The Impact of Choice on Access to Care

by Fred Gluck

On the surface, providing a wide range of choice is a sensible way to permit individuals to select a program that offers coverage at premiums they can best afford. However, there are a number of problems with thinking about insurance this way. First, it puts primary emphasis on premium cost and deemphasizes the additional out-of-pocket costs of paying for care when it is actually delivered. Second, choice of coverage has little or no effect on an individual's access to care when hospitalized. Third, the requirements for cash outlays for outpatient care often lead to avoiding necessary routine or chronic care when an individual is short on cash at the time of need. Fourth, and perhaps most important, the total costs to our healthcare system of providing choice (which far outweigh the benefits) have been largely ignored when considering reform. None of this should be surprising because there is a poorly understood fundamental flaw in the rationale for choice.

Treating private health care insurance as a consumer product is that fundamental flaw.

The real conflict over how to proceed with healthcare reform is not between the Democrats and the Republicans or between the Liberals and the Conservatives; it's between the American people and the healthcare insurance providers.

The American people consider health care to be a basic need and want guaranteed access. A recent Reuters poll found that more than 70% of Americans support guaranteed access to health care for all Americans including a majority of Republicans.

On the other side of the conflict, the private insurance companies want to continue to treat health care as a hugely profitable cost-plus consumer marketing business with all the attendant complexity introduced by market segmentation. More specifically the only constraint the Affordable Care Act places on healthcare insurance companies is the Medical Cost Ratio that requires them to pass through a minimum of 80 to 85% of premium dollars to the providers of care. In other words, the more complex the insurance system is, the more people it takes to administer it and the more money the insurance companies make. Not surprisingly, the number of home office employees in the health insurance industry increased from approximately 300,000 people in the year 2000 to approximately 500,000 in 2017.

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. For example, in our modern society an automobile is a necessity for most adults. People need their cars. The consumer's decision of how to satisfy that need, however, can range from a beat-up 10-year-old Chevy to a Cadillac or a Lamborghini. That choice is driven not only by need but also by want and ability to pay. Providing those choices is the purpose of market segmentation in consumer products. The more you pay the better the product or service you expect to receive. Health care is very different. 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 fact, in health care there is very little difference in practice between need and want. In other words, health care 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 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) 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.

The major categories of care delivered outside the hospital setting are professional services ($694 Billion)
and prescription drugs ($333 Billion). In the outpatient setting 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 not affect 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. Total out-of-pocket spending by households for health care is about $370 Billion. Assuming the cost of care avoided is as much as 30% of that number, the total cost avoidance in the outpatient sector (effectively the total cost avoidance of the limitations on insurance coverage that constitute choice) amounts to about $110 Billion.