

Overview

Independent workers face many obstacles when it comes to finding affordable and adequate health insurance coverage. The independent workforce—freelancers, consultants, independent contractors, temps, part-timers, contingent employees, and the self-employed—makes up one-third of the U.S. workforce but is excluded from the traditional employer-sponsored health insurance system. For independent workers, finding adequate health insurance is costly and complex. Dealing with large insurance companies as an individual can result in higher premiums and inadequate healthcare. In many cases, the expense and hassle of purchasing insurance as an individual lead independent workers to forgo coverage, a situation that can prove both costly and dangerous for the individual and society.

All Americans and Health Insurance Access

In the past decade, the prices of both health care and insurance have spiked dramatically. Employers are cutting coverage and increasing their workers' share of the premium bill. Despite these hardships, employees are relatively well off, since most employers pay a portion of their costs, and the group rates they get are generally lower than those in the individual market.

The individual health insurance market, in which consumers buy coverage directly from insurance companies, presents a difficult choice to middle-class independent workers without access to employer subsidies and group rates. These workers generally earn too much to qualify for government programs but too little to afford market-rate premiums. In New York State, for example, monthly premiums average \$755 for an individual HMO plan or \$1,080 for a POS plan. Based on these figures, an independent worker in New York has to earn \$120,000 or more a year just to afford health insurance. This is especially difficult for independent workers early in their careers; virtually none under the age of 30 earn that amount. As a result, independent workers are often stuck deciding between expensive plans that offer inadequate coverage or forgoing coverage altogether.

Exorbitant premiums and outright coverage denials can prompt an independent worker to consider taking a traditional job simply because it offers a group health insurance plan. However, as health care costs rise across the board and the labor market changes, fewer insurance-providing positions are available, leaving many with no choice but the individual market.

Consequences of Uninsurance: Effects on health, financial stability, and public resources

Forgoing health insurance is a risky proposition for a person's health and financial security. Individuals without coverage are more likely to avoid routine preventive care. As a result, conditions that could have been treated easily become both serious and expensive. Without health insurance, many people fail to manage chronic illnesses properly, because the required medications and doctors' visits are simply too expensive. Unfortunately, skimping on treatments for these illnesses can have long-term negative effects on overall health. For the uninsured, the stress of receiving an upsetting diagnosis or sustaining a serious injury is compounded by the fear of financial disaster as a result of medical bills.

The uninsured put pressure on public resources as well. When these patients seek care in emergency rooms and public clinics, taxpayers ultimately foot the bill. Providing primary care in emergency rooms is expensive for both patients and the public. Patients may receive only stopgap treatment without follow-up, and the public pays much more for an emergency room visit than routine preventive care would cost in a doctor's office.

Navigating the Individual Market

Independent workers do not have access to traditional employer-sponsored health insurance plans. The current system, which ties access to health insurance to a single employer, is not

viable for the growing and highly mobile independent workforce and those who do not receive benefits from their employer.

Because these workers do not qualify for employer benefits, they are forced to forgo health insurance altogether or navigate the increasingly costly and complex individual insurance market.

A number of obstacles confront independent workers who do shop for health insurance. Complex plans and confusing terminology make it hard to comparison shop and even to understand the basic coverage a plan includes. Insurance brokers can provide consumers with some guidance on plans and benefits, but a broker's interests are generally aligned with the insurance company's, not the consumer's. Furthermore, pre-existing conditions, such as diabetes, cancer, or HIV, can make it virtually impossible for an individual to purchase affordable health insurance. Insurance companies are either unwilling to cover these individuals, or they charge prohibitively high premiums. Thus, an individual with a serious health issue may effectively be prevented from ever getting health insurance.

The complexities of the individual market and the high cost of health insurance make consumers particularly vulnerable to scams and to plans that offer little value. Many people who buy such plans don't discover the problem until well after they have incurred thousands of dollars in charges.

