverage for the non-union worker with the average hourly wage of the selected job occupations subsumes 31% of the employee's salary, even with the 40% wage increase applied from the previous decade. This Table also reveals the inadequacy of President Bush's proposals for addressing questions of affordability with his suggested 3,000 dollar a year tax-credit. Questions of healthcare coverage revolve around two issues: accessibility and affordability. Both must be adequately addressed before positive effects in coverage are to be realized.

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49. Employee Contributions to Employer-Provided Medical Plans by Bargaining Status, Private Industry, 2005 (U.S. Bureau of Labor Stats., U.S. Dep't of Labor, Wash., D.C.), Aug. 31, 2005 [hereinafter Employee Contributions], available at http://www.bls.gov/opub/cwc/cm20050829ch01.htm.
50. Id.
51. Id.
52. Id.
53. Union Members in 2004, supra note 7, at 2.
54. Nat'l Compensation Survey, supra note 6, at 5, 6.

Table 4: Percent of Salary Median required for Health Care Coverage.

Percentage Salary Median Union / Non-Union	Monthly Income[55]	Percentage Salary for Single Coverage[56]	Percent Salary for Family Coverage[57]	Projected Income 2014[58]	Projected Percentage of Salary for Single 2014[59]	Projected Percentage of Salary for Family 2014[60]
Union (median all)	3124.00	1.78%	6.34%	4339.24	2.89%	10.27%
Non-Union (median all)	2448.00	2.89%	11.56%	3400.27	4.68%	18.72%
9.18$/hr* Union	1469.00	3.79%	13.49%	2040.44	6.14%	21.84%
9.18$/hr* Non-Union	1469.00	4.82%	19.26%	2040.44	7.80%	31.19%
9.18$/hr * Non-Union plus 250$ per month addition (3,000$ per year) for a family of four earning under 25,000$ under Bush Proposals	N/A	N/A	N/A	2290.44	N/A	27.8%
9.18$/hr* Union with 12% salary difference.				2448.00	5.12%	18.21%

* (average of selected occupations)

As the premiums for healthcare coverage continue to escalate, previous trends indicate that more workers, especially minority women, will be forced to discontinue their participation in employer-provided health plans. Some of these employees may be eligible for Medicaid coverage, but a majority will simply go without, their income too high to render them eligible for the state-regulated, federally-funded program.[61] Thus, the number of completely uninsured

55. Union Members in 2004, supra note 7 (giving the median union and non-union salaries). As indicated in Table 1, $9.18 per hour is the non-weighted average of the hourly wage medians of the selected job occupations. A four week month was used.
56. Estimate reached by dividing the average individual monthly premiums, Employee Contributions supra note 49, by the calculated monthly salary, and multiplying by 100%.
57. Estimate reached by dividing the average monthly premiums, Employee Contributions supra note 49, by the calculating monthly salary, multiplied by 100%.
58. See Employer Health Benefits, supra note 9, at 1 ex. A. Income projection is based on an application of the previous decade's salary gains. Salaries have gone up 39% in the past decade. Health insurance premiums have risen 125% in the same time period; Union Members in 2004, supra note 7, at 2. The 12% salary difference between union and non-union members is applied separately in the bottom row.
59. See Employer Health Benefits, supra note 9, at 1 ex. A. Estimate reached by dividing projected premiums by projected income. Projected premiums reached by multiplying 125% to current figures, supra note 49.
60. Id.
61. Kaiser Commission on Medicaid and the Uninsured, In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families 8-9, 17-18 (2005), available at http://www.kff.org/medicaid/upload/In-a-Time-of-Growing-Need-State-Choices-Influence-Health-Coverage-Access-for-Children-and-Families-Report.pdf; see also Report of the Working Group on Challenges to the Employment-Based Health Care System, DOL Report (U.S. Dep't of Labor, Wash., D.C.), Nov. 14, 2001, available at

employees will continue to rise.

Employers too have felt, and will continue to feel, the weight of increasing premiums. Average employer contributions have culminated in annual payments of $3,413 for coverage of a single employee, and $8,167 for the coverage of a family.[62] Unrestricted by requirements compelling the provision of access, some employers have externalized the cost of coverage, redistributing the burden to tax-payers. The numbers of those insured by government programs increased yet again in 2004 from 26.6% to 27.2% as employment-based coverage declined.[63]

Employers' practice of redistributing healthcare costs to tax-paying citizens is problematic for several reasons. The current system allows employers to escape any of the financial burdens that a mandatory private or nationalized healthcare model would impose upon them. Either a public or private model would realistically demand certain concessions from employers and the public. A national healthcare program would impose higher taxes on businesses, land, or sales, to help defray costs, while our current private system imposes the partial costs of providing a healthcare plan for employees. By utilizing the current strategy, a percent of employers decline to fulfill their role as provider while advocating for a private system, thereby avoiding the potentially higher *a priori* tax burden a national system would impose, while simultaneously avoiding the financial encumbrance inherent in our current healthcare model. Both private and public systems rely on support from employers in some fashion. So far, however, a sizeable fraction of employers have substantially avoided paying for either one.

PART TWO: THE NLRA, CONDITIONS FOR UNIONIZING AND COLLECTIVE BARGAINING

Section 1. A Brief History

How might changing the climate for both organizing unions and negotiating collective bargaining agreements assist us in solving our current healthcare predicament? A tense historical relationship exists between race, gender and organized labor. It is not feasible to cover these relevant histories and issues here, large in scope and important as they are. Rather, a short overview of a problematic past and the current landscape will illustrate the complex relationship between union organizing and the workforce of the fastest-growing occupations, specifically women and minorities.

