The Powers Report Podcast

Episode 19

My Year Without Health Insurance

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

2020 brings a new year and a new decade. We're well into January and many of you may have already forgotten your new year's or even new decade's resolutions. I hope not, because most resolutions tend to be things that promote better physical and mental well-being. We pledge to do things like exercise more, sleep more, eat a healthier diet. Many of us want to get our finances under control or pay down debt. Please take time to double down on these commitments if you don't have a mechanism in place to remind you to do so.

I enter this year with less of a resolution and more of a continuing experiment. It will be my second year without health insurance. Actually, I should qualify that. I have health insurance but it's not the kind that I'm legally supposed to have. I have a short-term catastrophic plan, and I'll explain more of the details about it in a bit.

What I am supposed to have is dictated by the Affordable Care Act, or the ACA, which was passed in 2010. A decade ago. The major components of the law went into effect in 2014, so much of what I'm going to say may be old news to you. The ACA established the legal requirement that all Americans have health insurance. That's the so-called individual mandate. I'm self-employed. I can't get health insurance through an employer, which is the source of insurance for about half of all Americans. I'm not on Medicare or Medicaid, so I don't qualify for the government's public health programs. I have to buy health insurance on my own.

The market I'm in is small. There are about 330 million people in America. According to the Kaiser Family Foundation, about 13.8 million people bought some sort of insurance – including non-ACA compliant plans – in 2018 (1). Then throw in the number of people who are uninsured, which went up between 2017 and 2018. In 2018, according to the US Census Bureau, 27.5 million people didn't have health insurance at all (2). I know I'm adding numbers from different sources which is kind of a no-no, but it provides a ballpark of the size of the pool who could be buying ACA-approved health insurance plans. It's 41.3 million people. 12.5% of the population.

The insurance pool I'm in is larger than other states because I live in Texas. We have a lot of people. More pertinent to this topic, we have the highest rate of uninsured residents, with 17.7% of the population going without health insurance (3). Much of this is attributed to the fact that Texas did not expand the Medicaid program, which was an expectation of the policy makers who designed the ACA. That means my pool has a bunch of lower income Americans who, in other states, may have qualified for Medicaid coverage had the program been expanded.

As you may know, lower income individuals have health outcomes and conditions that are lower than average. This is a function of a lack of education about health, lack of access to good food, lower levels of employment precluding access to full-time jobs that could provide insurance coverage…there are a lot of social and economic issues that we, as a society, need to address to improve health disparities.

So we've got this sicker than average pool. Everyone's got access to the same plans, regardless of their health status, because the ACA outlawed the ability for insurers to deny coverage based on an applicant's pre-existing conditions. This aspect of the ACA is probably its most popular feature. I mean, we can't even articulate what a pre-existing condition is. According to the Centers for Medicare and Medicaid Services, or CMS, "A 'pre-existing condition' is a health condition that exists before someone applies for or enrolls in a new health insurance policy. Insurers generally define what constitutes a pre-existing condition."(4).

Excellent. Insurers get to decide whether a person has a pre-existing condition or not. I think we all understand that having diabetes is a pre-existing condition. But an insurer could deny coverage to someone who had a blood test that indicated that their cholesterol is too high. It would be nice if the regulatory agencies could legally define what a pre-existing condition is but doing so would be incredibly complicated and worse yet, would set the stage for discriminatory pricing. It's just easier to eliminate pre-existing conditions, whatever they are, from consideration in insurance coverage.

Because of the ACA, the products I am legally obligated to buy have a slew of so-called benefits that I don't want or need. I have to pay for mental health benefits and rehab and drug coverage that I don't use. Many Americans require these services and policy makers contend that if these services weren't covered under an insurance plan, people wouldn't access them. This is the overarching logic to providing universal health care coverage. Everything should be covered so people can access the health care they need.

While that all sounds right and just from the media's perspective, here's the practical reality. As much as I want to help my fellow Americans, I am going to put my health and the financial well-being of my family before the health care needs of my fellow citizens. There. I just admitted it publicly. I feel comfortable saying it because I know that most of you would do the same thing too!

