Choice of healthcare insurance has limited effect on the necessary care a person will receive but drives enormous unproductive costs

Health care insurers in the United States market insurance as a consumer product offering an astounding 10,000 choices of alternative coverages. However, a person's choice of which alternative to select primarily affects who will pay for the care when it is delivered not whether or not they will receive the care they need.

Equally astounding, the cost of this enormous complexity of choice has been estimated by the National Library of Medicine as creating about $500 Billion in unproductive administrative costs and contributing to another $300 Billion in fraud and overutilization. No wonder our healthcare system is broken.

Consumer product marketing is based on market segmentation that provides a broad range of choices to people based not only on their needs but also on their wants and their ability to pay – think automobiles. Providing those choices is the purpose of market segmentation in consumer products. When you make a choice, you know what product or service you will get. Health care is very different. There is no connection between the choice of insurance you make and the specific care you will eventually need. With the exception of preventive care, routine checkups and emergency care (which together amount to a very small percentage of care delivered) people don't **want** health care unless they **need** it. There is no significant difference between need and want in healthcare. A person with appendicitis doesn't choose whether or not they need to have their appendix taken out. The physician does. Nor does the patient decide whether they want a Cadillac or beat-up old clunker version of an appendectomy. The physician does; he or she will choose the standard of care procedure. In other words, healthcare is not a consumer product.

Once a physician determines that a person has a medical need that requires hospitalization whether this occurs in a private physician's office or in an emergency facility or a neighborhood clinic they will be admitted. As an inpatient, they will receive all necessary care independent of their insurance coverage or ability to pay as required by Federal mandate. If insurance doesn't fully cover the cost, the hospital will bill the patient, attempt to collect and, in many cases, turn it over to a collection agency. If all attempts to collect fail, the hospital will write it off as a bad debt or charity care. But in all cases the care will have been delivered**.** So, an individual's choice of insurance coverage doesn't determine what care you will receive in a hospital; it only determines who will pay for it. In other words, the built-in limitations of insurance coverage (e.g. deductibles, copays, coinsurance) that drive complexity and are designed to contain unnecessary delivery of care produce little if any cost avoidance. So the delivery of care in hospitals (which accounts for about $1.1 Trillion in annual expenditures or about 50% of care delivered) is unaffected by one's choice of insurance. The real-world impact of the limitations is to kick off the collection cycle when a patient is discharged with all its attendant costs and emotional and financial stress for those who lack full coverage or are uninsured. And in the end only a fraction of these out-of-pocket charges is actually collected.

In the outpatient setting (professional services and pharmaceuticals that account for the remaining 50% of care delivered) the limitations on insurance coverage are effective in discouraging unnecessary delivery of care. However, these limitations also encourage patients short on cash to skip routine care (e.g. annual check-ups and diagnosis of early symptoms) and outpatient treatment of chronic diseases (monitoring, adhering to prescribed medications and outpatient procedures). Unfortunately, these categories of care are the most cost/effective ways of preventing and controlling the chronic diseases which account for about 90% of total healthcare expenditures. Accordingly, the denial of access to necessary care leads inevitably to higher costs and less effectiveness in preventing and treating these diseases.

In summary, the choice a person makes in selecting a specific coverage plan is hollow when it comes to access to care. It will have little effect on the care she or he will receive when hospitalized and the only effect it has on outpatient care is to deny care to those who are unwilling or unable to pay out-of- pocket costs when care is needed.