The largest federation of unions in existence in the United States today, the American Federation of Labor, Congress of Industrial Organizations (AFL-CIO), formed in 1955. The federation formed after calls for different organizing and

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http://www.dol.gov/ebsa/publications/AC_1114b01_report.html; 2004 Data Update, supra note 4.

62. See Employer Health Benefits, supra note 9, at 2 ex. B.

63. Income, Poverty, and Health Insurance, supra note 1, at 16.

representation models, changes in resource allocation, and a transformation in attitudes towards race and globalism, spurred the foundation of the independent CIO, which eventually merged with the AFL. These historic appeals for reform resemble the tensions currently articulated by the "Change to Win Coalition," a partnership formed by several unions that disaffiliated from the AFL-CIO in 2005.[64]

The original AFL espoused craft unionism, an ideological and methodological form of organizing and representation that enabled exclusion of women and minorities from membership.[65] The CIO, often commended for its more progressive policies, may have "plant[ed] the seed of interracial solidarity," but was plagued by its own racial inconsistencies before being subsumed by the federation in 1955.[66] The AFL-CIO has historically lagged behind in efforts to organize women, with a 13% to 20% female to male differential as late as 1989.[67] However, its traditionally industrial base of workers, defined by a markedly white male demographic, is eroding, driving a significant reformulation of union politics.[68]

The intersection of labor and race, like that of labor and gender, has also proved to be contentious. The AFL-CIO has a well-documented history of systematic exclusion and discrimination against people of color who sought to join unions.[69] Xenophobic discourse abounded throughout even modern restructuring of organized labor and its foreign policies.[70] Repeating the hierarchical refrains used to exclude women and racial minorities, unions viewed immigrants, too, as a threat to the working class, and saw them as destabilizing the structure of "American jobs" and leading to the deterioration of working conditions and career loss for the traditionally employed.[71]

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64. See Change to Win Coalition Statement (Change to Win, Wash. D.C.), http://www.liuna.org/pubsnews/pdfs/coalitiontowin.pdf (last visited Jan. 21, 2006); see also Change to Win Official Website (Change to Win, Wash. D.C.), http://www.changetowin.org /index.asp?Type=B_BASIC&SEC={5D0F143E-A8B4-47AF-8EE8-68B41B15E6 (last visited Mar.. 24, 2006) (discussing need to increase diversity at all levels of central strategy, to integrate globalism, and to address modes of union representation, and new organizing); see also Matt Bai, The New Boss, N.Y. Times Magazine, Jan. 30, 2005.
65. See generally Marion Crain & Ken Matheny, Labor's Identity Crisis, 89 Cal. L. Rev 1767 (2001).
66. Id. at 1779.
67. See Marion Crain, Feminizing Unions: Challenging the Gendered Structure of Wage Labor, 89 Mich. L. Rev. 1155, 1157, 1160-70 (1991) (discussing a history of gender exclusionary organizing tactics and disproportionate union leadership numbers).
68. See Ansley, supra note 13, at 1757–84.
69. See generally Crain & Matheny, supra note 65; see also Marion Crain, Whitewashed Labor Law, Skinwalking Union, 23 Berkeley J. Emp. & Lab. L. 211, 216-21 (2002) [hereinafter Whitewashed Labor Law].
70. See Tim Shorrock, Labor's Foreign Policy Heads in a New Direction, FPIF Comment. (Foreign Pol'y in Focus, Wash., D.C.), Aug. 11, 2005, available at http://www.fpif.org/ pdf/gac/0508labor.pdf (focusing on the AFL-CIO's relationship to NED and USAID, and the AFL-CIO's involvement in Chile and Venezuela).
71. See David Bacon, Which Side Are You On? David Bacon Stories and Photographs May 20, 2001, http://dbacon.igc.org/Work/05WhichSide.htm (discussing the AFL-CIO's support of

The history of the labor movement in this country bespeaks the oft-articulated argument that the state of unions today arose not only from corporate strategy, but also from labor's lack of tactics and vision, and perhaps even from labor's internal, self-destructive tendencies.[72] Unions' refusal to support women, racial minorities, and immigrants has lead to current conditions in which entire industries, at one time reasonable targets, are now beyond labor's influence. Consequently, organized labor is striving to redefine its role within American society out of sheer necessity. In 2004, union density dropped to 12.5% of the wage and salary workforce, down from a high of 20.1% in 1983.[73] In private industry, the numbers have even further dwindled, hovering at 7.9%.[74]

Despite the labor movement's woes, or perhaps because of them, unions have begun adapting to the modern economic reality of America and its workforce. The central importance of the work space as a location for enfranchisement both politically and socially has redefined organized labor's role in the world of identity politics. Notwithstanding its negative reputation, labor has not always performed poorly. In 2004, Blacks were the most likely identity group to be union members at 15.1%, and Asians and Hispanics increased their probability of union membership to 11.4% and 10.1% respectively.[75] Just over 12% of Whites were union members at this time.[76] Mirroring this growth, the membership probability for women was 11.1% in contrast to men's 13.8%.[77] This represents a significant narrowing of the gap between the two genders since 1983, when the rate of membership for men was ten percentage points higher than that for women.[78] During that era, the differential between the two groups was 18% to 28% respectively.[79]

Today, labor theory and practices have begun to diverge from their historic patterns. While many significant problems continue to exist, certain attempts and changes should be noted. Union membership demographics indicate that there are more Black union members than NAACP members, and more female members then the National Organization for Women boasts.[80] Unions have provided opportunities to mobilize around gender- and race-based economic

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the 1986 'passage of employer sanctions' which made it a crime for undocumented workers to hold a job, and labor's new attitude toward immigrants).