I've had to buy insurance on my own since before 2014, so I have seen the premiums creep up. Worse yet, I've seen the premiums kind of stabilize, but the deductible levels shoot up. More narrow networks have been introduced to the market, meaning plans may have lower premiums and deductibles, but I can't get the doctors I want. I'm healthier than the average American and I require very few health care services. For years, I've been dramatically overpaying for health insurance.

But hey, you've probably been overpaying too, even if you get your insurance through your employer. That's because one percent of the population is responsible for 20% of health care costs (5). Five percent of the population is responsible for about 50% of costs. Most of us are subsidizing high cost utilizers. We are all frustrated by the rising cost of health care in America.

Then came the 2017 Tax Cuts and Jobs Act. That ostensibly eliminated the individual mandate. It's still a legal requirement to have health insurance. But the 2017 legislation removed the penalty for breaking the law (6). It's sort of like saying we're making the highway speed limit 55 miles per hour, but if you speed, you're not going to get a ticket.

After years of overpaying for insurance and an increasingly tight financial situation, I decided, in 2019, to break the law. I didn't buy an ACA-sanctioned health insurance plan. And I didn't do it in 2020 either. Yes, the repeal of the individual mandate was a drive in my decision. But I felt comfortable taking the risk because for all the years I was paying for insurance, I was still paying out of pocket for all kinds of health care.

In fact, my rationale for going with the short-term plan goes back to an incident that occurred during Thanksgiving in 2016. That's when I sliced off part of my thumb with a mandolin. For those of you who do not have advanced knowledge of kitchen gadgetry, a mandolin is basically a horizontal kitchen razor used to thinly slice vegetables. I was preparing Thanksgiving dinner, hastily trying to slice a parsnip. Along with the parsnip, I wound up pushing my thumb, nail first, through the mandolin.

I will spare you the gory details except to say that the cut was not deep enough to reach the bone. What I did do was side-swipe the nail bed with a clean, albeit bloody cut. I scream. I will spare you the profane details except to say that my teenage daughter arrived on the scene, phone in hand. Pictures were taken. Obviously. That's the most important thing to do. Then she checked the internet.

Her first piece of advice was for me to take a painkiller. Her words, "Mom. You should probably take a pain pill, if you have one."

My stupid response, fueled by the massive amounts of adrenaline pumping through my veins: "I don't feel any pain. I'm fine."

Her ever-so-wise responsorial counsel: "You may not feel anything now, but you will later."

Logic set in and I took a pain pill. I had a stash left-over from a root canal I had a few years back. So much for opioid addiction.

Then she bandaged me up. Alcohol of varies kinds were utilized during this process. But the bleeding stopped and I could settle in and make an assessment of the situation.

Now, a normal person probably would have gone to the emergency room. I, however, chose not to. First, I was delirious. Remember? I took a pain pill and had alcohol. Second, I'm alone, with my kids, neither of whom can drive. It's 2016. A ban on Uber and Lyft in Austin had been raised in March of that year, so ride sharing hadn't completely caught on yet. Third, it's Thanksgiving, so it's going to be difficult to find someone to drive me to the ER, and even if I could, it would be a massive inconvenience for them. Fourth, an interestingly what seemed the most important factor at that time, the turkey was in the oven and was supposed to come out in ten minutes. The entire meal – aside from the root vegetable side dish I had been preparing – was pretty much ready to go.

I could have eaten dinner and then gone to the ER. But, I reasoned, what was the point? My thumb was covered in copious amounts of gauze and we had just had, remarkably, a fantastic dinner. The idea of going to the ER and getting charged Lord knows what just to re-wrap the wound seemed ridiculous.

Also ridiculous is the idea that I could have had an infection. I knew I needed to get that wound cleaned. Isn't this the reason I had insurance? So I could get the health care I needed? Well, I made the executive decision to call my primary care doctor first thing the following morning instead of going to the ER that night. Did I take a risk? Yes. Was it worth it? Hell yes.

So here it is, the Friday after Thanksgiving. My thumb is throbbing. Maybe I have an infection. I definitely have a hangover. I learn that getting in to see the primary care doctor is not going to happen because no one is returning my calls. Telemedicine wouldn't have helped – and it wasn't available then like it is today – because no doctor can sterilize a wound over a video chat. So I opted to pay about $155 for an appointment at a minute-clinic.

