The Health Insurance Tsunami – Healthcare for ONE DAY!

By Margaret Eden, freelance writer

Inside the Vortex of ObamaCare

February 2nd the healthcare tsunami caught up with me. In fact, it washed over me carrying me bumping along to parts unknown. The carnage of broken plans, promises and dreams threaten to drown me, and many other Americans as well, under its crushing weight these days.

Through no fault of my own, when I signed up at the Healthcare.gov website in Nov, something happened that caused my policy to begin and end only 24 hours later. Feb 2nd, the day AFTER Open Enrollment Scott & White Health recorded my health insurance as terminated, and now it appears my husband and I have – at least for– have joined the ranks of the uninsured. We registered, we paid our premiums, yet now it appears we have no insurance.

This is not my first health insurance tsunami. In 2001 after my mother's death my husband and I moved from Georgia to Texas. During the move Blue Cross Blue Shield (BCBS) canceled our insurance because we crossed state lines into another BCBS district with different regulations and policies. Before I could wrangle another policy with them, my doctor diagnosed me with Clark Stage II melanoma which in 2001 rendered me uninsurable. So this is not my first time navigating the troubled health insurance waters.

So far I've survived melanoma, and years later, at great expense, I acquired insurance again, but I know first-hand what its like, what horrible things can happen if you don't have health insurance. Not having health insurance can kill you. It kills people every year because they cannot afford treatment. Struggling to get care once they have insurance kills them too. Patients must navigate the complicated waters of policy choices, paperwork, unanswered customer service calls, complicated treatment applications, rejections based on technicalities or poor communication, uncooperative General Practitioners…and more. Patients can get snagged on any of these murky obstacles at any point making it impossible to obtain the necessary treatment. No everyone is strong enough or able in many ways to navigate the treacherous waters of healthcare. So despite generally conservative views, like many others I felt guardedly optimistic about Obama's promise that under ObamaCare insurance companies would no longer decline customers for pre-existing conditions. Obama further promised that: "if you liked your doctor you could keep him and if you liked your insurance you could keep it." (Excuse me while I projectile vomit for just a moment. Okay…now I can continue.)

Part of the 440,000 Thousand Who Received a Dear John Letter from BCBS

Still, it surprised me when BCBS announced late last year they planned to discontinue all PPO policies in the State of Texas, mine among them. Like 440,000 others I received a form letter announcing they'd canceled me. To "protect me" from falling into the murky depths of the uninsured outside the Open Enrollment period, they rolled me into another policy with three times the deductible and less than half the benefits, an HMO rather than my much loved PPO policy. This policy requires a general practitioner

to oversee all care and sign off on all referrals to specialists. My new plan, the BCBS Solution 102, Multi-State HMO Plan (sm) (Why is it that I think of Harry Potter's fantastic broom when I write this—The Nimbus 2000?) offered 23 doctors as managing General Practitioners (GPs) in a 25 mile radius of home. None of my specialists were in the network, not my skin specialist or cardiologist. Of the GPs listed, 18 were the same doctor only with different facilities and different addresses. (Was he cloned or maybe nurse practitioners are running the facilities?) BCBS also took the liberty of assigning me to a recommended GP and since I didn't currently have one, I decided, what the heck, to give him a try.

In the meantime I checked the BCBS online portal looking for physicians who accepted the plan. I could not find any I recognized. The selection seemed so bad I concluded perhaps most physicians had not had sufficient time to sign up to accept this new policy? I called the BCBS help line but the customer care person could not access her system, making it impossible to determine if any other doctors were available on the policy at that time. So I decided to review my BCBS options through the Exchange to see if I could find a better policy.

So What's It Like to Pick a New Healthcare Plan?

I downloaded and studied nine plans by printing and laying out all product descriptions on my office floor. The plans papered half my office floor in fine print. After reviewing the policies through high-powered bifocals, with a highlighter in hand to note preferred options, I decided to keep the policy BCBS assigned me because it was the only one of nine policies that offered to pay *anything* on non-emergency Out of Network expenses—unfortunately the limit on Out of Network expenses no longer applied (that means if you have a heart attack in Kentucky and live in Texas if it costs three million dollars, you owe half that, yeah—instead of the old ceiling of say $10,000). Some policies cover nothing at all. Thank you ObamaCare! Makes me never want to leave home again! However, these were the only policies I could afford.