72. See Bai, supra note 64.
73. Union Members in 2004, supra note 7. This downward trend began just after the watershed Air Traffic Controllers strike in which then President Ronald Reagan infamously invoked the threat of termination and potential incarceration to break the statutorily prohibited strike by the federal employee members of the Professional Air Traffic Controllers Organization in 1981.
74. Id.
75. Id.
76. Id.
77. Id.
78. Id.
79. Women in the Labor Force: A Databook, supra note 42, at 3.
80. Dan Clawson, The Next Upsurge: Labor and the New Social Movements 15 (ILR Press 2003).

marginalization and have served as valuable locations for dialogues on race and gender, as experienced in both the workforce as well as a larger social context.[81] Recently, current AFL-CIO President John Sweeney has reversed its former policies vilifying immigrants and has started organizing campaigns specifically targeted at these important populations of workers.[82] For example, previous federation affiliate, the Service Employees International Union (SEIU), has gained notoriety for its "Justice for Janitors" campaign, a landmark city-wide organizing model. This campaign couples labor and community organizing in immigrant and racial communities with a "corporate campaign" strategy using media, public protest and other methods, in order to pressure both property owners and contractors to recognize their employees' efforts to unionize.[83] Members of the AFL-CIO and the present "Change to Win Coalition" organized the "Freedom Rides" in 2003, which brought nearly 1,000 immigrant workers from cities all over the country to ride in buses to Washington D.C. to lobby for the rights of undocumented workers.[84] On the international front, calls for a global union movement have also determinably taken root.[85]

Consciousness of labor's historically disparate treatment of race and gender has permeated leadership choices. Notably, the demographics of labor's upper echelons, while still patently unrepresentative, have noticeably improved. The SEIU executive board is 40% female, and 33% people of color.[86] And finally, labor proponents also point to the still-prominent factor that collective bargaining, by creating a substantial vehicle for meaningful negotiations and providing a mechanism by which employee interests are given validation, attain comparatively better working conditions than their non-union counterparts, including benefits and pay.[87] The organization thus supplies a valuable avenue for addressing the differential treatment of female and minority workforces often times unavailable through current anti-discrimination statutes.

Still, despite all these changes, the occupations most dominated by women and minorities in the private sector lag behind in union representation (see Table 1 above). Unionization density overall is dropping.[88] Simultaneously, the effectiveness of unions is decreasing. Barely half of newly organized workforces

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81. See generally Wendy Wilbanks, Union Power, Soul Power: Intersections of Race, Gender and Law, 26 Golden Gate U. L. Rev. 437 (1996).
82. Whitewashed Labor Law, supra note 69, at 228-29.
83. See SEIU.org, Justice for Janitors "Si Se Puede," http://www.seiu.org/property/janitors/si%5Fse%5Fpuede/ (last visited Mar. 25, 2006).
84. Teo Reyes, Rallies Across the Country Greet the Immigrant Worker Freedom Rides, Labor Notes (Labor Notes, Detroit, MI.), Nov. 2003, available at http://www.labornotes.org/archives/2003/11/a.html.
85. See generally Bai, supra note 64.
86. See Gerald Hudson, Rebuilding the Union Movement to Empower Communities of Color (The Black Commentator, Mullica Hill, N.J.) http://www.blackcommentator.com/127/127_seiu.html (last visited Jan. 21, 2006) (comments by SEIU vice-president).
87. Union Members in 2004, supra note 7.
88. Id.

across all industries are able to negotiate a first contract.[89]

There are many competing theories as to why both the rates and effectiveness of union organizing have decreased so dramatically in the past few decades. When the NLRA was enacted in 1935, unions saw a previously unimaginable increase in membership in the private sector, those industries governed by the legislation. The numbers continued to increase until 1983, but have since exponentially declined.[90]

Section 2. The Ideological Impulse Grounding Collective Bargaining Legislation

A major contributor to organized labor's currently difficult terrain is the co-optation of the NLRA by its later amendment the Taft-Hartley (or Labor-Management Relations) Act. The NLRA defines unfair labor practices for both labor and employer organizations.[91] In its preamble, it articulates an aversion to strikes and other forms of commerce infringement, the causes motivating its adoption.[92] Currently, strikes are considered unfair labor practices (ULPs) as defined by section 158 of the NLRA in a variety of circumstances, including when committed during the life of a contract with a no strikes/no lockouts clause (a vast majority of contracts).[93] Similarly, during negotiations over "economic interests" upon expiration of a contract, the employer may "permanently replace" their striking employees, successfully infringing upon their right to strike even though the undertaking is technically legal under the Act.[94]

The Supreme Court initially elaborated on our permanent strike-replacement doctrine in *NLRB v. Mackay Radio and Telegraph Co.*[95] Self-explanatory in title, the permanent strike-replacement doctrine allows employers to replace striking employees permanently if the action is deemed illegitimate.[96] This practice became increasingly popular with employers beginning in the 1970s and 1980s.[97] Matters were further complicated for negotiations between labor unions and employers when the Taft-Hartley Act, enacted in 1947, banned secondary boycotts, sympathy strikes, and awarded employers the ability to

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89. Cynthia Green, Congressional Democrats Seek to Streamline Unionization Process With Card Check Bills, Labor Research Ass'n Online (Labor Research Ass'n., New York, N.Y.), Nov. 13, 2003, available at http://www.laborresearch.org/story.php?id=334.

