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Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The problem of choice: From the voluntary way to Affordable Care Act health insurance exchanges



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ARTICLE INFO

Article history:

Received 14 October 2016

Received in revised form

23 March 2017

Accepted 25 March 2017

Available online 28 March 2017

Keywords:

United States

Affordable Care Act

Risk

Insurance

Medical anthropology

Ethnography

Choice

Access to coverage

ABSTRACT

This article takes a genealogical and ethnographic approach to the problem of choice, arguing that what choice means has been reworked several times since health insurance first figured prominently in national debates about health reform. Whereas voluntary choice of doctor and hospital used to be framed as an American right, contemporary choice rhetoric includes consumer choice of insurance plan. Understanding who has deployed choice rhetoric and to what ends helps explain how offering choices has become the common sense justification for defending and preserving the exclusionary health care system in the United States. Four case studies derived from 180 enrollment observations at the Rhode Island health insurance exchange conducted from March 2014–January 2017 and interviews with enrollees show how choice is experienced in this latest iteration of health reform. The Affordable Care Act (ACA) of 2010 created new pathways to insurance coverage in the United States. Insurance exchanges were supposed to unleash the power of consumer decision-making through marketplaces where health plans compete on quality, coverage, and price. Consumers, however, contended with confusing insurance terminology and difficult to navigate websites. The ethnography shows that consumers experienced choice as confusing and overwhelming and did not feel “in charge” of their decisions. Instead, unstable employment, changes in income, existing health needs, and bureaucratic barriers shaped their “choices.”

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1. “More choice is always good”

Following the passage of the Affordable Care Act (ACA) in 2010, Rhode Island created a state run insurance exchange (or marketplace) where residents signed up for private health insurance coverage; accessed federal tax credits and cost-sharing reductions; and enrolled in the expanded Medicaid program that covered adults up to 138 percent of the federal poverty level. I participated in the state’s health exchange “expert advisory committee” from 2013 to 2015 that met regularly to offer advice to state policymakers. These meetings occurred in a heated political context with a gubernatorial election in November 2014 and criticisms of Obamacare dominating national media coverage. At one such meeting in October of 2014, on the eve of the second open enrollment season, the Director launched into a vigorous defense of the exchange. “It’s working!” She told us, “we’re bringing information to people.” She passed around materials that included new decision aids for insurance shopping.

I tried to make sense of the aid, a crowded spreadsheet with

miniscule font and dozens of technical insurance terms like: premium, copay, deductible, coinsurance, network, metal level, and HSA (health savings account). I raised my hand and asked, “Isn’t this somewhat confusing? Is there a way to simplify the information?”

Her emphatic reply was, “My position on this is that more choice is always good,” and moved on.

In her statement, the Director of the health insurance exchange described choice in moral terms, choice is good. The Director’s exhortation about the importance of choice is the point of departure for this article. Her statement is interesting, not because it seems outlandish, but because it encapsulates a widespread and taken for granted approach to thinking about choice in health care. Choice is desirable above almost anything else, the logic goes, it is what makes the American health care system distinctive and great. This article seeks to answer two questions: How did choice come to be seen as a moral good in reference to access to health coverage? And, do people actually experience their ability to choose as a moral good when they shop for coverage on insurance exchanges?

This article takes a genealogical and ethnographic approach to the problem of choice; I argue that what choice means has been reworked several times since health insurance first figured prominently in national debates about health reform. Understanding

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who has deployed choice rhetoric and to what ends helps show how differing and at times contradictory ideas about individual choice have been bundled together to create a common sense justification for why our non-universal health care system should be defended and preserved. In the second half of the article, I use ethnographic narratives from observations at the Rhode Island health insurance exchange and interviews with enrollees to show how choice is experienced in this latest iteration of health reform, that like so many previous reforms, places great emphasis on choice. The ethnography shows that consumers experience choice as confusing and overwhelming and do not feel “in charge” of their decisions. Instead, unstable employment, changes in income, existing health needs, and bureaucratic barriers shaped their “choices.”