The Regulatory Environment Compounds Individual Market Challenges

Each state in the U.S. imposes its own regulations on insurance carriers. Some states require insurers to keep prices the same for everyone in the individual market. This is known as community rating. In some other states, the market can be split into two rating pools: a relatively affordable one for those with no history of serious illness or other risk factors and a very expensive one for those considered "high-risk."

Both of these regulatory strategies create serious problems for consumers. In a community-rated state, the risk pool theoretically works the way it does in a large-employer group: the healthy

subsidize the sick. But, as costs rise, healthy individuals often drop out of the pool, and without them to share risk, premiums grow more expensive. Those who need care are left to wrestle with increasingly unaffordable premiums as the relatively healthy go without any coverage at all. In states with a high-risk pool, the healthy have access to more affordable insurance, but those who need care the most are forced to pay huge premiums, often thousands of dollars a month.

Why Groups Matter: Understanding risk pools

Employer groups keep costs lower by spreading risk over a large group that includes both the healthy and the potentially sick. Within the group, the healthy subsidize care for others but are ensured access to care when and if they need it. This model works because the healthy are unlikely to leave a group with affordable premiums, and because employers typically subsidize much of the cost. The individual market fails when high prices cause the healthy to drop out, leaving those who require care to face spiraling premiums. The result is that people buying insurance in the individual market are systematically disadvantaged, both in terms of access and cost, compared to those purchasing health insurance through employer-sponsored group plans.

The NCE's Model: Piloting a market-based approach to individual insurance

The challenge in the individual market is to offer premiums that are low enough to entice healthy people to buy insurance. The NCE is able to give individuals access to a large group that keeps rates low. This model shows that it is possible to attract enough low-risk consumers to create a healthy risk pool within the individual market. By mimicking the large employer model, The NCE has been able to provide affordable health insurance to tens of thousands of people—high- and low-risk together—in most states in the country.

This represents a new model for health insurance coverage, with benefits permanently tied to the individual rather than to a transitory relationship with an employer. It allows an independent worker to hold on to health insurance while moving from job to job or provide for the small business employee who's employer does not provide access to benefits. The workforce as a whole and these individuals in particular need access to this kind of mobile and flexible health insurance system, one that serves the needs of a mobile and flexible workforce.

The Future of Health Insurance: Intermediaries and innovative approaches to care

Insurance companies and policymakers need to reconsider the relationship between routine health care on the one hand and insurance against high-cost, unpredictable illness and injury on the other. In the future, high health care costs will continue to put pressure on insurance companies to pare back coverage and raise premiums. To control costs, insurance companies typically cut coverage for the services that people use the most. Of course, this ensures only that people will not get the routine, preventive care they need. The next model for health care must find a way to finance the routine care that consumers need, while continuing to provide insurance for unpredictable events that would otherwise be financially devastating.

As the labor market shifts toward independent work, and as employers less often offer health coverage, the insurance landscape will change dramatically. Independent workers and those not receiving benefits from their employer, navigating the individual market requires intermediaries. These organizations can act as consumer advocates in a challenging market and can create alternative risk pools that will maintain affordable premiums. To make this possible, independent workers must be able to form groups that will negotiate and advocate on their behalf. As a group united by common interests, the independent workforce will be better able to secure the benefits they desperately need, as well as to seek policy change to eliminate the disadvantages and challenges of the current system.

Individuals dealing with insurance companies have very little power when it comes to negotiating a fair price, filing claims, and, perhaps most importantly, finding a plan that matches their individual needs. Through intermediary organizations, individual workers are able to increase their negotiating power with insurance companies, getting plans that equal or exceed in value those available to traditional employees. Plus, as companies continue to cut back on the benefits they offer, intermediary organizations will play an even greater role in securing affordable health insurance for both traditional and independent workers

Conclusion

Independent workers in the United States deserve access to affordable health insurance. As the workforce continues to change, more people will leave the single-employer system, and will need another model for benefits delivery. Intermediary groups offer an innovative, alternative approach to accessing health insurance. Rather than dealing with insurance companies as individuals, independent workers will increasingly need to obtain benefits such as health insurance through intermediary groups.