90. Union Members in 2004, supra note 7.

91. National Labor Relations Act § 8, 29 U.S.C. § 158 (2000).

92. Id. at § 151.

93. Lance Compa, Human Rights Watch, Unfair Advantage: Worker's Freedom of Association in the United States Under International Human Rights Standards 282 (2000).

94. Id.; see also National Labor Relations Board, Basic Guide to the National Labor Relations Act, (NLRB, Wash., D.C.) http://www.nlrb.gov/nlrb/shared_files/brochures/basicguide.asp #righttostrike (last visited March 1, 2006).

95. See generally Michael H. LeRoy, The Mackay Radio Doctrine of Permanent Strike Replacements and the Minnesota Picket Line Peace Act: Questions of Preemption, 77 Minn. L. Rev. 843 (1993).

96. Id.

97. See Compa, supra note 93, at 282.

litigate outside of the usual constraints of the National Labor Relations Board (NLRB) through the district court system. Taft-Hartley also automatically granted costs to the plaintiff employer for litigation stemming from illegal secondary strike and boycott actions, and allowed employer recovery not only for actual losses incurred, but also for lost profit and consequential damages.[98] Additionally, the Taft-Hartley Act reintroduced the possibility of court injunctions against strikes.[99] A violation of section 303 of the Taft-Hartley Act receives mandatory injunction and full expectation damages against the union.[100] Further, the Taft-Hartley Act provision barring secondary boycotts has been expanded to ban attempts to get foreign importers to rebuff certain American suppliers.[101]

The Taft-Hartley Act and NLRA do not treat labor practice violations symmetrically. No equivalent remedies are available against an employer, nor do unions have an independent cause of action against an employer for contract or labor law violations outside of the NLRB.[102] Instead, antidotes are generally restricted to notice remedies or, when applicable, the reinstatement of unfairly terminated workers with back-pay. Under the guiding principles of contract formation and breach, these remedies include the duty to mitigate damages, but not the ability to collect consequential damages.[103]

Section 3. The Mismatch of Theory and Practice

Herein lies the problem. Contractual damages for labor law violations are rooted in the underlying ideologies defining contracts in general.[104] While the NLRA specifically enumerates a series of unfair labor practices by employers, it is well documented that employers still choose to break the law with predictable frequency.[105] In 62% of all union organizing drives, employers use five or more of the following practices: threats, discharge, promises of improvements,

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98. Labor Management Relations (Taft-Hartley) Act § 303, 29 U.S.C. § 187 (defining remedies for a secondary boycott, now a ULP within the definition established by the NLRA §158(b)(4)).
99. Id. at § 208, 29 U.S.C. § 178.
100. Compa, supra note 93, at 306.
101. Eileen Cedrone, Note, Labor Law-NLRB Jurisdiction- NLRA Governs American Union's Attempt to Solicit Japanese Importers' Boycott of American Stevedores, Dowd v. Int'l Longshoremen's Ass'n, 975 F.2d 779 (11th Cir. 1992), 17 Suffolk Transnat'l L. Rev. 609 (1994).
102. See NLRA, supra note 91.
103. C.J.S. Labor § 896 (2005); Robert Worster, If It's Hardly Worth Doing, It's Hardly Worth Doing Right: How the NLRA's Goals are Defeated through Inadequate Remedies, 38 U. Rich. L. Rev. 1073, 1083-90 (2004).
104. C.J.S. Labor § 896, supra note 103.
105. 29 U.S.C. § 158(a); Kate Bronfenbrenner, Uneasy Terrain: The Impact of Capital Mobility on Workers, Wages, and Union Organizing, 43-48 (Sept. 2000) (submitted to the U.S. Trade Deficit Review Commission), available at http://www.citizenstrade.org/pdf/nafta_uneasy_terrain.pdf; Worster, supra note 103, at 1077.

unscheduled unilateral changes in wages and benefits, bribes, or surveillance.[106] Nearly one in every three new organizing campaigns results in unlawful terminations.[107] While unions win at least one unfair labor practice claim or settlement in at least 70% of all charges they file, this victory rate does not appear to deter employers from violating the law, as they have far more to gain than to lose by acting in such a manner.[108] Employers who have historically not run anti-union campaigns during a new organizing drive, only 3% in total, lost every NLRB election in which their employees were choosing whether to form a union.[109] Conversely, election rates in favor of representation dropped to 36% when employers ran the type of anti-union campaign described above.[110]

Conflict continues even after representation is elected. The NLRA defines negotiations as only conferment in "good-faith," obliging no concessions from either party.[111] The assumption then is that the two parties will bring proportional bargaining power to the table and negotiate a written contract for mutual benefit. If the employer, as is noted in the NLRA's *Findings and Policies*, seeks to inhibit his employees' rights, the NLRA aims to restore equal bargaining strength to the employees, enabling them to acquire a reasonable contract through standard, unregulated, private negotiation procedures.[112]

