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How health navigators legitimize the Affordable Care Act to the uninsured poor

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ABSTRACT

Health navigators are a new health care workforce created by the Affordable Care Act (ACA) to assist low-income minority populations with acquiring health insurance. Given the high levels of distrust among the poor toward government and the medical profession, this article asks: How do health navigators build the legitimacy necessary to persuade low-income uninsured clients to enroll in health insurance? Through ethnography of face-to-face interaction between navigators and the uninsured poor in Chicago, this study shows that successful navigators deployed a combination of cultural repertoires for building trust and legitimacy. These repertoires included ceding control of the conversation, creating ethnic solidarity, and disassociating themselves from government bureaucrats or self-serving insurance employees. These findings demonstrate the usefulness of cultural sociology for understanding health insurance provision to the poor, ACA outreach efforts, and the more general study of how occupations legitimize themselves to clients.

From website glitches to misleading media coverage, millions of uninsured Americans did not know who or what to trust when the Affordable Care Act rolled out in 2013. In anticipation of such chaos, policymakers created a new health care work force called "health navigators," who provide free "help to consumers, small businesses, and their employees as they look for health coverage options and complete enrollment forms" (Healthcare.gov 2015). The U.S. Center for Medicare and Medicaid Services (CMS) allocated $67 million to fund navigator programs in 34 states that, in total, employ 28,000 health navigators nationwide (Pollitz et al., 2014). This new bureaucracy faces a classic problem of building legitimacy in the eyes of a clientele newly eligible for health insurance (Lipsky, 1980). This work is especially challenging in low-income minority communities which have high levels of distrust toward both government bureaucrats (Levine, 2013; Soss, 1999) and the medical profession (Gamble, 1997; LaVeist et al., 2000). Using the case of health navigators, this article asks: how do bureaucrats build legitimacy with distrustful low-income clients?

The study of health navigators is a new and growing area of social science. To date, studies of health navigators have used interview or survey data to show they are helping boost enrollment rates in some states but not others (Tummers and Rocco, 2015; Sommers et al., 2015). These studies, however, provide little insight on which face-to-face strategies succeed and fail at convincing clients to enroll. To get a deeper understanding of navigator action, this study used an ethnographic approach. For five months, I trained and worked with 15 health navigators in Chicago as the ACA rolled out in late 2013, observing them in action as they interacted face-to-face with low-income uninsured adults in churches, community organizations, and health fairs. Findings show that health navigators can overcome client distrust and build legitimacy by deploying combinations of cultural repertoires. Repertoires are strategies of action for problem solving or achieving goals (Hannerz, 1969; Swidler, 1986), they are like a tool-kit navigators draw upon when interacting with clients. Navigators built legitimacy by deploying repertoires that constructed a shared interest or identity with clients, responded to challenging questions, and distinguished their work from occupations clients distrusted.

These findings have implications for the study of frontline health workers serving low-income minority populations. Studying health worker repertoires at the micro level can illuminate concrete structural factors constraining health outreach work. In the case of ACA outreach, observing health navigator repertoires revealed the damage inflicted by decades of poor people's experiences with a heavy handed and retrenched welfare state (Levine, 2013; Soss et al., 2011). Many clients initially viewed health navigators no differently than the untrustworthy and impersonal welfare

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bureaucrats they had been accustomed to facing when applying for Medicaid. Clients' negative perceptions of government, distrust of health insurance bureaucrats, and previous negative experiences with Medicaid enrollment constrained navigators' ability to build legitimacy. By observing health worker repertoires, scholars can identify concrete ways that 1) social structures impede enrollment in health programs and 2) how health care workers overcome structural barriers through deploying combinations of cultural repertoires.

1. The challenges of building legitimacy in ACA outreach

One of the central tenets in the sociological study of occupations is that professionals need legitimacy to compel trust and obedience from clients (Abbott, 1988; Starr 1982). Suchman (1995, 574) defined legitimacy as "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions." In the medical world, legitimacy is rooted in communities that have objectively validated competence. Doctors and hospitals, for example, go through extensive training and certification processes by professional associations or government bodies (Ruef and Scott, 1998; Starr 1982).

As an occupation in its infancy, health navigators do not have the same legitimacy in their interactions with the population. Although navigators undergo extensive training and certification by the state, many uninsured people have never applied for health insurance nor been made aware of what health navigators do. In low-income communities, people are most likely to first learn about health navigators when they encounter a navigator face-to-face at a health event or neighborhood organization. In these situations, clients do not take navigators' legitimacy for granted; rather, legitimacy is something navigators must achieve through interaction. Sociologists have described this as "relational work" (Zelizer, 2012), or work that professionals must do to build legitimacy with clients and conduct tasks such as diagnosing autism (Eyal, 2013) or inducing compliance with regulations (Huising 2014).