I got an appointment before noon. I got friend to drive me. I had some professionals take a look at my mutilated finger. Then I experienced more pain than I have ever experienced in my life. Three lidocaine shots in the open wound of my thumb. I swear, the tech must have used the biggest needle on the planet. Like she could have used it to inject something into a horse. The team bandaged it up, gave me a prescription for painkillers, and I went home. The cost for the prescription was covered under my insurance. The visit wasn't. I didn't really need the prescription. So why, I wondered, did I even have health insurance?

The following year was 2017 and I dutifully bought health insurance. I don't think I used it for anything besides an annual well check and a mammography. Then the Tax Cuts and Jobs Act was passed. I bought insurance in 2018 and then decided, in 2019, to take the short-term insurance plunge.

First off, I'll tell you that I don't regret my decision. I don't have any regrets primarily because nothing happened to me in 2019 that I could not financially manage. In fact, the health issues that did come up I wound up managing with options that probably would not have been covered under an ACA-qualified plan. And this is what's really interesting about not having insurance versus having it. It's a phenomenon that many of us have experienced, and that is the weird behavior that many engage in because we're on a high deductible health plan.

High deductible health plans are popular because people make a trade off. They pay a lower monthly premium in exchange for paying more out of pocket should they need to access health care not covered under their plan. They also have to pay out of pocket if the health care that is covered under their plan is inconvenient to access and if the pricing is exorbitant. Like when you cut off part of your finger on a national holiday.

Those of us on high deductible health plans are pretty good at arithmetic. We take our monthly premiums and multiply them by 12. Then we add the annual deductible. We know we're going to have to pay all of that before non-routine stuff is covered. When I was shopping for insurance for 2020, the cheapest plan available had almost a $500 premium and an $8,000 deductible. Even worse, my physician wasn't covered. So I was going to pay about $6,000 in premium payments just so I could go to a doctor I didn't know. And if anything was wrong, I'd have to pay another $8,000 before my insurance kicked in. $14,000 out of pocket should something go wrong.

So then there's more math. How much would it cost out of pocket to see the doctor I wanted and to get the mammography that I needed. Well let me tell you, in 2019 and in 2020, it was a lot less than $14,000. The two together cost less than my monthly premium would have cost me.

What about medications? Well, the vast majority of medications are generics. You can shop around to get the best pricing on drugs on places like GoodRx. Or just go to Costco, because they seem to be one of the lowest cost providers. Say I have high cholesterol. I can get 90 tablets of generic Lipitor for under $15. Why pay over $6,000 a year in premiums when I can get a year's worth of medication for a common condition for under $100? And by the way, there's been a continuous freak-out about birth control pills. They cost about $15 a month. I'd pay $500 for a monthly premium to "save" myself $15. That math doesn't add up.

Knowing all of this, I decided to buy a short-term health plan in 2019. I can tell you more about what it doesn't cover than what it does. It doesn't cover the doctor visits and the mammography and the drugs. But that's OK, the math says go with the catastrophic plan. How much would I be out of pocket if I were to get cancer? Or be in an accident? I have no idea. And I would have no idea with regular insurance either because aside from the $14,000 I'd have to pay, I'd also be on the hook for a percent of charges I'd rack up in the hospital. I may have to pay 20 or 30% of the hospital bill, were I to get admitted. That would be on top of the $14,000. Or, I could get this catastrophic plan and be just as in the dark, but out a lot less money.

So it's 2019. I'm braving the year without an approved health insurance plan. Sure enough, in the summer of 2019, I started feeling pain while running. I was a college athlete and I've been running and working out regularly – like five to six times a week – for over 30 years. There's a term for pain while running that applies to people like me. It's called aging.

I knew nothing was broken. The pain came and went and it impacted different parts of my left side. Nonetheless, I can't tell you how many people told me to get myself to the doctor right away. Then the numbers start flying around about specialist fees and MRIs and physical therapy and everything else I'd have to pay a ridiculous out of pocket sum to access.

Instead of seeing a doctor, I applied logic to the situation. I thought to myself, "If I do this thing that hurts, maybe I should stop doing it." And that is very hard for runners. Decades of running and now I had to stop? I'd get fat and worse, I'd get angry. I need the running to meditate.