This application of the general law of contracts to collective bargaining is erroneous. The NLRA seeks not to dictate the contents of the contract, nor to regulate the process by which it is negotiated, but to impart sufficient bargaining strength to the two parties and then let the dice fall as they may. Labor law theory assumes that from such a stance, the two parties will reach a contractual agreement. Unfortunately, such a construction fails to incorporate an essential reality of union contract negotiation. Namely, unlike the theories of mutual benefit and desire underpinning standard contract formation, collective bargaining exists only through a mechanism of incentive leverage, and original party inclinations factor little into reaching the result. Even with the employer disincentive of power redistribution aside, as the wage and health insurance information in the first four tables above illustrates, an employer has very little to "gain" in the traditional sense by negotiating with his unionized employees. Rather, a company's sole motivation to reach an accord, as the NLRA insinuates, has been to avoid economic losses.[113] Desire does not factor into the equation. Thus, the Taft-Hartley Act and court interpretations of strike restrictions in the

106. Bronfenbrenner, supra note 105, at 43-44.
107. Chirag Mehta and Nik Theodore, Undermining the Right to Organize: Employer Behavior During Union Representation Campaigns, 9-10 (Dec. 2005) (unpublished report, online with the Center for Urban Economic Development, University of Illinois at Chicago), available at http://www.americanrightsatwork.org/docuploads/UROCUEDcompressedfullreport%Epdf.
108. Bronfenbrenner, supra note 105, at 49.
109. Id. at 44.
110. Id. at 46.
111. 29 U.S.C. § 158(d) (2005) (obligation to bargain collectively).
112. Id. at §151.
113. Id.

NLRA have effectively stripped labor's ability to exchange the mutual "consideration" required for a valid contract. Once consideration is eliminated, the employer has no rational impetus to enter into agreements where all of the negotiated benefits are essentially allocated to the employees, and all the risks and burdens are positioned upon the company. It is quite rational, then, that employers seek to avoid collective bargaining. Employers have justifiable interests in profit margins and growth. But, as national and global historical patterns of objectionable treatment attest to, these aims often conflict with the interests of employees as the employer attempts to control labor costs as one of the few avenues available to increase profitability and potential returns for investors. Labor's role, then, is to serve as an impartial and independent fundamental safeguard for employee's interests, a check-and-balance in our free-market economic model, but one that can only continue to function as such if it is less restricted by labor law.

Common compensatory remedies associated with general contract theory are insufficient to motivate the employer to heed labor law during union organizing drives, or to induce constructive bargaining in good faith once negotiations are mandated.[114] To reinstate the necessary leverage and material consideration elemental to contract formation back into the labor process, the threat of economic loss must be restored. While many labor law changes could fulfill this function, the private negotiations process general contract theory invoked is too deeply embedded in our cultural mores for easy usurpation or de-emphasis, and a reevaluation of permanent-strike replacement theories or boycott legislation is realistically infeasible at this time. Therefore, imposition of lesser changes through the establishment of punitive fines for labor-law violations appears to be the most immediately attainable remedy, interjecting some oversight into the unionization and collective bargaining processes without fundamentally changing the individuated nature of negotiations.

PART THREE: PERCENT-BASED PUNITIVE DAMAGES FOR ULPS, AND THE POTENTIAL EFFECT OF HEALTH CARE COVERAGE FOR WOMEN, AND SPECIFICALLY WOMEN OF COLOR.

Section 1. Suggestions for Reform

In this vein, worthwhile legislation, including the Employee Free Choice Act introduced by Senator Ted Kennedy (D-MA) and Representative George Miller (D-CA) in 2003 and reintroduced this year, appropriately attempts to invoke a much needed dialogue about union/employer relationships and

114. Worster, supra note 103, at 1089-90 (noting that employer's violations are rational business decisions which will continue to occur until remedies are serious enough to outweigh the gain of successfully halting union organizing drives).

collective bargaining in this country.[115] Among other elements, the bill introduces punitive damages in the form of treble damages for unlawful terminations during union organizing and first contract campaign drives, and civil penalties of up to 20,000 dollars for unfair labor practices including failures to negotiate in good-faith.[116] Contemporary labor law models have undermined organized labor's capabilities by holding inalienable the rights of commerce and productivity. In order to address this quandary, one of the several theoretical prongs of the NLRA must be altered, whether the concept of a completely insulated contractual relationship, or the public policy favoring employers' ability to operate.[117] Because the latter seems less attainable than the former in the moment, Kennedy and Miller's bill is well-timed.

The bill is a laudable initial step. It should be fully supported in its current form as an attempt to address the inadequacies of the NLRA and labor law as they are currently interpreted and practiced. However, one alteration in the bill is necessary to address the expected occupational job growth of the future, and the realities of an economic landscape largely dominated by sizeable employers. The proposal should incorporate the relative economic assets of the employer in calculating a sum for punitive damages.

The NLRA would more effectively address the dearth of health insurance coverage in private employment in occupations dominated by women, especially women of color, if it assigned punitive damages by attaching a "percent-of-profits" standard. In this manner, the statute would better facilitate union organizing and first contract negotiations with large, for-profit employers. Such employers are the relevant target audience because of their role in dictating broader market conditions. Despite their crucial position in governing overall wage and benefit standards, large for-profit employers are increasingly passed over for public employer or non-profit union organizing campaigns because of the strong barrier against employees organizing their additional resources creates.[118] Tailored penalties in labor law would also ensure that small businesses are not disproportionately affected by new labor legislation. A 20,000 dollar fine for a ULP would significantly affect a small business's ability to operate, while serving nearly no deterrent effect for a much larger corporation. However, a percent-of-profits damages standard would be sufficiently threatening to force small employers to enter substantive contractual negotiations, thereby increasing healthcare access for the most underrepresented employee class.[119] Small businesses neglect this duty at an inappropriately high