2. Interrogating choice rhetoric

This article builds on a rich body of work in critical medical anthropology and related fields that has interrogated choice rhetoric in public service provision, usually as part of a broader critique of market-based medicine that questions whether market logics, rather than a human rights ethos, should determine the distribution of medical care (Rylko-Bauer and Farmer, 2002). Health economists have long questioned the appropriateness of viewing health care as a traditional market ruled by consumer choice. The field's founder Kenneth Arrow pointed out that consumers usually cannot predict when they will need medical services and they do not shop for health care like other commodities because of knowledge asymmetries (Krugman, 2009).

Instead of a mechanism that helps health care markets find their equilibrium, many argue that choice functions primarily as a moral good. In their influential treatise on the consumer, Gabriel and Lang argue that choice is the moral foundation and ‘core value’ upon which market reforms to public services are justified: “Choice is inextricably linked with morality, notions of right and wrong, good and evil” (2006, 26; see also Malone, 1999; Mulligan, 2014, 189–207). The problem arises when having choices is seen as a good in and of itself irrespective of the content of those choices.

Mol, (2008) examines choice as a “logic” that countervails care,

especially because it shifts responsibility when things go wrong onto the patient:

In order to make decisions actors have to consider the relevant arguments and weigh up the advantages and disadvantages of the options available. This is not easy and all but impossible if you have a fever, are in coma, or if you are shaking with fear ... What follows from your choice, for better or worse, is your responsibility. (Mol, 2008, 92)

Several other observers point out that an emphasis on choice creates a dilemma for consumers who often do not have access to the specialized health or financial information that they need to make prudent decisions (Beck, 1999; Nordgren, 2010). In the case of insurance, it is nearly impossible for consumers to make informed decisions since the most important information necessary to pick their coverage—health and financial status for the coming year—is literally in the future. (Baker and Simon, 2010).

Other critiques have focused on the gaps between the lofty promises of choice rhetoric and what actually happens when people make health related choices. Feminist anthropologists have long shown that reproductive choices are made amidst multiple, overlapping constraints (Ginsburg and Rapp, 1995; Lopez, 2008). López (2005) demonstrates how beneficiaries of the public insurance benefit for low-income people known as Medicaid are “dis-entitled,” as they are subject to opaque and unwieldy processes during enrollment and exclusions by medical clinicians when they actually try to access care (López, 2005; see also Willging, 2005). Reading these scholars together provides insight into how the notion of “choice” in public service provision operates with some dubious assumptions: choice is experienced as “good”; information is available to make prudent decisions; people are willing and able to predict the future; and beneficiaries should bare the responsibility for their decisions, no matter the cost.

3. Methodology

Most of the research on choices related to insurance exchanges has come from economists and the major health foundations that

2015 INDIVIDUAL MARKET PLAN BENEFITS

As of October 01, 2014. This is a partial summary of benefits and coverage and should not be considered a contract. This information, including all quantities, shall be subject to individual plan rules and may be subject to change without notice. We do not warrant the benefits and coverage shown here. We do not warrant the accuracy of the information about covered benefits, limitations and exclusions.

	Insurance Company	BCBSRI	BCBSRI	BCBSRI	NHPR	LHC	UHC	BCBSRI	BCBSRI	BCBSRI	NHPR	NHPR	LHC	UHC	BCBSRI	BCBSRI	BCBSRI	UHC	UHC	BCBSRI
Basic Plan Information Plan Name		Blue Cross Blue Shield of Rhode Island	Blue Cross Blue Shield of Rhode Island	Blue Cross Blue Shield of Rhode Island	Northern Rhode Island	United Healthcare	United Healthcare	United Healthcare	United Healthcare	United Healthcare	Northern Rhode Island	Northern Rhode Island	United Healthcare	United Healthcare	United Healthcare	United Healthcare	United Healthcare	United Healthcare	United Healthcare	United Healthcare
Network Type		Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type
Annual Premium (21-year-old)		\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200	\$1,200
ACA Qualified		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How You Get Your Care Network Types		Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type	Network Type
Out of Network Coverage, Non-Emergency		Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Maximum Out-of-Pocket (MOOP)		\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family	\$10,000 individual, \$18,000 Family
Deductible - Medical		Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000	Individual: \$1,000, Family: \$2,000
Deductible - Drug		Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100	Individual: \$50, Family: \$100
Primary Care		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Specialist Visit		50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Prescription Cost		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Emergency Room		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Maternity Services		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Behavioral Health		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Telemedicine		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Wellness Programs		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Network Renewal		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

Fig. 1. Decision aid. HealthSource RI, 2015.

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