For health navigators, building legitimacy is especially challenging because low-income and minority uninsured populations have high levels of distrust toward government bureaucracy and health professionals. Prior to the ACA, many low-income uninsured people enrolled in Medicaid at public aid offices where welfare bureaucrats worked more as gatekeepers than benefit providers. For example, the low-income women in Levine's (2013, 55) study described welfare bureaucrats as "making you feel stupid" and making promises to deliver benefits only to be later told "you don't qualify for that." Similarly, Hays's (2003, 35) study found welfare case managers to be "cold and impersonal." Even worse, the public aid offices where low-income people apply for Medicaid often share client names with law enforcement agencies searching for individuals with outstanding warrants (Gustafson, 2009). In the pursuit of various public benefits, the poor have been subjected to deception, long waits, and intrusion into their private lives (Lara-Millan, 2014; Soss et al., 2011).

To complicate matters further, the African–American population still harbors mistrust toward the medical profession in the aftermath of the infamous Tuskegee syphilis study where individuals were experimented upon without their consent (Gamble, 1997; LaVeist et al., 2000). Mistrust of legitimate health professionals and medical institutions remains associated with African–Americans' unwillingness to consent to invasive medical procedures and body donation (Anteby and Hyman, 2008. Harris et al., 1996). It is in this context of pervasive distrust that navigators are attempting to build legitimacy with the uninsured poor.

This article describes cultural repertoires as a key component of the relational work health navigators must employ to build legitimacy and enroll clients in health insurance through the ACA. The concept of repertoires in cultural sociology provides a useful heuristic for identifying structural factors impeding outreach work, as well as face-to-face strategies navigators use to overcome challenges during interactions with clients. For example, navigators faced questions from clients about whether they earned commission, or whether the government was really protecting the uninsured from being denied coverage on the basis of pre-existing conditions. In response, navigators deployed a combination of repertoires such as mirroring clients' perceptions of government or distancing themselves from bureaucrats with whom clients expected to interact. Successful health navigators transformed low-income clients' perceived illegitimacy of government and health care bureaucrats into a tool from which to build legitimacy. Studying such relational work provides a clearer picture of the cultural and structural forces shaping ACA outreach and, more generally, the processes whereby members of occupations build legitimacy with clients.

2. Fieldwork methodology

From September 2013 to January of 2014, I observed 25 interactions between low-income uninsured individuals between the ages of 21–35 and health navigators in four neighborhoods of Chicago (Humboldt Park, North Lawndale, Little Village, and Logan Square). While I use real neighborhood names, I use pseudonyms to hide the identities of the individuals and organizations in this study. Informed consent was obtained verbally and with the approval of the institutional review board at Harvard University. I observed face-to-face interactions through two data collection strategies: shadowing navigators and shadowing uninsured respondents.

First, in the process of shadowing and observing 10 health navigators, I observed and audio-recorded 10 face-to-face interactions with clients. To recruit navigators, I volunteered and underwent training to become a certified health navigator in Illinois. Through attending the multiple training sessions, I built relationships with 10 health navigators working in these four west side Chicago neighborhoods. This provided me access to outreach events at churches, parks, community organizations, and clinics. Second, as part of a larger study of the ACA, I recruited and interviewed 45 individual low-income uninsured people. Recruitment occurred at fast food restaurants, church services, art galleries, and coffee shops, where I introduced myself as a researcher and offered $25 to respondents to participate in an interview about their thoughts on the ACA. By shadowing 15 uninsured interviewees who sought to enroll, I observed and audio recorded an additional 15 face-to-face interactions with health navigators. For this article, I only use data from ethnographic observations because interviews with uninsured respondents were conducted prior to enrollment efforts and, thus, provided little insight on the ethnographic observations. To conduct the ethnography, I carried a digital recorder to fully capture the audio of the interactions observed. At all times, I carried a notepad to write down observations and important body language cues during interactions.

The sample of uninsured clients consisted of 8 whites, 10 Hispanics, and 7 African Americans. I included racial variation to collect a sample resembling the more general uninsured population. In both Cook County and the nation, blacks and Hispanics make up nearly 40% of the population, but account for over half of the total uninsured population (Kaiser Family Foundation, 2014). My sample of health navigators consisted of 4 whites, 13 Hispanics, and 8 African Americans. All navigators were employees of

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