Pressure to make the correct decision was intense. According to the ObamaCare website the average cost per policy for six out of 10 people is $100 (they don't say if that's per minute, month or year). I don't know anyone who have $100 policies. For me the cost for my husband and me came to approx. $1600 per month. A subsidy would reduce that amount to $1155.00 per month (if we qualified) with a $6,000 insurance deductible for myself and an additional $2,000 for my husband. That means to receive benefits from my policy I'll need to spend $28,200 this year if we both meet our deductible. Such a policy results in my paying for a policy that I cannot afford to use, so my daily health needs go unmet. Perhaps good in a crisis (it might keep me from losing my house in the event of a heart attack, but results in small problems escalating to larger ones. This year we spent $4,000 out of pocket in addition to premiums and did not even meet our deductible. What family can afford this? I know we cannot.

So you'll understand why having to make this decision causes me to walk the floor, wring my hands, have chest pains, and spend many sleepless nights. I can't go w/out insurance, yet the insurance costs me so much I cannot afford to use it, nor can I afford to go without it. My decision? Cancel all non-essential expenses. Oh…forgot…did that last year. So I trim more. Already got rid of the extra car. Already quit contributing to the 401K. Between high premiums and high deductibles health care for us

last year consumed the lion's share of our income, more than our house payment, our remaining car expenses, and all our utilities combined – and neither of us had actually been sick! High premiums have eaten up any hope of retirement for my husband and me. It's also washed away all hope of retirement for many others as well, in addition to smashing and ruining huge chunks of the average American's family budget. As independent business owners we've experienced declining sales for the same reason. Clients aren't buying as much these days, and we understand why. As a result we find ourselves pelted from both side, losing income while experiencing increased expenses. Still, when I considered everything, at the time this seemed my best option. I selected this policy on the Exchange.

My new BCBS cards arrived in the mail an efficient week later. Interestingly enough two sets of cards arrived. One set for the policy BCBS issued us, and one for the policy I confirmed on the Exchange. Same policy and group number however the emergency room deductibles for the policy purchased on the Exchange ran hundreds of dollars higher. This caused me to wonder if policies on the Exchange, despite identical names, might carry reduced benefits in other ways as well? A suspicion that later my insurance agent confirmed was the case with some (but not all) companies.

If You Like Your Doctor, You Can Keep Your Doctor--Not

After reviewing the doctors with this policy I could find none of mine at the portal. In the absence of helpful information there, I decided to call my doctors directly to see if they accepted my new plan. I called my skin care specialist Jennifer Cather, MD first, regarding necessary annual follow up for melanoma. Her office informed me they would no longer take *any* BCBS policies. I called my cardiologist, Darryl Kawalsky, MD in Dallas. His business office informed me they no longer accepted BCBS HMO insurance *at all.* I asked what we could do if my husband's heart condition worsened. They informed me the doctor had many customers in the same situation, and they planned to work with us--*if possible*. NOT TO DELAY treatment, if we needed it. I called my gynecologist of 29 years, John Bertrand, MD in Dallas. Sorry, they could not accept my new policy either. I talked to the business office and they informed me, while my situation seemed unfortunate, there had many patients more unfortunate than me. Many patients mid-pregnancy had received the same notice I received from BCBS and found themselves without coverage and unable to find another OBGYN willing to accept them mid-pregnancy. Dr. Bertrand also planned to work with his patients to insure safe deliveries.

Clearly these doctors were struggling to survive in the healthcare tsunami much like their patients. THEY SHOULD BE APPLAUDED. They answered their phones! They cared! They treated their clients *like humans* rather than numbers and worse than animals. They were sharing the burden of these unfortunate events. They were working to make sure their patients received good quality care and to prevent gaps in care, often at their own expense. However, it was also apparent that they, too, were becoming casualties of the new healthcare requirements. Many were losing long-time patients, suffering reduced appointment scheduling due to patients losing their insurance while at the same time suffering under reduced negotiated payment rates from government subsidized policies! So just where is all this money flowing into the government going if not to cover the cost of the policy and not to the doctor? I wondered, and I'm still wondering. It appeared my head was not the *only head* struggling to remain above troubled waters of healthcare.