115. S. Res. 1925, 108th Cong. (2003) (a resolution to amend the NLRA).
116. Id. at § 4(b) (discussing remedies for violations).
117. See Gary Minda, The Common Law, Labor and Antitrust, 11 Indus. Rel. L.J. 461, 529-536 (1989).
118. Bronfenbrenner, supra note 105, at 34-35.
119. See Table 3, supra Part I (reporting that the rates of access in union and non-union work locations differ by 24%).

rate.[120] Concurrently, large firms, responsible for the employment of two-thirds of the private sector, will be motivated or compelled to cover a larger percentage of the premiums, thus increasing the affordability and participation of employees in workplace healthcare plans.[121]

The 125% premium increases over the past decade have been felt by both employees and employers alike.[122] Despite such increases in premiums, a policy allowing employers to circumvent their health insurance responsibilities has lead to counterproductive employer efforts to destroy comprehensive healthcare reform.[123] Proposition 166 in California, which mandated employer contributions of 75% of their employees' health insurance premiums, was defeated in 1992 when small and large business organizations united against it. Organizations such as the National Federation of Independent Businesses (NFIB), the California Chamber of Commerce, and the California Manufacturing Association formed a coalition that ran intensive media campaigns to convince Californians that the proposition would cause massive job loss and precipitate small business closings, despite evidence that this result would not occur.[124] Perhaps the most recognized example of recent employer efforts to stifle systematic changes to federal healthcare policy is the failure of the Clinton administration to enact its healthcare reforms of 1994. Assorted companies colluded in the efforts to stifle the legislation, though predictably, small business associations were the core of the opposition.[125] As noted, small businesses offer access to health insurance for their employees only 59% of the time, while large employers provide at a 98% rate.[126] Retailers and small businesses donated as much as three million dollars to defeat the reforms.[127] The NFIB and similar organizations played a large role in stymieing Clinton's efforts and dissuading congressional supporters.[128] Small business associations continue to wield significant political power, while umbrella organizations for larger corporations, which are notoriously split on the question of healthcare reform, continue to flounder, uninspired to take the essential step of organizing for reform.[129]

Increased employer coverage through collective bargaining agreements could serve as that currently lacking motivation. Fears of profit loss are well-

120. Gencarelli, supra note 12, at 3.
121. Id.; see also rates of coverage, supra Part I.
122. See Employer Health Benefits, supra note 9, at 3.
123. See Cathie Jo Martin, Employers: Passive Purchasers or Provocateurs?, 28 J. Health Pol. Pol'y & L. 317, 329-331 (2003); see also Michele L. Procino, Note, The Death of Healthcare Reform in 1994: Another Example of Congress' Inability to Enact Major Reform, 1 Widener L. Symp. J. 547, 582-83 (1996).
124. Ronald F. Wilson, Federal Tax Policy: The Political Influence of American Small Business, 37 S. Tex. L. Rev. 15, 49 (1996) (also noting that research existed contradicting such job loss and closings would occur).
125. Martin, supra note 123, at 329-30.
126. Employer Health Benefits, supra note 9, at 4 ex.E.
127. Procino, supra note 123, at 581.
128. Wilson, supra note 124, at 50-51.
129. Martin, supra note 123, at 328-29

founded, and would encourage coalition-building for fundamental changes in the system, whether HMO profit caps, or a national administered system. In the current political climate, little has effectively induced public officials to reign in profits of private insurance companies. Profits for the nation's HMOs increased by 80% in 2003.[130] They continued their momentum in 2004, increasing gains by 10.7%, and earning an aggregate income of 11.4 billion.[131]

Despite policy reifying an employment-based private coverage model, no legislation dictates that employers offer affordable access. Nor does any current statute, including the latest Bush proposals, force a cap in profits for HMOs. This demonstrates an obvious gap in the attempts to insure the public. Because employers are the party best able to absorb the burden associated with increased coverage, they must necessarily bear the financial brunt of any scheme. As a result, they are the unfortunate beneficiaries of poor public policy regarding insurer excess. But, introducing the proposed modifications in labor law could drive employers to form key alliances with their employees, thereby creating an effective mechanism for political pressure at the state and federal levels to affect change in the national policies governing health insurance. Consequently, this effective partnership could reverse the skyrocketing expenses of coverage for employers. To this end, the proposed labor legislation does not seek to penalize employers, but to increase health insurance coverage for women, especially women of color, while at the same time eliminating the increasingly costly premiums that hurt businesses.

Section 2. Projected Increases in Healthcare Coverage

The pervasive lapses in labor law theory have expanded as the years have progressed. On one end of the polemic, we find the positive influence of legitimization of the collective bargaining process. On the other end, we see the restrictive forms that legitimization has taken in adopting theories of general contract law. This adoption of contract law theory ignores the fundamental difference between a mutually beneficial contract which both parties desire to enter, and one in which a party has no desire or impetus to participate in exchange. This tension between theory and reality has greatly crippled the labor force's ability to both organize, and to maintain or improve economic conditions through the process of collective bargaining. The adoption of such a mistaken theoretical framework has an especially acute impact on populations of employed women of color, because it hinders their ability to participate in employer-based health insurance plans. It further impacts employees' ability to improve working conditions in an institutional system that has promulgated standards of differential treatment for the working conditions of women and minorities. Finding themselves particularly vulnerable at the juncture of HMO

130. Press Release, Weiss Ratings Inc., Nation's HMO Profits Increase 10.7% in 2004 (Aug. 8, 2005), available at http://www.weissratings.com/News/Ins_HMO/.