But I looked back on my personal athletic history. During college, I had a stress fracture in my tibia, or one of the bones in my lower leg. The pain I was having now did not feel like that. I had sciatica pain while running about seven years prior. Nerve pain. This pain felt like that pain. Back then, I went to an acupuncturist. So this time around, I did that same thing and it helped tremendously. $85 a pop.

In addition, the last time I had the pain, I went to a podiatrist and had custom insoles made for my running shoes. They cost over $400. I thought that maybe I needed new ones. Then someone suggested I get my gait analyzed – meaning get a professional to look at how I run. Maybe what was happening was a bit of a mechanical problem. So I went to a place called RunLab in Austin (7). It cost me $275. They videotaped me running. I had a physician talk me through some of the issues I was having and he gave me some corrective advice. He also recommended that I ditch the insoles and get different running shoes. It was one of the best ways to spend $275.

All the while, I stopped running. I knew the pounding was causing the pain and if I stopped, I could hopefully let my body heal. I was also becoming increasingly inflexible. I'd get back from jogging and it was painful to bend over and untie my shoes. I was dehydrated…it was summer in Texas, so that's no surprise. But instead of just stopping cold turkey, I tried something else – swimming. I joined a nearby gym for about $55 a month and it has been one of the best decisions I've made.

Had I been on insurance, it would not have covered the RunLab tab or the visits to the acupuncturist. (If I were on a generous employer-sponsored plan, those things may have been covered.) So I was out of pocket about $600. As for the gym fee, some employers offer their employees complementary gym memberships. My employer does the same thing because my employer is me. I pay for the gym membership.

I share all of this for quite a few reasons. First and foremost, I must emphasize that I am not a doctor. None of us are doctors unless you are, well, a doctor. And even then, you may not be

the right kind of doctor to diagnose what may be wrong with you. When we have health concerns, we need to see a professional. We shouldn't depend on Dr. Google to fix everything ourselves.

That said, I think many of us want a quick fix. We want a pill or surgery so we can resolve issues and move on. Such an approach doesn't let the body try to fix itself. There have been many instances where I have gone to a doctor and have wound up with a prescription. When I have a infection that's not viral, I want a prescription. But how many of us have had a nasty cold that drags on for over a week? It feels like you've been sick for a month. We want drugs to make it better, but drugs can't make it better. We have to slow down, hydrate, eat better and most importantly, sleep. Basics.

I think many of us have a lack of understanding about how our bodies work. The older we get, the more things are going to change. We're going to need more sleep than we did when we were 22. We may not be able to eat or drink like we did when we were younger. Pills can't cure aging. Oftentimes, the best thing to do is adapt your behavior. If eating a big meal late at night give you an upset stomach, don't go straight for the acid reflux meds or for the Tums. Eat earlier. Eat less. Eat something less filling.

One of the biggest frustrations with the American health care system is that our primary care doctors don't have the time or the inclination to have these discussions with us. They provide meds. Or procedures. You have an upset stomach? You're regularly constipated? Time for a colonoscopy. After all, if you have insurance, your preventive colonoscopy is covered, so it's no out of pocket cost to you! Yay!

In closing, there are two important takeaways I'd like to share with you from my year without health insurance. First, take a good hard look at how your behavior is impacting your health outcomes. What you're eating, how much and what kind of exercise you're doing, how much stress is in your life, how much sleep you're getting – these simple behavioral attributes are going to have a greater and greater impact on your health as you age. Prevention is cheap. Getting sick is not. And that goes for everyone, whether you have health insurance or you don't.

Second, manage your expectations about what you can get out of the health care system. There's only so much it can do, and odds are, it won't be on your schedule. Avoid the quick fix and instead work with a professional to figure out the root cause of your problem. Spend time fixing that. Adapt your behavior. Doing so doesn't mean that you're unhealthy or that you've failed. It just means you're human.

I wish you all a wonderful 2020 and a fantastic decade. Here's to being as healthy as we can be!

This is The Powers Report Podcast. Please subscribe to our show and please follow me, Janis Powers, on social media. Please see our website at powersreportpodcast.com to submit

questions and ideas on the Contact page. I look forward to hearing from you. Thanks so much for listening!

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