What Happens During that Wonderful Free Annual Visit?

I set up an appointment with the assigned GP, collected all my medical records and 10 days later went to meet David C. Kuo, MD, PhD, my newly assigned, bonafied, insurance recommended healthcare manager. During my Well Visit Dr. Kuo explained Well Visits were designed so patients and doctors could get to know one another. He also explained that his purpose as my GP was to keep health insurance costs low, not to satisfy my whims to see other doctors for frivolous reasons. (Does anyone go to the doctor for frivolous reasons?) He did not say he was there to provide me with excellent healthcare, yet early in the appointment I remained optimistic. He continued on, saying to allow patients to select their own doctors had bankrupted the insurance companies and did not provide any benefits to the patient which explains why *we are-where we are*. At this point I offered my health records to him for review, but he declined to review them. Free annual visits were not designed to discuss specifics, he informed me. First he would need blood work. Then I could come back *in a month* for a *paid* visit at which time we'd discuss the specifics and he would determine if and when I needed to see someone else. He also let me know he preferred to be the one asking the questions. However, he never quite seemed to ask the right ones—in my opinion.

I tried several times to interject a few facts about myself into this increasingly one-sided "get to know you free annual visit process," but after the third question I noticed his eye began to twitch, and after the fifth question he explained to me there were other doctors in the area and how I might avail myself of them if I liked. In short I left without him learning much of anything about my medical needs. And much to his disappointment I refused to schedule the blood work because he could not provide me with a price for the service.

As a tidal wave of thoughts propelled me out onto the sidewalk and into my car I considered the benefits and liability of my hard won Well Visit Obama against all the coverage my prior PPO had once included. I considered the whopping cost of the new ObamaCare plan and could actually feel my blood pressure rising like a sea of red ink threatening to completely blind me. I took a deep breath and contemplated the birds and the trees and considered they knew nothing of insurance yet they flourished. While I did realize that Dr. Kuo might not be typical of assigned GP's under the new HMO plans, I still felt a cold wave of primal fear wash over me. How can anyone survive this? I wondered.

Insurance Companies Experience Their Own Stressors under ObamaCare

Not comfortable with my new GP navigating the direction of my health care, I logged back onto the Exchange to explore my policy options (it was still Open Enrollment, a.k.a. musical chairs of healthcare). I selected a new policy this time from Scott & White, which happens to be the only healthcare plan left standing in the State of Texas offering PPO coverage. I booked and confirmed the policy and waited for my cards and intro package to arrive by mail. I waited 10 days. It did not come. Then about the 10th day I got a flier in the mail from Scott & White offering to sign me up for a plan. ??? I called the number thinking I'd ask about my insurance cards. The number connected me with Wyatt Coleman, licensed insurance agent and financial planner and agent for Scott & White. Wyatt reviewed my records online and confirmed that my policy with Scott White existed. He told me Scott White was running a bit

behind due to the large number of individuals thrown off their BCBS plans (you know—that part Obama said wouldn't happen), but that I should get my cards within 10 days, maybe sooner. A few days later I checked on the Exchange which showed my plan with Scott & White active, and I sent in my check to them for my first month's premiums. Easy, right? Well….not exactly.

No cards arrived. I tried calling Scott & White several times at the only customer service phone number provided at their website (1-800-321-7947) over the next couple of weeks, but could not reach a human. The call would either disconnect before anyone answered, or if someone did answer, they were unable to hear me and would hang up. This happened many times over the ensuing weeks. There was no selection on the automatic service for my situation. Meanwhile I could hear the open enrollment period clock ticking away in my head increasing in pace and tempo as did my increasing blood pressure and heart rate. Sometimes it ticked so loud, I had to lay in the floor of my office for a bit and take deep breaths. I felt great relief when my premium check cleared the bank. Even if I didn't have cards, I was insured, right?