131. Id.

profits and employer attempts to externalize health insurance costs, women, especially minority women, find themselves disproportionately uninsured despite similar employment levels.[132]

Changing conditions for labor organizing and collective bargaining would substantially increase access and participation in employment-based healthcare coverage for working women, especially those of color. Alterations could allow women to both form unions in these previously low union density occupations, and successfully bargain for increased access to affordable health insurance. As shown in Table 5 below, in the occupations expected to grow most by 2014, as many as 1,469,520 additional women would gain coverage through this method, including an additional 454,554 Black women, 297,866 Hispanic women, and 121,048 Asian women.[133] In the broader community dependent upon these women for coverage, nearly three million individuals could gain coverage via the privatized employment-based system.[134] This sizeable change in the general population's coverage would occur even though the seven selected occupations in this study compose only 11% of the total workforce projected for 2014.[135]

It is technically illegal to discriminate in affording coverage to employees based on the protected categories enumerated in Title VII of the Civil Rights Act of 1964.[136] Title VII prohibits discrimination on the basis of race, color, national origin, sex and religion in "compensation, terms, conditions or privileges of employment."[137] Such express forms of discrimination are in theory protected against; however, more implicit forms of differentiation continue to go unaddressed. Sixteen percent fewer full-time working women have healthcare coverage than full-time working men.[138] Furthermore, 50% fewer part-time employees have coverage than full-time employees.[139] Part-time statistics are particularly relevant, because women are more likely than men to be part-time or temporary employees, and are likely to work in lower-paying occupations associated with higher rates of uninsured.[140] Women are a majority of food service employees and health aides, the two occupations most likely to suffer

132. See Income, Poverty, and Health Insurance, supra note 1, at 16.

133. See Table 5, infra Part III.

134. See id.

135. Estimates reached by dividing total number of employees in selected workforce, Table I, supra Part I, by total number of projected workers in 2014. Employment Projections, supra note 19 (expecting civilian labor force to reach 162.1 million by 2014).

136. 42 U.S.C. § 2000(e-2)(a)(1)(2005); Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266, 1268 (W.D. Wash. 2001); Peter M. Panken et al., American Law Institute – American Bar Association Continuing Legal Education ALI-ABA Course of Study, SJ056 ALI-ABA 453, 460 (2004).

137. 42 U.S.C. § 2000(e-2)(a)(1).

138. Alan L. Gustman & Thomas L. Steinmeier, Employer-Provided Health Insurance and Retirement Behavior, 48 Indus. & Lab. Rel. Rev. 124, 125 (1994).

139. Id.

140. Lillian Gonzalez-Pardo, Women's Health Care: Limited Access Despite Majority Status, 3-Fall Kan. J.L. & Pub. Pol'y 57 (1993); Women in the Labor Force: A Databook, supra note 42, at 2 (giving the recent percentage of male and female part-time workers at 26% to 11% respectively).

lack of coverage.[141] While surprisingly few statistics exist on women of color as a demographic within these industries, the distribution of minority women in these occupations is disproportionately high compared to the total workforce, as estimates from Table 1 above indicate.[142] These estimates, coupled with the low coverage rates of minorities and juxtaposed with information regarding single-parent households and employment data, present a grim picture not only for women of color but for their families. The numbers are especially disconcerting when considering the low levels of coverage and the nature of the workforce found in the occupations selected for this study.[143]

Section 3. Consequences of Being Uninsured

The consequences of being uninsured are substantial. Studies have indicated that the uninsured suffer from increased mortality rates, in part due to later diagnosis of serious risk illnesses such as cancer, and higher death rates from preventable diseases. The uninsured have a higher rate of risk for infant deaths, and have lower income and educational attainment.[144] These problems are compounded for women of color, who have diminished health insurance access through there employers.[145] While 16% of White women are uninsured, more than one-third of Hispanic/Latina women are uninsured (37%), and 20% of Black women do not have coverage; again, due to their high rates in employment occupations which have lower levels of coverage.[146] Hispanic/Latina and Black women are covered by employer-based healthcare coverage only 44% and 52% percent of the time respectively, while White women are covered by employer-based health insurance at a rate of 66%.[147] Further aggravating the situation, all women have lower rates of employer-provided coverage; the usual coverage numbers deceptively include coverage through husbands' employment-based plans, not only coverage through direct access.[148] It is imperative that workforces dominated by women, and women of color in particular, be able to negotiate independent coverage from their employers rather than depend on partner insurance coverage. A vast majority of single parent households are headed by

141. Gonzalez-Pardo, supra note 140, at 2.
142. See Table 4, supra Part I (estimating percentage women of color in each of the selected occupations).
143. 2004 Data Update, supra note 4, at 26.
144. The Kaiser Commission on Medicaid and the Uninsured, Sicker and Poorer: The Consequences of Being Uninsured: Executive Summary 10-13 (2003), available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13971.
145. The Henry J. Kaiser Foundation, Racial and Ethnic Disparities in Women's Health Care Coverage and Access to Care: Findings from 2001 Kaiser Women's Health Survey, Issue Brief 2 (2004), available at http://www.kff.org/womenshealth /upload/Racial-and-Ethnic-Disparities-in-Women-s-Health-Coverage-and-Access-to-Care.pdf.
146. Id.
147. Id.
148. New America Foundation, supra note 4 (noting that much of the coverage women receive through employer-based plans is as dependants of husbands, not independently).

women.[149] High rates of divorce leave women vulnerable to loss of insurance, and single women have almost no access to Medicaid funded programs.[150]

As larger restructuring efforts of the healthcare system continue, the populations most affected by our current healthcare scheme, women of color, must not be forgotten in the moment. Current trends of coverage practiced in the expected job growth occupations of the future have serious ramifications for the expanding workforce. Though only a temporary measure until essential changes in the national healthcare coverage model are enacted, altering the treatment of unfair labor practices by introducing a proportional "percent-of-profit" based punitive damages measure would directly influence the coverage and participation rates of those most affected by our current problematic healthcare policies.