So February 1st rolled around and I tried again to call Scott & White. This time after three 90 minute aborted attempts an agent answered (be still my heart). She informed me, after reviewing my policy, that my cards have not arrived in the mail because my policy **THE POLICY had started Feb 1st but then ended Feb 2nd.** Scott & White insured me for exactly one day. Essentially, despite the fact that I signed up for it, they approved it, and I paid for it, I had no insurance. She created a "ticket" (Why do I get a ticket when they do something wrong?) for me and told me to give it a couple of days and to advise my agent of the issue so they could correct it on their end --if possible. That she could correct it on her end, only if was *their* error (and she wasn't saying if it was). So whose error was it, if not theirs? I wondered.

I called my agent and he assured me nothing was amiss on his end. So then I tried to call Scott & White back the next day to see if they'd fixed the problem, only to discover I could no longer reach them by phone—at all. The phone lines produced a rapid busy signal, or simply dropped the calls after a few rings. So I tried the single email address provided (swhpques@sw.org) and they referred me to the phone. (AHHHH!) I asked via email if there was another way to contact customer support and explained that currently it appeared they'd canceled my policy in error. Email response was that the email address I was writing to would shut down that day and no longer respond after Feb 2nd. In effect, rather than providing much needed additional ways to communicate with their clients, Scott & White chose to reduce the methods by which clients could communicate with customer support. That worried me—a lot. As I sat reading this email, I considered my position. The government had ordered me to buy a product from a company, and I now had passed the deadline by which time I must hold a policy—Scott & White must know this, so what incentive did they have to address my needs? It wasn't like I could find another policy, right? Lack of any accountability by the company to the customer surely washes all traction out from under my feet. And all unintended consequences of this would be mine including a whopping $2,000 penalty by the government for a lapsed policy.

I contacted my agent Wyatt Coleman. Wyatt said his sources at Scott & White were aware that something was *and continued to be* amiss, and they were working on the problem. **That a "significant number" of people were experiencing the same situation I faced.** That Scott & White understandably

was not prepared to handle such a large influx of clients seeking their PPO policy in such a short period of time. According to Coleman between 32K and 40K individuals from BCBS applied for insurance coverage with Scott & White in 90 days. That represents a significant number of folks, and no doubt sheer numbers have clogged the system. I asked Agent Coleman if he thought Scott & White would honor my policy. He told me as long as he had breath in his body he'd see that Scott & White honored the policy, but I continued to feel on shaky ground about the entire scenario.

After this series of unfortunate events, I reached out to the Media Relations office at Scott & White to allow them an opportunity to share what steps they planned to take to rectify the many problems customers were experiencing. They declined to offer specifics.

The following is the statement made to me by Julie Smith in Public Relations at Scott & White: "We have certainly acquired more new members than expected this enrollment period. In fact, we are experiencing record enrollment resulting in call volume that is substantially higher than anticipated. We have added Customer Advocates and increased the number of lines going into our call center. We also centralized online inquires through an enhanced messaging platform in our member portal so that we can more quickly direct each inquiry to the appropriate contact. We are working every day to make the right adjustments to better serve our members, and we thank them for bearing with us through this busy time of year."

Unintended Consequences of Government Organized Healthcare

At the time of this notice I could tell no difference in call wait times. It still remained around 90 minutes for a Scott & White customer advocate to answer a call, and calls were simply dropped. At this point my issue remained unresolved

Scott & White did not publicly offer any advice to countless people who currently do not have their insurance ID numbers, their cards, or any visible proof of insurance. In short nothing really helpful for people who, during this time, may have experienced car accidents, need cancer treatment, delivered babies or countless other things that humans encounter in their daily lives for which they need their insurance.

I can't help but feel many large healthcare corporations are slipping into a murky legal alternate universe where normal regulations and expectations no longer apply. In the interest of self-preservation, moral, legal and ethical behavior seem to fly out the window replaced by lawyering up, carefully crafting policies based on actuaries to figure out how they can avoid the more costly coverages yet still comply with what the government requires. They avoid communicating with their customers to avoid lawsuits and public scandals that might send stock tumbling at the expense of the lives of the very customers they are supposed to serve. Such behavior will likely bring about all the things they fear most! Also, government cannot legislate this away. The variables are infinite and U.S. citizens bear the brunt of all of it. They both have their money taken and lose their access to healthcare.

In many ways I feel bad for Scott & White. I WANT them to make it because we desperately need PPO policies in Texas. But failure to acknowledge a serious problem and provide customers with advice and access does not solve the problem --it makes it unimaginably worse.

We are, in reality, facing a meltdown of healthcare in this country. While U.S. News reports that the uninsured peak numbers are now declining from a max of 34.8 million (18 percent) in 2014, the resulting tradeoff of insurance benefits in exchange for issuing token policies is staggering. While you may have an insurance card, the difference in the policies is horrifically bad, getting worse, and availability of heath care is rapidly declining as well. Many doctors simply are disinclined to wade through the red tape necessary to process claims and are retiring, some are choosing to opt out of the system and practice concierge medicine charging elite clients a base fee to remain open and available only to a select few who can afford to pay. Still others are joining forces networks like Scott & White who, control both the insurance side *and* the care provider side of business. They hope that option will help them retain their profitability—and maybe they are correct in this hope. However it removes these doctors from other markets where they are badly needed, and it eliminates competition in the market place. There are fewer incentives to keep cost low for the patient.

What the Statistics Tell Us

According to the ObamaCare website the projected cost of healthcare for 2025 will be 1,207 TRILLION DOLLARS. If it goes higher, I'll have to buy a more expensive calculator because mine won't go over single digit trillions. In Nov 2015 United Health Care, the largest market insurer in the nation, announced that it would likely lose 500 million on Affordable Care Act, and they may exit the Exchange in 2017. Many others have already left and others will follow. I'm an English not a math major, but even a fifth grader can tell you, our economy cannot sustain this kind of expense. No one can. There's no such thing as free money or a free ride!!! When an individual state website costs 18 million dollars to implement, you have to ask yourself, *are we spending money wisely? Did we lose sight of the objective—to insure the uninsured? Are we spending money on the right thing, developing websites, rather than paying for healthcare?* If we are only trying to include 34.8 million people into the system, why did we break the system for 320 million to include that 34.8 million? Why didn't we just divert a half million each to those people from the money we planned to spend on *just one* of those dysfunctional website, and call it a day. And why is Obama spending 1,207 TRILLION on healthcare? That's 3.77 million per person. I don't think in my wildest dreams it will ever cost the government 3.77 million to take care of me. Do you?

Conclusion

A few days ago, at about 7 p.m. I finally did reach customer care advocate with Scott & White who called himself Dave. Dave told me my policy still reads *expired.* He agreed to escalate the issue to see if they can breathe life back into my policy. In the meantime he instructed me to see the doctor if necessary and retain all my receipts to submit once they've corrected the snafu. According to Dave, I'm not the only one experiencing these hiccups. He tells me there's a glitch in the communication system between Healthcare.gov (tell me again--how much did we pay for this site?) and Scott & White that causes the

policies to begin and terminate within 24 hours. I asked him if Scott & White intended to honor the policies, and he said he sees no reason why they would not. (Does that mean yes, or no?)

I can't help but wonder what's happening who've had car accidents, delivered babies, been caught in the middle of cancer treatment or other things during this period of rough transition at Scott & White. Will Scott & White honor all PPO policies in a timely fashion? Will they answer the phone when customers call and will they process claims quickly enough? And what will they do for the people who were in the middle of chemo, child birth, car accidents during the period when they took their money but did not issue them policies or cards? I don't know, and Julie Smith in media relations at Scott & White isn't saying.

Update

This morning I successfully logged onto Scott & White Healthcare and managed to complete my registration and print health insurance cards. My insurance has been reinstated though I have no way of knowing if I'm the norm or the exception. I also have no way of knowing at this time if my insurance lapsed and if I'll be required to pay the $2,000 penalty, or not. I've received no follow up from either my agent or from Scott & White regarding my experience. It appears I've found a log to cling to in this healthcare tsunami—for now. I hope others will be so fortunate.