149. Families with own Children, supra note 40.

150. New America Foundation, supra note 4; see 2004 Data Update, supra note 4 (discussing lack of access for both genders in attaining health insurance through public assistance if without dependents).

Table 5: Projections of Employer-Based Health Insurance Coverage by Selected Populations for Total Sum of Future Selected Job Occupations for 2014[151].

PROJECTIONS POPULATIONS AND SELECTED JOB OCCUPATIONS	EMPLOYED IN 2014[152]	SINGLE COVERAGE[153]	FAMILY COVERAGE[154]	TOTAL EMPLOYEES COVERED[155]	NUMBER OF TOTAL POPULATIONS[156]	COMPARISON OF NUMBERS[157]
ALL WOMEN UNION AT CURRENT RATE	660,490	246,693	301,513	548,207	1,102,006	
ALL WOMEN NON-UNION AT CURRENT RATE	10,452,808	1,834,467	2,242,127	4,076,595	8,194,771	9,296,777
ALL WOMEN UNION TO HYPOTHETICAL 36%[158]	4,000,649	1,494,242	1,826,296	3,320,539	6,674,947	
ALL WOMEN NON-UNION TO HYPOTHETICAL 36%	7,112,265	1,248,202	1,525,581	2,773,783	5,575,859	12,250,807
TOTAL DIFFERENCE				**1,469,520**		**2,954,029**
BLACK WOMEN UNION AT CURRENT RATE	101,633	37,960	46,395	84,355	169,572	

151. See Table I, supra Part I.
152. Estimate of employed by demographic in total workforce of the selected occupations reached by multiplying the total number employed in the selected job force, Table 2, supra Part I, by the weighted average unionization rate, Table I, supra Part I, and non-unionized rate.
153. Estimate reached by multiplying the total employees employed in 2014, Table 5, supra Part III, by percentage employees participating, Nat'l Compensation Survey, supra note 6 tbl.2. The rate for union was 83%, for non-union average median wage under $15 it was 39%. Those numbers were then multiplied by 45% for the number of employer related health care coverage attributed to single coverage participants according to Employer Health Benefits, 2003 Annual Survey (Kaiser Family Foundation, Wash. D.C.), 2003, at sec. 3, available at http://www.kff.org/insurance/ehbs2003-5-2.cfm (stating 45% of participants choose single coverage, 16% individual plus 1, 39% family coverage).
154. Id. Similar equation used for family participation except individual plus one, and family coverage combined to equal 55%.
155. Estimate for total employees reached by adding two previous columns.
156. Estimate for total number affected uses the figure from single coverage gained, added to the total specific population in the workforce multiplied by .16, multiplied again by 2, added to the total specific population in the workforce multiplied by .39, multiplied again by 3.18. Note: Participants in coverage plus one dependent and family coverage are lumped together under family coverage. Individual plus 1 is that rationale for multiplying the subset by 2; US Census Bureau, 2004 American Community Survey Data Profile Highlights 2004: Average Family Size, available at http://factfinder.census.gov/servlet/SAFFFacts?_sse=on (last visited Jan. 21, 2006). The size of the average American family, 3.18, is the rationale behind multiplying that subset accordingly.
157. Compiled differences between the sums from previous column.
158. Union Members in 2004, supra note 7. The number 36% as a union density rate was chosen to mimic the union density in the public sector. In the public sector, employer campaigns tend toward less traditional models because they cannot use taxpayer money to run anti-union campaigns and are not governed by the NLRA.

Projections Populations and Selected Job Occupations	Employed in 2014[152]	Single Coverage[153]	Family Coverage[154]	Total Employees Covered[155]	Number of Total Populations[156]	Comparison of Numbers[157]
Black Women Non-Union at Current Rate	1,608,435	282,280	345,009	627,290	1,260,978	1,430,550
Black Women Union to Hypothetical 36%	615,603	229,928	281,023	510,951	1,027,114	
Black Women Non-Union to Hypothetical 36%	1,094,406	192,068	234,750	426,818	857,990	1,885,104
Difference				**226,123**		**454,554**
Asian Women Union at Current Rate	27,065	10,108	12,355	22,464	45,157	
Asian Women Non-Union at Current Rate	428,330	75,172	91,876	167,048	335,801	380,959
Asian Women Union to Hypothetical 36%	163,936	61,230	74,837	136,067	273,523	
Asian Women Non-Union to Hypothetical 36%	291,443	51,148	62,514	113,662	228,485	502,008
Difference				**60,217**		**121,048**
Latino/Chicano Women Union at Current Rate	92,577	34,577	42,261	76,839	154,462	
Latino/Chicano Women Non-Union at Current Rate	1,465,112	257,127	314,266	571,393	1,148,616	1,303,078
Latino/Chicano Women Union to Hypothetical 36%	560,749	209,439	181,514	390,954	819,406	
Latino/Chicano Women Non-Union to Hypothetical 36%	996,887	174,953	213,832	388,786	781,537	1,600,944
Difference				**131,507**		**297,866**